TRIPLE HELIX

Winter 2003

For today's Christian doctor

MEDICAL MISSION

WHAT'S THE FUTURE?

SEX LOTTERY

CONDOMS

ABORTION AND BREAST CANCER

LITIGATION

LATE TERMINATION

POSTING RICE PUDDING

THE PEARL EFFECT

OVERSEAS OPPORTUNITIES

ISSN 1460-2253

Triple Helix is the quarterly journal of the
Christian Medical Fellowship
157 Waterloo Road
London SE1 8XN

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Website www.cmf.org.uk

A registered charity no 1039823

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

For special offers see the coupon enclosed.
Enquiries: Tel 020 8559 1180 (Monday-Friday, 9am-5pm).

Contributions
The editor welcomes original contributions which have both a Christian and medical content. Advice for preparation is available on request.

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EDITORIALS

The consultants' contract

Family friendly first

Many people will find it hard to understand why hospital consultants in England and Wales should have rejected a deal promising a 20% rise in starting salary to new consultants and pay rises of 9 to 24% across the board. But the reality is that most doctors do not go into medicine for the money. Whilst no one would deny that consultants are generally on comfortable incomes, they do earn less than many equivalently qualified professionals in the private sector. Most doctors are motivated far more by the knowledge that they are doing high quality work. The government seems not to understand this.

It was unfair and disingenuous of health ministers to imply that consultants had rejected the contract because they were uncommitted to bringing down waiting lists and wanted to earn more money in private practice. Whilst this is undoubtedly true of some, the majority of consultants already work more hours for the NHS than they are paid, and the new contract would have disrupted team functioning and taken more evening and weekend family time from those who already have considerable out of hours work commitments, without necessarily delivering better patient care.

The contract considered up to 10pm at night during the week and up to 1pm on Saturdays and Sundays as normal working hours to be remunerated at normal rates of pay and many consultants were freshly concerned by a leaked NHS document to hospital managers urging them to push ahead with weekend and evening work and to only pay extra to the 'deserving few'. They feared that they would become the pawns of policies aimed more at fulfilling political targets than properly prioritised patient care.

The really urgent need is still for more consultants, and attempts to shift blame onto the medical profession when the reality is that the health service in this country remains amongst the most poorly resourced in Europe, will only succeed in fuelling more feeling that government and health managers are out of touch with realities at the coalface.

Britain has one of best-trained and committed hospital consultant work forces in the world. It would be a great tragedy if a heavy-handed approach by government led to an exodus of top consultants from the NHS. It would then be those least able to pay for good quality healthcare that would miss out. The government will make far more headway in negotiations if it seeks to listen to doctors and understand their concerns.

Christian doctors especially need to work hard at better communication with government and managers, and push for a contract that is more family-friendly and conducive to good patient care.

The sex lottery

More condomania

'Don't play the sex lottery. Use a condom' is the slogan driving the government's new £4 million 'safe sex' campaign to try to curb the rising trend of sexually transmitted diseases, up 61% in England, Wales and Northern Ireland since 1991. The www.playingsafely.co.uk website's brave claim that 'only condoms provide "all-in-one" protection against pregnancy and sexually transmitted infections' swamps the smaller print several mouse clicks removed which only weakly advises that condoms do not protect adequately against three of the most common STIs: Herpes, HPV and Chlamydia.

Web surfers are advised to 'play the lottery' to see if they might have certain diseases by 'scratching' over photographs, and a 'hide this site' button is provided, presumably to enable a quick cyber-exit if mum or dad should make a surprise appearance.

With failure rates for condom users running at one in seven per year (see *Triple Helix* 2002; Summer:10-11), those who follow the government's advice on avoiding STIs may find themselves playing not the lottery, but Russian roulette.

Egg freezing

A step in the right direction

Helen Perry, a Jehovah's Witness from Shropshire, has become the first woman in Britain to have a baby using a frozen egg, due to a new anti-freeze method that increases egg survival rates. Over 100 babies have now been born from frozen eggs worldwide, and new results presented on 15 October 2002 by the Florida Institute of Reproductive Medicine, at the Seattle conference of the American Society for Reproductive Medicine, could overturn conventional wisdom about egg freezing being too risky or complicated. Pregnancy rates of 47% were close to the 58% achieved using fresh eggs.

Although the study size was small (only 14 births thus far), if duplicated in larger trials and confirmed to be safe, the new technology will be good news for women undergoing cancer treatments that put fertility at risk; and could significantly raise reproductive chances after chemotherapy or radiotherapy. It may also save women with tubal infertility having to undergo repeated egg-harvesting procedures.

From an ethical point of view it is also far preferable to other fertility techniques involving egg donation or embryo freezing. Embryos are human beings worthy of the utmost respect. Eggs are not; and provided the technology doesn't lead to a higher rate of congenital abnormalities as embryo freezing has, it will be a good advance. If you can freeze eggs there seems little reason to freeze embryos.

But like all new technologies there is potential for abuse. It should be reserved for those with genuine medical reasons for being unable to have children; and not misused by those who wish to postpone childbearing in their own, rather than their children's, interests.

This new advance is a step back in the right direction but it does not go far enough. A review the HFE Act in the light of recent high-profile fertility treatment fiascos is long overdue.

Peter Saunders is Managing Editor of Triple Helix

Greg Gardner probes a ticking time bomb

Photo: Welcome Trust

ABORTION AND BREAST CANCER

Is there a link?

KEY POINTS

Breast cancer is the leading cause of death in Western women aged 30-50 and the incidence has increased 40% coincident with the widespread availability of abortion. It makes sense biologically that abortion could increase the risk for breast cancer both by abolishing the protective effect of a first full term pregnancy and by increasing oestrogen exposure. The majority of studies published since 1957 do in fact show a clear association; but there is also clear evidence of attempts to cover this up through ignoring, concealing or misclassifying incriminating data. The truth should be told and those responsible should be held to account.

If a scientist discovered a risk factor that increases the chance of breast cancer by 30%, you'd have thought it would have spurred huge headlines and impassioned demands for action. With the exception of AIDS, no other health issue has been as politicised as breast cancer. Yet as scientists zero in on what one called the single most avoidable risk factor for breast cancer, barely a peep has been heard for more research, more funds or more information. That's because the risk is abortion.[1] *(D Byrne)*

The theory

For several decades now, the incidence of breast cancer in the Western World has been increasing. The lifetime risk of breast cancer in women is now around twelve percent. There are several possible explanations in the literature but one in particular is a recurring theme: the connection between abortion and breast cancer.

Finding a link between abortion and breast cancer is of limited significance if there is no plausible biological explanation. A 1980 study looked at the effects of a known carcinogen on rats of differing parity.[2] Rats allowed to become pregnant and go to term before exposure to the carcinogen had a mammary carcinoma rate of six percent. The rates in virgin rats and rats with induced abortions were 68% and 78% respectively.

The authors suggested that abortion can increase the risk of breast cancer in two ways: firstly by abolishing the protective effect of a first full term pregnancy and secondly by superimposing its own independent risk. This second proposed factor is related to oestrogen exposure: oestrogen promotes both normal and abnormal breast tissue growth and has a specific effect on undifferentiated breast tissue. It is the undifferentiated cells that are particularly vulnerable to malignant change later in life. Early pregnancy is characterised by high mitotic activity and proliferation within the breast. A woman who goes through several weeks of a normal pregnancy and then has an abortion is left with more potentially malignant cells. In contrast, the well-known risk reduction of a full term pregnancy results from differentiation and fewer potentially malignant cells. By eight weeks gestation, oestrogen concentration is typically six times higher than at conception. In contrast, first trimester miscarriages usually do not generate oestradiol in quantities greater than the non-pregnant state.[3]

The data

The earliest study linking induced abortion with later development of breast cancer was published in Japan in 1957.[4] Women who had had abortions carried a 2.6 relative or 160% increased risk compared with women who had not had abortions. In addition, this study did not find any association between miscarriage and breast cancer. Generally, this has been confirmed in numerous studies since. A 1981 Californian study concluded that, in the absence of a full-term pregnancy, young women were 2.4 times more likely to develop breast cancer if they had had an abortion.[5] A 1989 prospective study showed a 90% increased risk.[6] An alarming 1994 paper compared approximately 900 breast cancer patients against a control group.[7] In women with no relevant family history there was a relative risk of breast cancer after abortion of 1.4; those with a positive family history had risks of 1.8. A small subgroup of women with first abortions below the age of 18 and a positive family history had incalculably high risks: every one of these women developed breast cancer by the age of 45.

By 1996 there were 23 studies, 18 of them showing increased risk. A meta-analysis revealed at least 30%

increased risk of breast cancer after abortion over and above loss of the protective effect of first full term pregnancy.[8] In the UK Patrick Carroll of the Pension and Population Research Institute published a major analysis of our own data.[9] Using figures from the Office of National Statistics he discovered a high positive correlation (0.84) between cumulated breast cancer incidence and cumulated abortion rates in women aged 45-49. Projection of the trends of increased breast cancer incidence to the year 2023 suggests a 60 percent increase in this age group. The total number of cases in women of all ages is expected to more than double to around 77,000 per year.

The Cover Up

There has been a reluctance to inform the public about the ABC (Abortion Breast Cancer) link. Some of the more egregious examples include the following:

Claims are made despite the absence of data

A 1982 paper concluded, 'The results are entirely reassuring'[10] However, a closer look at the results section shows that their data included 'only a handful' of women who had had an abortion; a figure is not given, therefore no valid calculation can be made. Furthermore, figures for abortion and miscarriage were combined, masking any hope of finding the answer. These results were not 'entirely reassuring': they were completely irrelevant.

Data is deliberately concealed

An Australian study looked at risk factors, including abortion, for breast cancer but failed to report on the abortion factor.[11] The data only came to light in another small 1995 meta-analysis by a French group; they looked at the Australian figures and calculated a 160% increased risk of breast cancer after abortion.[12] In fact abortion was the strongest risk factor but the original researchers had concealed their findings. 'It was the strongest risk factor they found. It was the only one that was clearly statistically significant. And this you don't do. This is not what you see in scientific research, ever. I've never seen it before, where the most significant finding in a study is specifically left out of a research paper...and we hypothesise that there is more of it.'[13]

The response bias theory

In an accompanying editorial to Daling's 1994 study, an official of The National Cancer Institute tried to explain away the 50% increased risk as response bias.[14] This is a theory that women who had abortions and later develop breast cancer are more likely to admit to their abortion than women who had abortions and don't develop breast cancer. In 1991 Swedish researchers first suggested it as seven women who had reported abortions weren't on the national computerised abortion registry and were therefore thought to be making it up.[15] In 1998 they finally admitted that this registry is incomplete but the response bias theory is still used as a way of 'explaining' research that suggests the ABC link.[16,17] Abortion is associated with significant amounts of denial so it seems at least equally plausible that women who develop breast cancer could be more likely to deny their abortions. Whatever this theory's merits, Daling's researchers had tested specifically for response bias and found no evidence of it.

Data misclassification

A 1997 Danish record linkage study claimed to show no evidence of increased risk.[18] It contains a catalogue of errors. The researchers counted abortions from 1973 when the law was liberalised and a computerised registry begun; however, Danish abortions had been hand recorded since 1940. Using data on the median age of abortion, it was possible to calculate an exclusion of around 60,000 women who had had abortions but were not included in the study. Another major error includes logging breast cancer cases from 1968 but abortions since only 1973. This breaks one of the most basic rules of epidemiological research: exposure must precede outcome.[19,20]

Conclusion

If the lifetime risk of breast cancer is close to twelve percent and abortion introduces an extra 30% risk, this 1.3 relative risk increase means a four percent increased risk in absolute terms. Using the figure of a 25% mortality rate from breast cancer, this works out as at least one extra breast cancer death per 100 abortions or 1,000 deaths per 100,000 abortions. As there are 190,000 UK abortions each year, there will be roughly 1,900 extra breast cancer deaths over the course of a lifetime for each yearly cohort of aborted women.

- Breast cancer is the leading cause of death in women aged 30-50 in Europe and North America.
- Abortion is the commonest surgical procedure performed on women.
- 28 out of 37 studies published since 1957 show an association between abortion and breast cancer.
- There is a plausible biological explanation.
- Breast cancer rates are up by 40% since the 1970s.
- Abortion is a preventable risk factor.

It is no longer possible to argue that abortion is safe: abortion providers and their apologists should be held to account.[21]

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A fuller version of this article appears at medethics-alliance.org The author invites correspondence at g.gardner@euphony.net

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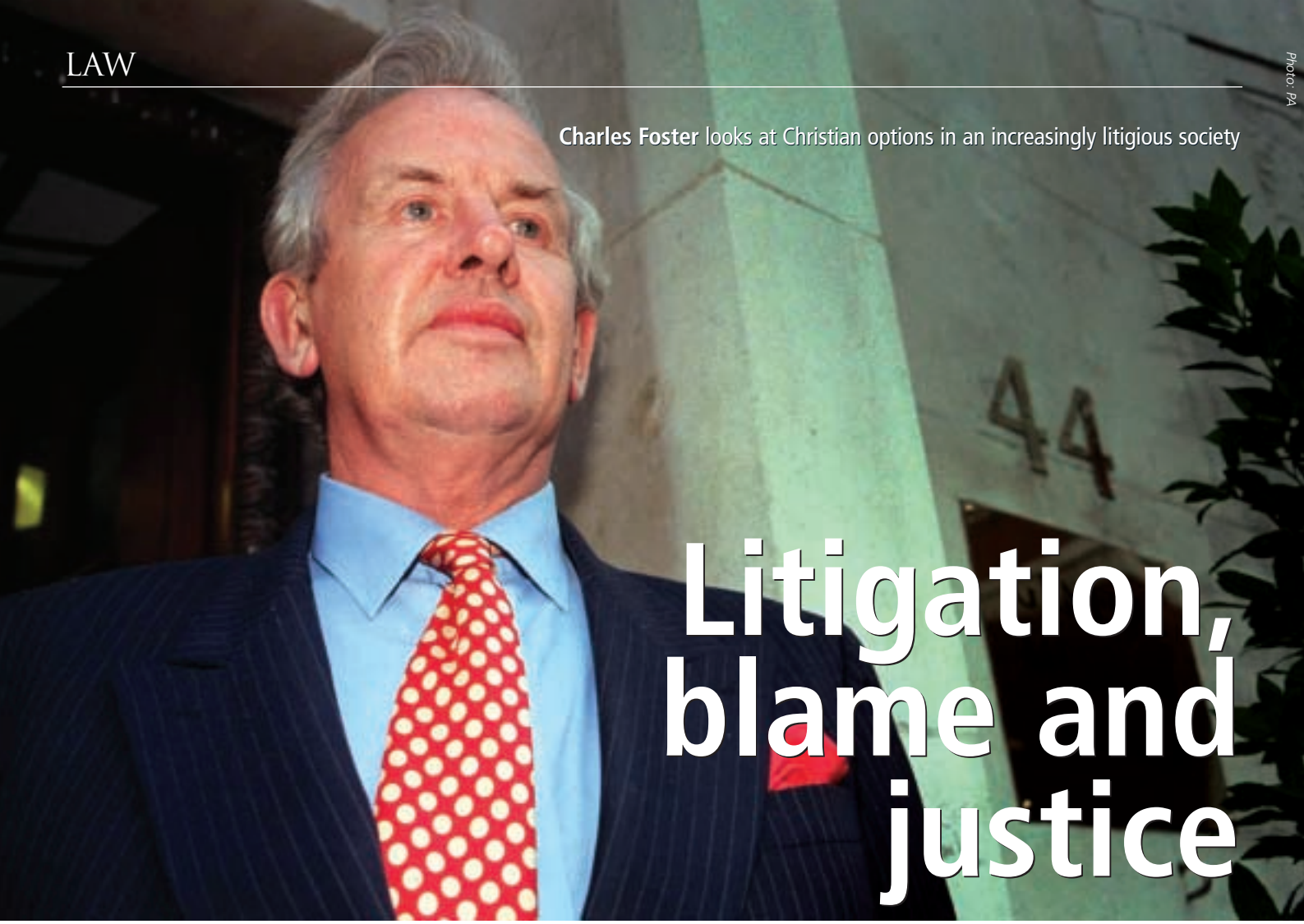
Photo: PA

Charles Foster looks at Christian options in an increasingly litigious society

Litigation, blame and justice

Everything, including intangibles like pain and inconvenience, is presumed to have a price tag

Above: Leading gynaecologist Rodney Ledward, 58, outside the General Medical Council in London, after he was struck off the medical register, for a seven-year catalogue of surgical blunders.

In 2001 the net value of known and anticipated clinical negligence claims within the NHS was £4.4 billion, almost doubled from £2.3 billion in 1998.[1] In England, the NHS received around 10,000 new claims in 1999-2000. The rate of new claims judged against the number of 'finished consultant episodes' rose by 72% between 1990 and 1998.[2] The same document notes that cerebral palsy and brain damage cases account for 80% of outstanding cases by value. These figures do not include claims against general practitioners or clinicians in private practice.[3]

Clinical negligence litigation is big business and many lawyers grow rich on doctors' mistakes. This state of affairs is bad for everyone except lawyers. As well as having been injured in a medical accident, claimants will often have to wait years for compensation, frequently putting their lives on hold until it is over. Some bereaved relatives cannot start grieving properly until the case is over. Litigation itself is time consuming and stressful. The English adversarial process raises emotional temperatures. It turns colleagues, patients and formerly trusted medical advisers into opponents. The clinicians involved are often traumatised and professionally damaged.

Litigation promotes expensive defensive medicine. Few professionals perform best when they think that someone might be looking critically over their shoulder. As clinicians try to cover their own backs, patients are sometimes subjected to unnecessary investigations or unnecessarily distressing and explicit explanations. Trust, formerly the basis of the doctor-patient relationship, is a casualty. Money, better spent on patient care, goes to barristers, solicitors and expert witnesses.

How it was

It wasn't always like this. Doctors used to be regarded as all-knowing and beyond contradiction. Anything that fell from the lips of a man in a white coat who had stumbled through basic medical exams and avoided censure by the GMC was regarded as indisputable. A patient injured through medical incompetence would limp out of the hospital and buy the doctor a bottle of whisky to help him get over the trauma of a bad result. He would shrug off his own misfortune, thinking that he was lucky to have had any medical attention at all and saying, 'These things happen'. It would never occur to him to question his doctor's version of events or competence, let alone instruct solicitors to sue.

Why the change?

Why such a radical change? Many reasons have been suggested and some are considered below.

Is more compensation needed now?

No. If anything, less compensation is needed now because the NHS meets many more medical and nursing needs. In addition, there is more state

Photo: PA

Left: Diana Hill and son James Parker lay floral tributes outside the General Medical Council where three doctors at the centre of the Bristol heart surgery scandal were found guilty of serious professional misconduct.

Below: Maralyn and Alvin Adey, parents of Kristian Adey, a 15-year old boy with Down's Syndrome, lost their legal action against Leeds Health Authority and the NHS Litigation Authority. They claimed hospital consultants were negligent in failing to advise them that Kristian needed surgery when he was a baby to treat a congenital heart defect.

Photo: PA

and charitable funding of the financial consequences of disability.

Are we following the USA?

As in so many areas of life, are we in fact aping the USA? Can it be that we find everything about US culture so irresistibly attractive that we swallow the lot, always arriving at their conclusions ten years after them? This seems unlikely. To say that we are just getting like the US explains nothing: it simply pushes the question one stage back and forces us to ask, 'Why is the US like that?'

Is a new crusading instinct responsible?

Are we more concerned about basic injustices, wanting to put things right so that others don't suffer later? Do we have a new or revived instinct to make things right? It seems unlikely that we are suddenly more morally aware or altruistic creatures than we were. It is more probable that we are less religiously reverential of doctors, just as we are less religiously reverential of almost everything and more aware of our right to sue. Today, more lawyers are prepared to do clinical negligence work, previous difficulties about the funding of actions can be overcome and doctors are less coy about breaking ranks and criticising their professional colleagues.

Are we greedier than we were?

Certainly, financial expectations are higher than they were. Materialism has had a further by-product: everything, including intangibles like pain and inconvenience, is presumed to have a price tag.

Does bad luck no longer exist?

Increasingly, there is a tendency to believe that we are masters of our own destinies. Although individual doctors are fallible, properly practised medicine is seen as being omnipotent. There seems little room in the modern mind for bad luck, fate or the 'will of God'.

Christians and litigation

God recognises that laws are necessary in societies although he is distinctly dubious about the power of law to produce moral behaviour.[4] God gave man stewardship responsibilities over the world.[5] He appoints the rulers of societies: in some sense, their authority is his.[6] The Old Testament is full of elaborate rules of criminal and civil law.[7] However, Jesus does urge his followers to steer clear of the court: although not denying the need for a justice system, counter-productive acrimony and legal expenses can result.[8] Lord Woolf expressed similar concerns, recently railing against the sloth, complexity and expense of legal proceedings. As Jesus did, he urged the use of Alternative Dispute Resolution.[9,10]

It is often not sufficiently understood that our legal system is based on fault. Only if a claimant proves that there was negligence is he entitled to compensation. This can lead to some apparently unfair results. For example: two children, A and B, suffer identical obstetric brain injuries. Child A can prove that his injury was as a result of failure to do a Caesarean section. Child B cannot. In terms of cost of care, their needs are colossal and identical. Child A will get an award running to millions of pounds and his life will be correspondingly easier. Child B will get nothing and will have to make do with less care.

These examples can make would-be litigants search around for fault where fault is not easily found. They have grounded calls for no-fault liability schemes, by which Child A and Child B would both get what they needed from some very expensive, state-operated insurance fund. There are such schemes in various jurisdictions, the one in New Zealand being the most discussed. They give injured people what they need and avoid the need to point accusatory fingers at clinicians who were generally acting in good faith and simply made an honest mistake. Christians may applaud such schemes for precisely those reasons. However, it would be a mistake to conclude that a system of litigation that gives a remedy in some cases is wrong because it does not give an answer in all.

What doctors should think

The practice of medicine is the exercise of a stewardship responsibility. All that the English law says is that if you choose to exercise a responsibility, you must do it properly. There is nothing offensive to Christians in that idea. If something goes wrong, the law tries, insofar as money can do it, to put the victim back into the position in which he would have been in had the job been done properly. Again, there is nothing offensive about that. Damages for the intangible elements of a civil claim (what lawyers call damages for 'pain, suffering and loss of amenity') are notoriously small. Nobody in England launches a civil action to get rich. A judge should rigorously stick to the rule that damages must do no more and no less than compensate. Part of the civil litigation problem in the USA is that damages are not assessed scientifically but by juries who tend to assess damages by multiplying their cat's birthday by their orthodontist's phone number and adding the National Debt. This makes

KEY POINTS

The recent escalation in negligence claims reflects changes in patients' expectations, doctors' status, media publicity and the availability of lawyers. Litigation can promote expensive defensive medicine, damage relationships and yet still fail to satisfy aggrieved patients. But whilst there are morally bad reasons for litigating (avarice, revenge and self-vindication) just compensation for breach of duty is a biblical principle and money, although it cannot restore lost function, can be a tremendous help in living with the consequences of medical misadventure. Honest explanations and apologies may mean that litigation can be avoided, avoiding the acrimony and legal expenses of the courts.

Below: Helen Rickard holds the hand of Sam Shortis (12), as bereaved families held a minute's silence outside the General Medical Council, where three doctors at the centre of the Bristol heart surgery scandal were found guilty of serious professional misconduct.The GMC ruled heart surgeon James Wisheart and Dr John Roylance, former chief executive of the United Bristol Healthcare NHS Trust, should be struck off the medical register. A second heart surgeon Janardan Dhasmana was banned from carrying out heart surgery on children for three years.

Photo: PA

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American litigation a lottery that is worthwhile spending a lot of money to enter. It makes avarice a reason for entering it. So, as long as damages are compensatory, such civil actions are surely all right.

Of course it is true that lots of people litigate for the wrong reasons. Many actions are launched for revenge, explanations or apologies rather than compensation. Some actions would not have been launched if the doctors involved had sat down with patients and families, explained and, if necessary, apologised. Often it is true that the law will seem to be unfairly overcompensating patients, for instance by awarding patients damages to cover the cost of private treatment when the patient will have the necessary treatment free on the NHS. Still, the basic principle is sound: a breach of duty that has caused damage deserves compensation.

What patients should think

It is wrong to think that everything must be somebody's fault. Human beings are immensely complex organisms. Biology is unpredictable. Not everything that goes wrong with our bodies can be repaired perfectly and not every bad result is a consequence of somebody's mistake. Medical science has made huge strides over the last few decades and the lay understanding can be that there is nothing that it cannot do. That is simply not the case. Doctors have become the victims of the unrealistic expectations that their own success has generated.

There is an increased tendency to talk in terms of 'rights'. Christians will be wary of this; Christian morality expresses itself in terms of willingly shouldered obligations to others. The parable of the Good Samaritan says nothing about the right of the Jew to be looked after: it is all about the obligation that the Samaritan felt.[11] So, Christians will be slow to assert that they have a right to anything. Still, sometimes it will be necessary to insist on reparation. We live in a world in which money is necessary. If a negligent act has deprived a patient of his ability to work, then there is nothing impressively spiritual about battling on in poverty where a claim against the negligent doctor would help. Sometimes there may be a positive moral duty to sue. A simple example is the case of a child who has suffered a brain injury at birth because of obstetric negligence. The child will need expensive expert care for his whole life. Money would make his/her life a great deal easier. It could well be argued that the mother's duty to her child demands that she bring legal proceedings in the child's name.

Of course, as mentioned above, there are some very bad reasons for litigating. Some are morally bad: avarice, revenge and vindication of one's own ideas. Others are just an unwise use of the process of litigation. If an explanation is sought, there are now various ways of obtaining one. Litigation often obfuscates rather than clarifies. If one is concerned that no one else should suffer in a similar way, there are better ways than litigation, one example being the NHS complaints procedure.

Photo: PA

Above: Jayne Elliot with her sons Andrew (hugging) and Sean (left) outside the General Medical Council, where three doctors at the centre of the Bristol heart surgery scandal were found guilty of serious professional misconduct.

THERE IS NOTHING INTRINSICALLY WRONG WITH THE IDEA OF LITIGATING TO OBTAIN JUST COMPENSATION... BUT CHRISTIANS WILL BE KEEN TO ENCOURAGE ALTERNATIVES TO THE ACRIMONIOUS ADVERSARIAL SYSTEM OF RESOLVING DISPUTES.

Conclusion

In a fallen world, professionals make mistakes; sometimes these cause damage that money can help to repair or mitigate. There is nothing intrinsically wrong with the idea of litigating to obtain just compensation, although the process of litigation can damage the individuals involved and the values and finances of the society in which it takes place. Claimants need to watch carefully their own motives for litigating. Defendants need to be sympathetic in realising what claimants' real agendas are, and should be quick to explain, apologise if necessary, and, where it is just, pay. Clinicians should be wary of the tendency towards defensive medicine and should strive to maintain trust in the beleaguered doctor-patient relationship. Christians will be keen to encourage alternatives to the acrimonious adversarial system of resolving disputes.

Charles Foster is a Barrister in London

Jacky Engel investigates two cases of late abortion for congenital abnormality

Late termination

Two stories about late termination of pregnancy for fetal abnormality have recently hit the headlines. In the first, a Cambridge student made an allegation of unlawful killing after discovering, in the official national statistics, a case of abortion after 24 weeks for cleft lip and palate.[1,2] The police will have to trace the identity of the mother and doctor in order to pursue the complaint. The second incident, at the Royal Victoria Infirmary in Newcastle, involved a 19 year old woman in her 35th week of pregnancy carrying twins, one of which was diagnosed with a serious heart defect.[3] A fetal cardiologist had recommended selective termination, by intra-cardiac potassium chloride infusion. However, other specialists were opposed to the procedure since the heart defect was operable, with an 85% chance of survival and normal development. The mother decided against the termination when she saw a second cardiologist who gave more accurate information about prognosis.

The 1967 Abortion Act currently sets an upper gestational limit of 24 weeks (on the grounds of viability), beyond which specific criteria must be fulfilled for an abortion to be legal. One of these is fetal handicap (ground E on the abortion certificate), described as '…a substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped.'[4] Practically all late terminations are carried out on this basis.

The statute does not define 'substantial risk' and 'serious handicap', and it is left to the medical practitioner to form a judgement 'in good faith'. The Royal College of Obstetricians and Gynaecologists (RCOG) has the responsibility of advising doctors on this matter. In their 1996 guidance they make the enigmatic statement, '…a risk may be substantial without satisfying the test of being more likely than not; equally the risk must be more than a mere possibility'.[5] They go on to highlight the importance of a positive antenatal diagnosis, so as to reduce the risk of aborting a normal fetus. 'Serious handicap' is defined according to the World Health Organisation's scale of severity of disability at point 3 or higher: '*Assisted performance*. Includes the need for a helping hand (ie. the individual can perform the activity or sustain the behaviour, whether augmented by aids or not, only with some assistance from another person.)'

The guidance also says that 'further factors' should be considered in making a diagnosis, including 'the probability of effective treatment, either *in utero* or after birth'. The cases cited at the beginning of this article clearly fall outside this definition, as effective treatment was available for both. Following this they would not require a 'helping hand' beyond that needed by any normal infant. The response of an RCOG spokeswoman to the cleft palate case was to affirm the doctor's discretion in deciding what is considered a serious handicap. One may wonder why the college issues guidelines at all if it has no intention to uphold them. The case could be very interesting if it gets to court.

The national statistics (for England and Wales) for the last three years show that these are not isolated cases. Abortions for fetal abnormality in 1999, 2000 and 2001 respectively were 1,859, 1,883 and 1,762.[6] Of these, 6.4% were late terminations (this number may actually be higher, since the Office for National Statistics fail to include 24 weeks and 0 days in a large proportion of their figures for late termination). The time limit of 24 weeks is, of course, irrelevant to those who object to these abortions on the grounds of eugenics or discrimination against disability. Should gestation really make a difference?

Abortions in England and Wales for residents and non-residents, 1999 – 2001[6]

Ground E abortions	**1999**	**2000**	**2001**
Any gestation	1,859	1,883	1,762
20-23 weeks (incl 24 wks 0 days)	537	564	496
>24 weeks	114	121	118
Principle medical condition (24wk+ - a selection)			
Anencephaly	3	3	2
Spina bifida	15	9	9
Cardiovascular system	11	8	16
Cleft lip and palate	0	0	1
Musculoskeletal system	3	4	7
Down's syndrome	5	8	15
Edward's syndrome	5	5	9

In a 1998 report,[7] the RCOG ethics committee argue, for reasons of 'consistency', that fetuses who would not be treated aggressively in a neonatal unit (if delivered at the same gestation) can be justifiably aborted. However, the same logic could be used to say that fetuses who *would* be treated aggressively in a neonatal unit *should not* be aborted. But this is not present practice. The RCOG is also assuming that 'killing' and 'letting die' are ethically equivalent acts in all circumstances. They are not.

With over 180,000 abortions a year in England and Wales, it is not surprising that many see abortion as a woman's right and a doctor's duty. But there is something about late termination for treatable abnormality that disturbs even hardened 'prochoice' activists. The RCOG guidelines imply that late termination should not be carried out for treatable abnormalities, or in circumstances where a baby, if born, would be given treatment. However, the RCOG does not appear to feel bound by its recommendations. In a medical climate that increasingly aims at consistency across treatment services, it seems unlikely that such decisions can be left solely to the practitioner's discretion for much longer. The meanings of 'substantial risk' and 'serious handicap' in ground E have not yet been tested in court, but it may not be long before they are.

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David and Maryann Lovatt and their Down's syndrome four-year-old daughter Louise, from Springfield, Chelmsford, Essex, in London, where TV weather girl Sian Lloyd launched a £21 million appeal to raise funds to help families cope with mentally disabled relatives.

The pearl effect

Janet Goodall argues that disabled children bring secret and special gifts

KEY POINTS

In a culture that views success and failure in materialistic terms, many perceive disabled children as an extra burden. But paradoxically, divorce rates and unhappiness are no more common in the families of disabled children than in those with healthy children. Like the grit in the oyster that causes a pearl to form, caring for a child with special needs often strengthens relational bonds and encourages spiritual growth. As the agony of Gethsemane led to resurrection life, so the reciprocal love between the disabled child and his parents and the care shown by professionals, families and churches can act as a catalyst for maturity and stability.

Twenty years after a paediatrician broke the news that her disabled baby would not survive, a mother spoke about how she had been introduced to the hospital chaplain. 'We'd not been religious before but my husband and I both became Christians and so did thirteen members of our family. Now I arrange Christian teaching for over 100 women in the city, and it all stems from the short life of our baby girl.' Like grit in the oyster, something uniquely painful had become productive.

This story encourages a more perceptive approach to disability, all the more urgent in a culture that measures success and failure in materialistic terms. Expectations change along with attitudes. Years ago, badly disabled babies were kept in hospital and parental visits discouraged. Sharing a painful diagnosis with families could be deliberately delayed. I know of two parents who waited months to be told bluntly that their child was a 'mongol'; asked to use a different expression, the doctor heartlessly replied, 'You can say "idiot" if you'd rather'. Today, although one in 50 newborn babies have a significant defect, the best units will keep parents sensitively informed and encourage early interaction with their infants.[1] Even so, parents can have a sense of shocked inadequacy, their baby sometimes being viewed as substandard. There is an occasional suspicion that health funds will go to more rewarding conditions.[2]

Professional dichotomy

For some sick newborn babies, battle is waged with all possible technological armory. For others there can be a temptation to hasten the end. Such fighting and fleeing are forms of denial, often shared for a time by both professionals and parents before better balance is achieved. For some infants, palliative care would be appropriate but prejudice can overlook that option.[3] Should the 'fight' become litigious or the 'flight' involve rejecting the baby, emotional progress is often thwarted. Without insight, staff-parent-child relationships can be fatally damaged and abscesses form instead of pearls.

Philosophical debate

Bioethicist Peter Singer has asserted that a normal week-old baby is a non-person and so its infanticide need not cause inquietude. His use of 'it' betrays an impersonal view of a little boy or girl who, he says, is inferior in rationality and value to many animals.[4] Denial itself is emotional, not rational, yet must under-gird this philosophy. That he would yield to parents who prefer their babies to live suggests that loving commitment can defy 'reason'. Love values what others demean.

Philosophers (and others) should know a normal infant can show preference for their mother's smell, voice and face within days of birth. Breastfeeding strengthens face-to-face attentiveness, an

ATTENTION TO THE PERSONAL NEEDS OF DISABLED PEOPLE IS NOT ONLY GOOD AND PROPER BUT CAN ALSO ENHANCE THE HIDDEN CONTRIBUTIONS THEY MAKE TO OUR COMMUNAL WELFARE

anatomical impossibility for mammals but not for disabled human babies.[5] Within weeks, interactive infants can indicate recognition of their parents, implying recall if not yet rationality.

Studies that may surprise

In a retrospective study of infants with inoperable spina bifida, parents encouraged to care for their child at home reported stronger family ties than those confined to hospital based care.[6] Involved parents appeared significantly more serene and saw themselves as wiser and better people. In these poignantly painful circumstances, agape love was given a growth spurt. Still, is this enough to keep parents of disabled children united? The marital strain they face could be said to justify early infanticide. Yet healthy children also bring problems and many childless marriages break up. A study comparing healthy school children with their mentally or physically disabled peers showed no difference in parental divorce rates, unless social deprivation had contributed both to developmental delay and family stress.[7]

Society often thinks of disabled lives as being unhappy. A study compared the mental states of both healthy and variously disabled school children. It was the older, healthy children who most significantly expressed frustration, worry or alienation. The disabled group favoured activities shared with companions; this tallies with the closer relational bonds described by the interactive parents of spina bifida babies. Whilst our culture promotes autonomy, it seems that the inter-dependence of these families acts as their cement.[8]

Research territory still to be explored

Old assumptions yield new research. Abortion, often advised for anxieties such as fetal anomaly, is now shown to risk unseen as well as unwelcome legacies.[9,10,11] As yet, few studies of disability look into less readily measurable criteria. Like our opening story, evidence for a harvest of pearls tends to be anecdotal or biographical.[12,13,14] Closer scrutiny is needed, but there are already clues to pursue.

Despite times of exasperation and bewilderment, the mother of a teenager with cerebral palsy wrote, 'The world of the handicapped is one of the most warm and loving sections of our community. We also realise that it is one of the most neglected and misunderstood but the genuine warmth and affection given by and to handicapped people is most rewarding'. Surely our fractured society needs such an asset.

The child with Down's syndrome, so dismissively labeled 'idiot', had three older sisters who all eventually entered caring professions. It would be interesting to explore a possible correlation between caring careers and a background of illness or disability within the carer's own family. Those with supposedly limited abilities may prove to be donors, not debtors, to our social services.

What about disabled people themselves? Do they wish they had never been born? Attempted suicide is common amongst healthy adolescents. Comparative figures would be interesting. Instead, many disabled people lead uniquely inspiring lives, worthy of wider recognition; for example, I know of a Christian woman, paraplegic from spina bifida and in constant pain, who maintains and visits a home for disabled children in India.

The image of God

Why, then, do some disabled families find pearls whilst others form abscesses? Personality must play a part but Paul Tournier believed that a sufferer's reaction to suffering depends more on support received than on hereditary disposition. 'Deprivations without the aid of love spell catastrophe...the decisive factor in making deprivation bear fruit is love.'[15] This is both the reciprocal love so often seen between a disabled child and his/her parents and care and support by professionals, families and church fellowships. Christians will seek to channel the love of God when breaking bad news or in looking for ongoing help for those so heavily burdened. Our God is a three-in-one deity, suggesting that part of his image in us should be our inter-relatedness. Keeping step with his Spirit will channel his costly love into many a bad situation, often helping the sufferers to commit themselves and their outcome into his hands. Then, as with the passion of our Lord, the agony of Gethsemane can lead to resurrection life. His love in action will soothe pain and form pearls.

Atheists and agnostics often cite the sufferings of disabled children as grounds for unbelief. Materialists may deny them adequate funding or even life itself. There is an urgent need to present credible evidence that attention to the personal needs of disabled people is not only good and proper but can also enhance the hidden contributions they make to our communal welfare. It is easier to count the acknowledged cost of their special needs than to value the secret and special gifts that they so often bring.

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Extracts from the 2002 Rendle Short Lecture by **Valerie Inchley**

Photo: Wellcome

Medical Mission: What's the future?

The Old Testament prophets… addressed issues of injustice, inequality, corruption, immorality, and idolatry at both personal and society levels…. In a very real sense, we are being called to assume a prophetic role.

There is an increasing amount of scholarship related to mission theology generally, but a paucity of literature related to medical mission. As Wilkinson points out, it was because medical missions arrived late on the mission scene that they have largely been excluded from theological consideration and the literature is mostly biographical.[1] Traditionally medical work has been seen as a relatively recent add-on to mission,[2] presupposing that it was not part of the original mandate. In fact, Medical Missions as we know them only came onto the scene in the 19th century, during the last of the classical eras of mission. But this is to ignore the broader dimension of medical mission that, I believe, has always been part of the ministry of God's people and the Christian church.

I believe we are now entering a new age. It may come as no surprise to hear that we are living in the midst of a major paradigm shift, which is affecting the whole of our lives – personal and professional. It may even come as a kind of relief, to help us understand why we are suffering so much stress. Our world has become a vastly different place from that in which Medical Missions were nurtured. Almost everything has been turned on its head, but in the midst of the changes there are also some exciting challenges.

In the West, secularism, with its mechanistic view of the universe, and materialism that leaves God out of account, have proved unable to answer the deepest questions of life, and so a supernatural dimension is once again being sought. Christianity is erroneously regarded as tried and found wanting. Dualism is giving way to holism. Absolutism is virtually synonymous with intolerance and the new relativism is reflected in religious pluralism, with Christianity just one among many options. Western superiority is an outdated myth. There is a new humility with regard to mistakes made by previous imperial powers, but combined with a lack of confidence to say anything definitive (even about the gospel) any longer. National boundaries keep changing and global communications have shrunk the world so that mission can no longer be defined geographically. As a result some have suggested a moratorium on missions.[3] Were they perhaps right? I submit that the answer is both 'yes' and 'no'.

'In one sense the days of the traditional medical missionaries are over,'[4] but there are still parts of the old vision that remain to be fulfilled, and it is clearly right that we do not immediately jettison all the components of the older paradigm of Medical Missions. But it is also important that we take a fresh look at this new age and see what should be the form of medical mission for the 21st century.

Old and new challenges

A new phase commits us to completing the original vision, the old work, but in new ways. There are few, if any, pioneer situations left in the old sense. But some of the new challenges in the wake of AIDS, civil war, genocide, terrorism, floods, land-mines, drought and famine require as much – if not even more – vision, initiative and professional adaptability as in the early days. In some places refugee medicine and disaster management have become the new face of third world medicine, with Christians again frequently in the forefront.

Curative care will always be needed, but its ultimate responsibility must lie in the hands of national governments, for as Tom Hale says, 'We (missionaries) don't set policy; we set an example…of compassionate medical care.'[5] But, while much of what was initiated by medical missions has, I believe rightly, already been handed over, this does not necessarily mean an end to all mission contributions. Super-specialists, particularly as tent-makers[6] seconded to government institutions, are usually still

welcome, although it is arguable that the promotion of general practice in these countries is more likely to offer greater help, in the long run, to both patients and the medical profession.

Many old diseases still remain to be controlled – leprosy lingers, TB has returned with a vengeance, and there are some new nasties. AIDS is becoming possibly the biggest single major medical problem the world has ever faced. Safe motherhood objectives were sadly not achieved by AD2000. Medicine still has a number of unsolved puzzles that need researching. In all these fields, partnership is often still welcomed. On the other hand, while many rural and urban areas remain underdeveloped, political unrest and militant anti-Christian attitudes in some lands are making community medicine increasingly difficult for expatriates. Training remains generally acceptable and may well continue to be so for some time. It is after all an on-going task with new trainees each session, and new techniques being developed each year. To pass on one's knowledge and skill, especially when it is combined with a testimony of one's faith, is still part of medical mission no matter where the training is located, or even whether it is conveyed through books.

The role of national professionals and churches

While there are new ideas and techniques that fit into the old forms, there are also two major changes discernible, both of which relate to the nationalisation of the work of medical missions. The first is the progressive hand-over to national medical professional colleagues, and the other, the increasing responsibility that national churches are assuming for various aspects of medical work. The former is an exciting sequel to the years of training invested, and the latter, an equally exciting outworking of the holistic theology of the younger churches. It is also perhaps significant that towards the end of the 20th century, the effects of the Charismatic revival began to be felt on the mission field, with a move towards the restoration of the dimension of healing prayer.

In Nepal, for example, missions are still involved in TB and leprosy work, but have extended their rehabilitation activities to those with other disabilities. Hospital-type treatment is now being taken to the districts in an extensive programme of camps. The problem of equipment maintenance has been addressed, as has quality control for laboratory services. Drug and alcohol dependence programmes are running. Para-medical disciplines like physiotherapy and speech therapy have been promoted and training courses initiated. The problem of AIDS has been considered. Professional training scholarship schemes are being promoted. National colleagues, some of whom are Christians, are increasingly assuming the leadership of programmes. Local communities and NGOs are being supported. The national church is also beginning to respond to the challenge of involvement in various kinds of medical ministry, and combining traditional evangelistic outreach with a service component.

A prophetic paradigm

On the other hand, a new paradigm implies welcoming a completely new vision, as well as working out new ways of fulfilling it. Medical mission is, and always has been, about fulfilling God's purposes for the whole person in the whole world. God's purposes remain the same but his plans for their fulfilment may be changing. The history of mission combined with a Biblical theology provides us with some essential principles, which include:

- God's view of mankind as one whole – with no false division between the physical and spiritual, his holistic pattern for mission – with evangelism and medical service fully integrated
- His equal compassion for individual patients and concern for communities, and
- The importance and value of prayer in and for healing.

Medical Missions worked by taking modern medicine alongside the gospel from one part of the world (the 'developed' western 'Christian' countries) to another (the 'underdeveloped' eastern or southern non-Christian ones) – essentially a geographical movement. Today, 'everyone agrees that…"mission" is no longer "the West reaching out to the rest".'[7] Such an approach is unfeasible, as partnership replaces paternalism, and the post-Christian West looks east for more holistic systems of alternative medicine, which seem to offer more personalised and spiritual approaches to healing. Diseases like AIDS, which know no geographical boundaries, threaten mankind in general, and the medical profession in particular. There is no apologetic for the new ethical dilemmas raised by the issues of abortion, euthanasia, gender and now genetics because the traditional Christian ethic of medicine has been eroded. As Tim Naish pointed out, 'there is (however) a closer relation between mission and ethics than is generally acknowledged within the church or by scholars of either subject.'[8] I therefore submit that the new paradigm may possibly prove to be a prophetic paradigm, and the medical missionaries of the 21st century, the ones who, wherever they are, raise a prophetic voice.

The Old Testament prophets were men who spoke out the truth about God to a people who did not want to hear. Their authority was derived only from God. They addressed issues of injustice, inequality, corruption, immorality, and idolatry at both personal and society levels. And they were ignored or eliminated. Stanley Browne said something very similar, 'Christian doctors should be able to exert a determinative influence at strategic points and at strategic moments, so that God's eternal purposes may be forwarded in a very real way.'[9] Within a medical context, malpractice needs to be exposed, gender and age discrimination abolished, expensive treatments fairly distributed, and standards maintained in research and its documentation. The rights of patients, including the very young and the very old, need to be upheld. God's opinion of homosexuality needs to be

Photo: Wellcome

KEY POINTS

The 21st century calls for a new paradigm of medical mission. Whilst old diseases remain, AIDS, civil war, genocide, terrorism, floods, drought and natural disasters have created new challenges; and God is now calling his people to 'be prophetic' in addressing issues of injustice, inequality, corruption, immorality and idolatry at both personal and society levels. National professionals and churches have an increasing role; but most critically we all need a biblical theology of medical mission that emphasises whole person care, the integration of evangelism and medical service, compassion for both individual patients and communities and the importance of prayer in and for healing.

Photo: Welcome

proclaimed. And perhaps we should ask, not whether it is ethically right to witness during a consultation, but whether it is spiritually wrong for the committed Christian not to do so when prompted by the Lord?

Missions in Nepal, for example, have always maintained Christian standards within their own projects, but today there is a new opportunity to speak out against some injustices in society and any wrongs in medical practice. Explosion of the private sector and growth in numbers of the medical, nursing and paramedic staff in general over the last decade, together with increasingly liberal attitudes and lax behaviour among the younger generation, has precipitated the medical profession into debate with government over ethical issues. An abortion bill has recently been tabled and in response, the Nepal Christian Hospitals' Association has drafted its own principles of action, and a statement to the government on behalf of its member hospitals.

Rendle Short himself was never 'strictly speaking' a medical missionary, but he was a man who proclaimed God's word and influenced the practice of medicine in many lands. His style of writing, and even some ideas, may strike us now as dated and even a little paternalistic, but this was precisely because he was speaking in and for his own contemporary generation. If he were here with us today, he would be one of the first to speak out in new postmodern terms and challenge us to meet the needs of 21st century global medicine.

The new medical missionaries

The new medical missionaries may therefore be any men or women of God with a profoundly biblical faith and a deep compassion that all of people might know God's full purposes. Not only will they will be closely in touch with God, they will also have learnt the language of communication with a postmodern world. These new medical missionaries may be 'called' from (almost) anywhere in the world to work (almost) anywhere in the world. 'The West is now itself a "mission field"' [10] and Keith Sanders has reminded us that, 'the same Christian attitudes to health care (should) be applied to the West as well as [in] more distant places.' [11]

These new medical missionaries will be those who share their faith while they serve the people. Their professional and personal lives will be beyond reproach, and they will be openly known as Christians. They will speak into contemporary issues with a word from God, declaring God's judgement on those who reject his mandate for mankind, and proclaiming God's *shalom* for all who suffer in any way. They will speak the truth in love, and without fear. And they will suffer for it.

These new medical missionaries may be community or hospital based: doctors, nurses or paramedics: generalists or specialists: physicians or surgeons. They may be clinicians, teachers, technologists, researchers, managers, writers, or even theologians. One thing only is certain - they will be pioneers!

THE NEW MEDICAL MISSIONARIES WILL BE THOSE WHO SHARE THEIR FAITH WHILE THEY SERVE THE PEOPLE…THEY WILL SPEAK THE TRUTH IN LOVE, AND WITHOUT FEAR. AND THEY WILL SUFFER FOR IT.

Such a new paradigm of medical mission implies that, 'whatever the geographical location or professional nature of our service, we are all in this business of commending the gospel by our life and work – and also word. In a very real sense, we are (all) being called to assume a prophetic role.' [12]

The original pioneers of medical mission were willing to do something no one had ever done before. Are we? Or are we content to remain 'strictly speaking not missionaries at all'?

The full text of this Rendle Short Lecture is available on the CMF website at www.cmf.org.uk/helix/win03/rendle.htm

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John Day and Chris Lavy make a case for thoughtful giving

Posting rice pudding

The rice pudding had been pushed around my bowl enough times to convince me that no efforts to rearrange or compress it would make it appear that I had eaten anymore than I had. 'Just think of all those starving people in Africa who would love to eat that and you're just going to throw it away,' protested my sister (who would be reminded of this appeal against wastefulness on a future occasion when she was faced with her own culinary nemesis). 'Well you can put it in an envelope and post it to them,' I offered.

A similar appeal to consciences could be directed at the huge disparity between the desperate need for basic medical resources for the majority of our world and the disposable culture that exists in our own health service. How many times have I discarded unused latex gloves after using part of the contents of a sterilised dressing pack? And how many times did my Indian elective hospital wash and autoclave each pair of surgical gloves before a surgeon's protruding finger would point an end to their life span?

WELL MEANING, BUT ILL-CONCEIVED, DONATIONS MAY CREATE PROBLEMS RATHER THAN PROGRESS

A practical, if painfully inadequate, response to bridging this resource gap has been attempted by many a theatre or casualty sister who has faithfully gathered remnants of unused or date-expired medical products and sent them to mission hospitals in needy nations where they can be put to good use. But, not unlike posting rice pudding to Africa, the outcome may fail to match the noble sentiment behind the endeavour. Some with greater ambitions appear to be encouraging surgeons in Malawi and Uganda to extend their operating repertoires by dispatching many metres of cardio-pulmonary bypass tubing. The Zambian mission hospital in receipt of a box of amphetamine-based appetite suppressants would no doubt still be awaiting a suitable candidate had the pills not been consigned to the bin. Such well meaning, but ill-conceived, donations may create problems rather than progress.

Of course recipient hospitals are free to dispose of donated items, which they cannot use, but even this can become an administrative headache. Import duties and transport costs have often turned a consignment designed to bless into a bureaucratic curse. Negotiating with a department of customs and excise can be a time consuming and morale sapping process for a hospital superintendent whose time would be better spent treating patients.

The World Health Organisation urges that donations be based on effective communication between donor and recipient, and strictly avoid any double standards in quality.[1] Good donations result in improvements to the delivery of effective health care, and saved lives.[2] However, the indirect benefits should not be underestimated; the collection or purchase of drugs and medical products can act as a focal activity for supporters, promoting prayer for the work of a mission hospital/relief organisation and a sense of meaningful participation.

Good communication and planning between donor and recipient is essential. Friends of Mvumi Hospital, Tanzania and Kiwoko Hospital, Uganda, for instance, have websites that provide information on current needs.[3] In general, mission hospitals and aid agencies find that monetary donations give them more flexibility (and often additional yield through gift aid), although individuals and churches may wish to designate it for a particular need. Purchasing drugs within a country, where available, avoids the complexities of importation and benefits the local economy. The purchase and shipment of drugs and equipment from the UK is usually best carried out by organisations with expertise in dealing with VAT exemption, packing and customs clearance.[4]

Mission hospitals continue to rely heavily on the generosity of their supporters to carry out their valuable ministry. Donors and recipients bear a responsibility to ensure that these relationships are of mutual blessing.

This article is based on Day JH and Lavy CBD, Pills to Africa: how to donate effectively, *BMJ* 2001;323:1315

John Day is a specialist registrar in London, UK
Chris Lavy is an orthopaedic surgeon in Blantyre, Malawi

References

1. Revised Guidelines for Drug Donations are available from the Documentation Centre, Department of Essential Drugs and Other Medicines, World Health Organization, 1211 Geneva 27, Switzerland. (reference WHO/EDM/PAR/99.4) or *www.who.edm/par/99.4.htm*
2. WHO calls for good drug donation practice during emergencies as it issues new guidelines (*www.who.int/inl-pr-1999/en/pr99-45.htm*)
3. *www.mvumi.org, www.fokh.org.uk*
4. ECHO International Health Services Limited is a charity with extensive experience in the cost-effective procurement of drugs and medical equipment *www.echohealth.org.uk*

Guidelines for responsible donating

Donors

- Ask first before collecting/despatching.
- Seek advice on the best method of transportation and completion of customs declaration forms.
- Discuss local policies on antibiotics, antivirals, psychotropic drugs and expired or nearly expired items.
- Enclose an itemised list in the official local language, including generic drug names (recipients may not be familiar with trade names) and information on shelf life.

Recipients

- Investigate whether your country has its own drug donation guidelines.
- Ascertain information on the local policy regarding expired products.
- Send a copy of the local drug policy/essential drugs list to your regular donors, or a shopping list of useful products.
- For equipment, consider practical details such as 'What will it plug into?', 'How will it be maintained?' and 'Who will benefit from it?'
- Learn to say 'No' without fear of causing offence.

How serious illness led **Wesley Finegan** to recall an important spiritual principle

Meeting disappointment HEAD-ON

As a teenager, I read these words on a calendar:
'Disappointment – His appointment'
Change one letter, then I see
That the thwarting of my purpose
Is God's better choice for me.[1]

I had no idea then how relevant those words would become to me personally. In January 1994 I was found to have a high-grade, rapidly growing, non-Hodgkin's lymphoma. This illness came at the peak of my career as a consultant in palliative medicine when I had plans for improving the care of cancer patients at our local hospital. God had different plans for me.

Following surgery, chemotherapy and radiotherapy I was in remission, but one year on, I was retired from my clinical position because my immune system had not recovered sufficiently. I was offered a job in medical education, specialising in palliative care. All seemed to be going well and I was quite content. I felt that God had placed me in a position where I could introduce the gospel to educational projects dealing with end-of-life issues. I was sure I could see God's plan for my life.

Then in January 2001 I slipped on ice, injuring my left arm. I treated myself with ibuprofen, support and rest until the swelling subsided and my range of movement had improved. One month later, at a routine oncology follow-up, the registrar noted some axillary swelling. We agreed that it was probably residual haematoma but I was sent for a CT scan. It showed a lymph node mass. Biopsies showed only the effects of injury but when the mass continued to grow, it was excised. The histology showed a lymphoma, believed to be a recurrence, which caused obvious concern.

I was understandably anxious on the day I was to receive the results of the relevant tests. My Bible reading for the day included these words: 'So Samuel told him everything, hiding nothing from him. Then Eli said; "He is the LORD; let him do what is good in his eyes."' (1 Samuel 3:18). Was God warning me? I went to the hospital, trying to prepare myself for the worst news I could imagine. On the contrary, analysis and comparison of the tumour DNA, confirmed that I had a new primary non-Hodgkin's lymphoma. It was the first time the oncology team had seen such an event. I started chemotherapy, but half way through the course, developed cardiac problems associated with the doses of adriamycin I had received in 1994 and again in 2001. Treatment was therefore switched to daily radiotherapy for four weeks. Now, having completed treatment, my CT scans are clear.

Lessons

What lessons have I learned from these events? I will share some of my thoughts and fears. Recorded in special diaries I kept during both illnesses. When I heard I had cancer again I didn't know what to think, and didn't know what to say to God. Why was God changing all my plans again? I felt confused and disappointed. My mind went to Romans 8:26, 'In the same way, the Spirit helps us in our weakness. We do not know what we ought to pray for, but the Spirit himself intercedes for us with groans that words cannot express.'

At every significant point in my illness I had some kind of message from God

In my search for comfort, I had zoned in on that verse, but I was shown over several months, that I had to see it in context. My daily readings repeatedly included Romans 8:27, which reads, 'And he who searches our hearts knows the mind of the Spirit, because the Spirit intercedes for the saints in accordance with God's will.' Those last five words jumped out at me! In my diary I recorded all the major events in my illness and tried to group them under the headings of 'Disappointment' or 'His appointment'.

At every significant point in my illness I had some kind of message from God. It came in the form either of a reading, a phone call, a letter or a visitor giving us encouragement and hope. God has been reminding me of his promises and that whatever happens, it is his appointment. I have recorded 46 such incidents in less than one year.

God has been teaching me:

- To read his word expecting to hear him say things that are relevant to me.
- That he speaks through his word, people and events
- Not to rush into interpreting what he is saying to me (as I did the day I expected to be told bad news)
- To ask for what I *need* – not what I *want* (Philippians 4:6)
- To pray for things that are *his* will- not mine (Romans 8:27)
- That he has a plan for my life and that his plan is the right one for me (Psalm 22:4-5). If I had not fallen, and not had the CT scan would my new cancer have been discovered as early?
- That *his appointment* for my life is best, even if I do feel some *disappointment* over how he carries out his plan.

Wesley Finegan is a Consultant in Medical Education to the Centre for Medical Education at the University of Dundee and also works freelance.

1. The full text of the poem is published in A Naismith (ed), *1200 Notes, Quotes and Anecdotes*, London: Pickering and Inglis (1971). The author is not named.

EUTYCHUS

Doctors and lethal injection

Almost all executions in the United States are now performed by lethal injection (155/160 since 2000) and doctors have helped in the development of this method, an article in the *BMJ* reports. Lethal injection is unique because it simulates a medical procedure - the intravenous induction of general anaesthesia. Medical professionals' organisations in the United States forbid participation in executions, but most doctors are unaware of the guidelines and are willing to participate. Their involvement creates a profound conflict of roles that is morally unacceptable, says Jonathan Groner, trauma medical director in Columbus, Ohio and author of the report. 'When doctors enter the death chamber, they harm not only their relationship with their own patients but the relationships of all doctors with their patients. Doctors take an oath to be healers, not killers, and they should not participate in executions under any circumstance. Lethal injection has a deeply corrupting influence on medicine as a whole.' (*British Medical Journal* 2002; 325:1026-8, 2 November)

Prevention not cure

Treatment of HIV/AIDS with antiretroviral drugs in rural African settings is not a practical option given issues of cost, compliance, monitoring facilities, drug interactions with TB medication and the availability of clean drinking water. In a letter to the *BMJ* doctors at St Anne's Mission Hospital in central Malawi eloquently argue for prevention as the only realistic approach: 'Education on preventing HIV has to be the main way forward, especially when all our resources are so scarce.' (*British Medical Journal* 2002; 325:838, 12 October)

Feminist attacks abortion pill

Feminist icon Germaine Greer has stunned her fans by attacking the abortion pill at a Sydney obstetricians and gynaecologists conference. Dr Greer said she had been asked to speak at the 'Best for Women' event to bring pressure to bear to improve access to RU-486. 'Of course we need also access to amputation but we need even more to make sure that as few people are in a situation where they need amputations as possible.' (*www.davidalton.com*)

The cost of tobacco

A Los Angeles court made the biggest individual damages award in US legal history on 4 October to a 64-year-old woman with lung cancer. The Philip Morris tobacco company was ordered to pay $28 billion (£18bn) to Betty Bullock of Newport Beach, California, who claimed she had believed the company when it said there was no evidence that smoking caused cancer, in spite of being told otherwise by her doctor. A Miami judge ordered the tobacco industry to pay $145 billion in punitive damages to 500,000 sick Florida smokers on 14 July. Appeal on both cases is pending. (*The Times* 2002; 5 October:17)

Being difficult

Being difficult is not necessarily a bad thing, and the NHS needs more difficult doctors, according to Coventry paediatrician Charles Essex. He cites two role models: Jesus Christ and the little boy who suggested that the emperor was wearing no clothes. He also quotes George Bernard Shaw on the 'unreasonable man': 'The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.' (*British Medical Journal* 2002; 325:1177, 16 November)

Essential reading for medical students

Primo Levi was an Italian chemist, who wrote of his experiences and reflections on life in a Nazi concentration camp. A recent review in the *Lancet* (2002; 360:882) recommends that all medical students should read his books, which enable 'those who were not witnesses (to) digest what happened, and hopefully, ensure that it is never repeated'. Sir William Osler recommended to his students 'a list of ten books which you may make close friends', and prescribed reading for half an hour before going to sleep. His 'top ten' included the Old and New Testaments, Shakespeare, *Religio Medici, Don Quixote* and Marcus Aurelius. (*British Medical Journal* 2002; 325:867, 19 October)

IVF price-hike

Private fees for in vitro fertilisation are to be raised by £100 per cycle under new government plans to introduce tighter regulation in the wake of recent high profile infertility botch-ups. Currently about 24,000 women pay £2,500 per cycle; or about £12,500 per live birth, if we accept a take-home baby rate of 20%. Only about 4,000 women, who have their treatment funded by the NHS, will not have to pay. So far over 50,000 babies have been born through IVF in the UK (*The Times* 2002; 26 November:3)

New sex laws

Offences such as buggery, gross indecency and soliciting by men are to axed under new Home Office proposals to reform 'archaic, incoherent and discriminatory' sex laws. The changes are outlined in a white paper, *Protecting the Public*, published by Home Secretary David Blunkett, which also includes measures to protect children from sex abuse and exploitation. Bestiality is to stay an offence with a two year term, and necrophilia is to become an offence with a maximum two year term. (*The Times* 2002; 20 November:4)

Brain dead?

Disquiet amongst anaesthetists over organ harvesting procedures is reflected in lack of consensus on practice, according to Cambridgeshire anaesthetist David Hill. He argues in the *BMJ* that, 'Some give full anaesthesia to organ donors (because they respond to surgery much like any other patient), whereas others withhold anaesthesia (which might look like an admission that the donors are still alive) but suppress the response to surgery by other means'. Are the 'brain dead' really dead; and is properly informed consent being given? (*British Medical Journal* 2002; 325:836, 12 October)

GPs increasingly say 'no' to abortion

One of four GP practices has a doctor who refuses to give consent to abortion, according to a nationwide audit of GP practices by the Teenage Pregnancy Unit. The audit of 40% of all practices (around 4,000) also found that 15% of GPs would refuse to see a patient under 16 years without their parents being present. (*GP* 2002; 7 October)

Avoidable deaths

The main avoidable hazards to health worldwide are malnutrition, poor water supply and sanitation, unsafe sex, physical inactivity and alcohol and tobacco, which together accounted for 15.5 million deaths in 1990, or 30.6% of all deaths. (*British Medical Journal* 2002; 325:928, 26 October)

BOOKS

Doing Member Care Well - Perspectives and Practices from around the World

Ed. Kelly O'Donnell
William Carey Library Publishing 2002
$19.99Pb 566 pp
ISBN 0 87808 446 0
Also available from Global Connections £11

What is member care? The editor defines it as 'the ongoing investment of resources by mission agencies, churches and other organizations for the nurture and development of missionary personnel. It focuses on everyone in missions (missionaries, support staff, children and families) and does so ... from recruitment through to retirement'. Its aim is 'to further equip sending organizations as they support their mission/aid personnel'. This should lead to a strengthening of mission and enable missionaries to grow as people, hopefully preventing premature return from the field.

The book contains some 50 chapters written by a wide range of authors from a variety of backgrounds and from both old and new sending countries. They include pastors, medics, personnel directors, psychologists, church leaders and missionaries themselves. Some will be well known to CMF members, such as Mike Jones of EIHC (Elphinstone International Health Centre), Debbie Lovell Hawker, Annie Hargreaves of Interhealth and Rhiannon Lloyd.

The book is divided into three parts. Part 1 explains something of the nature of member care and puts it in a biblical and historical context. Part 2 brings insights from the five major regions of the world. Part 3 looks at the various aspects of the provision of member care. It includes best practice guidelines on member care provision, health and safety abroad, training and development, team building, the care of families and missionary children, finance, crisis/contingency planning and debriefing. Most chapters end with some items for 'reflection and discussion'.

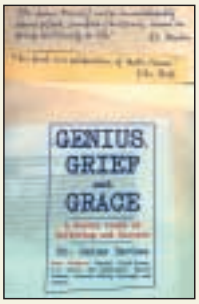
Paula O'Keefe's chapter on 'Surviving war as a care giver' is challenging. Kelly's chapter on 'Giants, foxes, wolves and flies' caught my eye and set me thinking. Rhiannon Lloyd's input on bringing the cross to bear in the aftermath of the Rwandan holocaust is almost unbelievable. Debbie Lovell Hawker's chapter on critical incident debriefing is excellent. These people are 'pure gold' and have much to teach us.

The breadth of experience and the depth of wisdom shared by the contributors to this book are impressive. Those working overseas need our prayers and support so we need to develop the expertise to provide it. For all of us involved in caring for people who are or have recently been working overseas, it is a mine of information and help. We would do well to learn and put into practice the ideals that it sets before us.

Peter Armon is CMF Overseas Support Secretary and formerly a Consultant in Obstetrics and Gynaecology

Genius, Grief and Grace

Gaius Davies
Christian Focus Publications 2001
£8.99 Pb 383pp
ISBN 1 85792 630 7



The notion that personal pain can be productive is generally unpopular, but here Dr Gaius Davies shares his professional perceptions about eleven afflicted yet famous people. With names well known to a Christian readership their genius has not often been attributed to a common background of suffering.

Dr Davies traces the possible connections between famous accomplishment and bipolar mood swings (as for Lord Shaftsbury) or obsessive-compulsive traits (in John Bunyan) as well as other personality problems affecting great people. He tells us about three single women who came to fame: Christina Rosetti, Frances Ridley Havergal and Amy Carmichael and, at least in part, attributes their ultimate success to sublimation of otherwise unfilled sexuality, a rarely discussed possibility nowadays. The last chapter in the book is devoted to the life of Dr Martyn Lloyd-Jones. Perhaps the writer's personal relationship with his subject has made it harder for him to give quite the same orderly appraisal here as for the other ten, although for each and all he has sought to portray them 'warts and all.'

Running as a gold cord through the sometimes-dark passages of these eleven lives is their desire to love and serve God. The message that something good finally emerged from all their difficulties is, after all, the message of the crucifixion and resurrection of the Lord Jesus Christ, who said to each of them, as to us, 'Follow me'. It is a testimony to his grace that, like a skilled surgeon, he is able to use a selection of strangely shaped instruments to fulfil some of his complex operations.

The occasional misprints and poor quality paper should not detract from a book to encourage all those who work with, or suffer from, disturbed personalities. It clearly illustrates that our weaknesses can be a channel for Christ's strength.

Janet Goodall is a retired Consultant Paediatrician and former CMF President

Look No Hands

Brian Gault with Helena Rogers
Hodder & Stoughton 2000
£6.99 Pb 200 pp
ISBN 0 34074 636 X

Although born without arms as a result of thalidomide, Brian Gault's description of his life is warm and encouraging, intertwining the themes of his Christian faith and living without arms. His story still has pertinence today. Thalidomide is used in developing countries to treat leprosy but sadly, inadequate explanations, or written explanations to illiterate people, lead to affected children being born. Proceeds from the book go to help these children.

Much of the book is about his struggle to be free of artificial limbs. I nearly cried as he describes being left in hospital aged two years for artificial limb training. He endures hardships that make me wonder about the sufferings of today's prosthesis wearers. He was expected to maintain a low weight to

maximise efficiency of his limbs, leading to two miseries – his calorie restricted diet and squeezing into his limbs after his mum had fed him up in the holidays!

He later realises that his mother loves him just as he is, but you can understand why he should doubt this. Later he describes his desire to 'be himself' rather than be forced to wear artificial limbs that restrict his abilities rather than enhance them. This reminds me of the need to retain the patient's perspective of interventions, as we cannot assume that our own normality is preferable. Brian Gault eventually gives up artificial limbs at 13, the same year that he discovers Jesus loves him.

The landmarks of his Christian life such as youth groups, conferences and Christian service, will be shared by many, although solving problems such as how to get your shirt tucked in at Bible College will be new! He goes on to learn how to use new technology, such as his foot-steered car and word processor, to liberate his energy and time.

This is a warm and readable book – read it and pass it on.

Caroline Hutchings is a Consultant in Rehabilitation Medicine in Southampton

Caring Well: Religion, Narrative and Health Care Ethics.

Ed. David H Smith
Westminster John Knox Press 2000
£ 17.99 Pb 276pp
ISBN 0 66422 256 0

Doctors have long struggled with ethical dilemmas such as the distinction between killing and letting die. This book uses narratives, like those written by two compassionate physicians about dying patients, to explore doctors' motives and to come to a clearer understanding of this difficult boundary. Other essays look at the perspectives of hospital Chaplains on organ donation, and help to ground the whole ethics of transplantation in the context of managing individual grief.

The book is a collection of essays that explore narratives from literature, personal commentaries or interviews of professionals and patients. Three major areas of care, each with different ethical conflicts, are addressed. These are the care of children, organ transplantation and care of the dying. Most of the religious input is from a Christian perspective, although there is one chapter based on the reflections of Jewish physicians.

The authors are mainly Professors of Religion, Ethics or Philosophy, with one clinician, and all are American. Differences in cultural and legal background will therefore make this book less relevant for doctors based in other countries. Furthermore, the first few chapters focus on the methodology and as such are directed more at fellow-ethicists and theologians. Readers of *Triple Helix* might well find it better to start at Part Two and leave these early chapters to the end.

This book is not a comfortable read, but it will certainly raise many interesting questions and help us reflect on how our own spiritual experience influences our care.

Carl Whitehouse is Professor of Teaching Medicine in the Community in Manchester

From Medicine to Miracle – How My Faith Overcame Cancer

Dr Mary Self and Rod Chaytor
Harper Collins, 2001.
£17.99 Pb 259 pp
ISBN 0 00711 563 6

As a teenager, Mary Self developed a rare tumour of her leg, subsequently shown to be a mesenchymal chondrosarcoma. She had an above-knee amputation. Sixteen years later, when she might reasonably have thought she was cured, she was unfortunate enough to develop a lung metastasis. This was successfully removed by surgery, while raising new doubts about her prognosis. Later that year, she developed pelvic pain. CT and isotope scanning now revealed a shadow on her pelvic bone. Her doctors assumed it was a further metastasis, giving her a very poor prognosis. Subsequent scanning, however, showed that the shadow had decreased in size. Over the next few months, it disappeared completely. An estimated 10,000 people around the world had been encouraged to pray for her healing. Their prayers, it seems, were answered though not, it should be said, in the instantaneous manner of New Testament miracles.

Dr Self told her surgeon that she believed it was a miracle. He replied, 'I will buy that.' He is quoted on the dust cover as saying, 'I have been a consultant for eleven years and have not seen a case like it.' The book does not report his further comments, which were quoted at the end of a double-page feature in the *Daily Mirror* in December 1999, written by the book's co-author, Rod Chaytor. There he recorded the surgeon as saying: 'She is saying it is a miracle. I am saying it is unexplained. It is important to say we do not have proof this was a metastasis in the pelvis. Everyone assumed it was on the basis of the scans.'

A biopsy had in fact been performed. The book describes her meeting with this surgeon to be told the result (p239) but obfuscates the issue, leading the reader to believe that it was malignant. She states, 'It has been confirmed three times now' (p240). In the *Daily Mirror* article, however, Mr Chaytor reported that the biopsy did not confirm a metastasis and that the specialist believed the scans 'weren't completely consistent' with a secondary. Why did he not include these statements in the book? The answer, it seems, is that they undermine the whole story.

This reviewer was invited by BBC TV to comment on her case. I accepted on the condition that Dr Self gave me written permission to clarify these details with her surgeon. There is no substitute for having direct access to the medical evidence when investigating such claims. Despite three requests, she did not agree and the interview was cancelled.

I found the book tiresome reading. It describes the endless roller-coaster ride of her emotions, with overwhelming despair, rather than faith, at every set back. More disappointing was the failure to be open and straightforward about the truth.

Peter May is a General Practitioner in Southampton

LETTERS

Stealing doctors

Stealing nurses is an even bigger problem, argues independent pharmaceutical consultant ***John Griffin****.*

Jason O'Neale Roach's article on 'Stealing Doctors' (*Triple Helix* 2002; Autumn:14-16) is timely, but there is another facet to the theft of health care workers from less affluent countries to bolster up our needs for trained personnel. This is the blatant recruitment drive to entice overseas trained nurses to work in the NHS. The scale of this exercise is most clearly shown in the table (below), which presents the numbers of nurses seeking work permits for the UK.

The health care needs of some of these countries are greater than that of the UK. These countries have also invested resources in their training and are not receiving a return on their investment. It is quite understandable that these nurses wish to benefit themselves both financially and perhaps educationally by spending time working in the NHS, and nobody would begrudge them this, but NHS authorities are not so altruistic. The NHS wants these staff to spend their whole working career bolstering up the NHS shortfall in training enough nurses for the UK's needs.

We are meeting our needs by plundering other countries' resources. The governments of their own countries cannot compete with the financial carrots being dangled in front of these trained personnel. Is it morally and ethically right? What should our position as Christians be? We welcome them as strangers, we offer hospitality, we are grateful for their professional help – however we should recognise our gain is another's loss and that this is not really an acceptable way for a country to behave.

Source Countries	Work permit applications by nurses to work in UK	
	Year 1998-1999	Year 2001
Australia	1,771	601
South Africa	1,114	2,514
Philippines	972	10,050
Nigeria	920	1,100
India	na	2,612
Zimbabwe	na	1,801

Source-Tajadens F. Health care shortages. *Eurohealth* 2002;8(3):33-35

Rowan Williams

Greg Strain*, medically qualified pastor in St Albans, takes issue with John Martin's editorial on the new archbishop of Canterbury.*

John Martin's editorial on Rowan Williams (*Triple Helix* 2002; Autumn:3) is admirably temperate and the call for prayer is surely a right one. But my fear is that the article could encourage people to accept RW's ministry. This could bring spiritual disaster.

The piece puts great faith in Alister McGrath's analysis of RW's theology. Other voices have been less reassuring. Gary Williams, a fine evangelical scholar at Oak Hill College, has come to a radically different assessment. He highlights not only RW's flawed ethics but identifies a deeply disturbing and errant doctrine of revelation. Is John *sure* that McGrath is right?

If RW is orthodox in doctrine and is willing to uphold the faith set down in the 39 Articles then yes indeed, let's pray for him in his difficult task. But if his theology is shown to be heterodox then evangelicals within the Church of England will need to stand against his appointment. We do *not* need to wait for him to make further pronouncement. His theology is in print, and to my knowledge he has not offered any retraction, so we should be able to see plainly what he believes.

John Martin *replies.*

My editorial on Rowan Williams has provoked more comment than any single item since the launch of the magazine. No reader has questioned the rightness of a call for prayer for Dr Williams. There were, however, expressions of concern about how the editorial represented his views of biblical authority and the homosexuality issue.

It's important to point out that many of the widely quoted statements of Dr Williams, and some of his writings, suffer for a lack of clarity in expression. This helps in part to explain why turbulence now surrounds him. He is learning quickly that Christian people look to those who hold high office in the Church for a clear exposition of the faith and how it applies, and that it is unhelpful to 'think out loud' in public statements.

It's important to note, too, that my editorial was drafted and typeset before the controversy surrounding Dr Williams hotted up. Some readers have questioned my statement that Dr Williams is 'crystal clear in his commitment to the authority of the Scriptures'. By that I did not mean that his position was identical with that of the CMF, in upholding the Bible as 'the supreme authority in matters of faith and conduct'. Rather, that like many Anglicans, he says he accepts biblical authority, but reads the Bible *through the lenses of tradition, experience and reason*. In his own words, 'how we read the Bible does shift, sometimes imperceptibly, from century to century….which doesn't at all mean that the Bible isn't continuously authoritative in the church, just that perspectives shift a bit.' (*Church Times* 2002; 29 November:12-13)

I am not persuaded that that the Latimer paper by Dr Gary Williams is to be regarded as the last word on the theology of Rowan Williams. Not all evangelicals affirm the methodology employed by Gary Williams in the Latimer paper. Rowan Williams commented subsequently: '…his book is so selective and deliberately tendentious that I feel that he can only have set out to find damaging quotations and ripped them with glee out of context.'

In conclusion can I offer two thoughts? First, I think it's important that rather than relying solely on media commentaries and soundbites, that CMF members read Rowan Williams for themselves. Second, I am heartened that Dr Williams has made it clear he intends to uphold the official policy of the Church on homosexuality as set out in Resolution 1.10 of the 1998 Lambeth Conference (as was the expectation of my editorial). However, I re-iterate: I share the concerns of many about Dr Williams' *private* views on homosexuality, in particular his apparent endorsement of monogamous gay relationships. Such a position is clearly at odds with Scripture and *Triple Helix* will be keeping a watching brief.

Gay adoption

***David Barnardo**, retired Consultant Physician and Chair of Council (Trustees) of Barnardos, believes there is a place for gay couples to adopt:*

Seyi Hotonu (*Triple Helix* 2002; Sping:8-9) purports to show the folly of extending rights of adoption to include both parties in a same-sex 'family' but does not address the issue in a balanced way and merely emphasises the sad fact that biological parenting often fails children. Children whose primary families have failed them show particularly poor outcomes whilst 'in care' of the State and therefore need carefully selected family units with monitoring and support from a variety of agencies.

Review of published evidence to date has failed to show significantly different outcomes for children raised by a biological parent in a 'gay' setting. I agree with the author that many studies are flawed and firm conclusions limited - that being the case we should be guarded in conjecture. There is no research data to show outcomes amongst children previously 'in care' who are subsequently fostered or adopted by gay family units and, whilst robust investigation (to confirm or refute the impression of many adoption agencies that this is not flawed policy) must be undertaken and practice modified according to evidence, many children urgently need families to foster or adopt them.

A recent assessment by the Fostering Network estimates that, in the UK, at least 8,000 additional foster parents are required (and this means several times as many applicants). Sadly, some 'gay' foster and adoption placements fail (this may have more to do with the challenging needs of these children). Nevertheless, it is dishonest to insinuate that traditional practising Christian families are free from such failure. They are not.

We should be concerned to develop a balanced theological understanding of the issues but at the same time there is the need for action (and I appreciate that individual Christians may respond, in compassion, in differing ways which should be seen as complementary).

Providing a variety of alternative family settings for children urgently in need of loving, stable, tolerant and resilient homes may appear to fall short of the God-inspired and biological ideal but I believe that God's love extends this far.

***Seyi Hotonu** replies:*

Like Dr Barnardo, I agree that children 'in care' need loving, stable, tolerant and resilient homes. As mentioned in my article, there is currently no reliable evidence about outcomes of adoption by gay couples. Yet, despite this deficiency, I am still meant to conclude that the most vulnerable children in society should be raised in alternative family settings. Why? Elsewhere in medicine, proposed therapies are expected to undergo rigorous testing before gaining widespread acceptance and usage. Why not here?

Dr Barnardo claims that my article 'merely emphasises the sad fact that biological parenting often fails children'. The same conclusion could be arrived at about the care system itself, which, he notes, also fails children and which is run incidentally by the very same social workers that are responsible for finding foster and adoption placements.

I appreciate the number of additional foster parents required but I also note that before the Adoption and Children Bill was even enacted, the number of children adopted from care, had doubled since 1997 from 1,900 to an expected 3,800 in 2002. The resulting fall in numbers of children in care was mainly due to the government's initiative.

What is a 'balanced theological understanding of the issues'? The Bible says that homosexuality is wrong. This is orthodox teaching. The Bible says that at its core the family consists of a father and a mother, not two fathers or two mothers. This is orthodox teaching. The Bible says that we should take special care of orphans. This is orthodox teaching. Dr Barnardo says that traditional practising Christian families fail. The Bible contains many examples of people who have failed. But as a result of this failure God did not leave us to compound our failures by sinning further but rather sent his Son to be our Saviour.

Children do need to be taken out of the care system but not at any price. The tragedy is that many Christian adoption agencies have abandoned 'the God-inspired and biological ideal' to support an unrelated political agenda.

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts mainly 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: *MMA HealthServe* at Barker House, First Floor, 106-110 Watney Street, London, E1 2QE. Tel: 020 7790 1336
Email: info@healthserve.org
Website: www.healthserve.org

Albania

GP mentors needed to work for one to two weeks alongside newly qualified doctors in GP postings in isolated village situations in Albania. Would suit someone recently retired.

Contact: PRIME – jgeater@which.net

India

CMC Ludhiana is planning to start a Rapid Response Unit along the lines of paramedic teams in the UK. They are looking for a doctor with skills in A&E to train the team. Their original trainer has had to drop out. Ideally they would prefer to run a 6 month course but someone able to run an intensive 3-4 week course would be acceptable. Board & accommodation provided but otherwise self funding required.

Nepal

General Practitioner, **urgently needed** at Okhaldhunga Hospital (United Mission to Nepal). This is a 32 bedded hospital close to a small isolated hill-top town. Ideally needs some surgical skills to deal with emergencies and Caesarean sections. Part of the job would be to supervise the training of 2 Nepali doctors in the last stages of their training for the MDGP degree who have both had some surgical training.

Contact: Email: John.Dickinson@umn.org.np
Tel: 00 977 1 228118

Surgeon, United Mission Hospital,Tansen (United Mission to Nepal). UMHT is located in a pleasant hill town and has a very active surgical unit. Surgeons are needed to share a busy and varied practice of clinics and emergency and routine operations. An advanced qualification and ability to work independently in general surgery is essential. A sub specialty might be useful, but the emphasis is on general surgery, including the surgery of trauma.

Contact: Dr John Dickinson at: John.Dickinson@umn.org.np

Physician, Patan Hospital (United Mission to Nepal). Patan Hospital is in Patan Municipality in the Kathmandu Valley. It provides in-patient and out-patient services to a large population. A general physician is required to be Chief of the Medical Service and manage a broad range of medical conditions including emergencies and a good deal of infectious disease. The physician should also be willing to teach junior doctors in the medical team.

Contact: Dr John Dickinson at: John.Dickinson@umn.org.np

Uganda

Medical Superintendent needed for Kiwoko Hospital in Luwero, Uganda. Ideally to be in place by April 2003. Needs to be a doctor with at least 5 years experience. The job involves supervision of all the hospital activities including community care (CBHC), supervising junior doctors, a nurses' training school and chairing the management team. The CBHC programme is one of the most respected in the country. The hospital comes under the Church of Uganda and while the candidate would not need to be an Anglican, he/she would need to be in sympathy with it.

Contact: Nick Wooding, Kiwoko Hospital, PO Box 149, Luwero, Uganda. Tel: 077 588 606 Fax: 041 610132

A Doctor (and nurse spouse would be an asset!) are needed to staff a fully renovated Clinic in Hoima, Uganda run by the Diocese of Bunyoro Kitara. It would be a 2-3 year paid post with accommodation and transport provided.

Contact: John Morris,
Email: johnemorris@blueyonder.co.uk

Zimbabwe

Bonda Mission Hospital is looking for a third doctor to work in this rural hospital in the picturesque Eastern Highlands of Zimbabwe. It is the only Anglican hospital in the country. It has 150 beds, 50 nurses and two doctors. The ideal candidate would have at least four years experience including medicine, surgery, obstetrics and paediatrics. The job offers a demanding but rewarding experience as part of a small team responsible for all aspects of health care in the hospital and surrounding district.

Contact: the medical superintendent, Bonda Hospital, Box 3896 Bonda, Zimbabwe.
Email: mmcnally@healthnet.zw

EVENTS

The Residential Refresher Course 2003 is booked from 7-18 July 2003 at Oak Hill College in North London. It is hoped to add various practical workshops and round table discussion to the usual lecture format of previous years.

MMA HealthServe Day – to celebrate a 125 years of their existence will be held on 12 July 2003 in the midst of the Refresher Course and at the same venue - Oak Hill College. There will be seminars and key note speakers with a thanksgiving service to wind up the day. Contact Steve@healthserve.org for details.

Preliminary notice of a **Medical Missions Day Conference – 28th June 2003**. being organized by CMF and held at Partnership House, London. Open to students and graduate members (and others). Looking at issues related to service overseas with parallel seminars/workshops for students and graduates at various stages of their careers. More details will be available later from Peter Armon.

ITEMS NEEDED AND ON OFFER

WANTED – Perkins' brailers for use in a Romanian school for the blind run by a Christian charity. Currently, they only have 5 between 130 pupils. Please ring 0113 255 0272 or 0208 555 7658. You can leave a message if no reply.

Offered free to a mission hospital - 4 year old Bench top autoclave/sterliser (Intstaclave 230 model) but collection and delivery would be required. Contact: Chris Gibb at Chris.Gibb@gp-L83137.nhs.uk

BNF's are always in demand

Contact: Dr Anne Merriman at Hospice Uganda, PO Box 7757, Kampala
Email: info@hospiceafrica.or.ug

Peter Armon draws spiritual lessons from a challenging case

Grateful to be alive

She walked into the antenatal clinic looking the picture of health. It was her first visit and I was recording her details. At 26 years of age she was expecting her first baby and was excited at the thought of being a mother. 'Have you had any serious illness in the past', I asked. 'Oh yes', she said, 'I've had a heart transplant.'

Four years previously she had contracted a viral illness that rapidly led to severe cardiomyopathy and heart failure. Following the quick and fortuitous finding of a compatible donor, she underwent heart transplant surgery. After making a full recovery, she was told that she could live a 'normal life' and had now decided to start a family.

She was monitored carefully throughout her pregnancy. A close eye was kept on the baby too, who developed normally. She was allowed to go into spontaneous labour at term and she had a normal delivery of a healthy baby girl. Mother and baby were well when last I saw them several months later.

This was a patient who made me think. She was grateful to be alive but she knew that she would have to stay under the close eye of a physician and take her immunosuppressive medication daily for the rest of her life. She needed to avoid contact with infection, which could prove fatal. She also knew she was taking a risk in getting pregnant. She was alive only because, at just the right time, someone died and provided her with a new heart.

The Bible tells us that we all have a serious heart condition that is beyond hope of cure. The prophet Ezekiel foretold that one day God would give us 'a new heart'[1] and Paul tells us that 'at just the right time'[2] Jesus came into the world to do just that, bringing us new life through his death. My patient had undergone costly surgery. The new heart Jesus offers comes as a free gift.

Living the Christian life means we too need to maintain a close relationship with Jesus, the very best of physicians, but how many of us are 'grateful to be alive' and make the effort to maintain and develop that relationship? How many of us neglect the daily 'medicine' we need: time spent in prayer, reading God's word and in fellowship with other Christians? How much effort do we make to avoid the things that do us harm? Deliberately putting ourselves in harm's way by the company we keep, the things we read or the TV programmes we watch can be asking for trouble. Peter reminds us, 'Whoever would love life and see good days must ... turn from evil and do good'.[3]

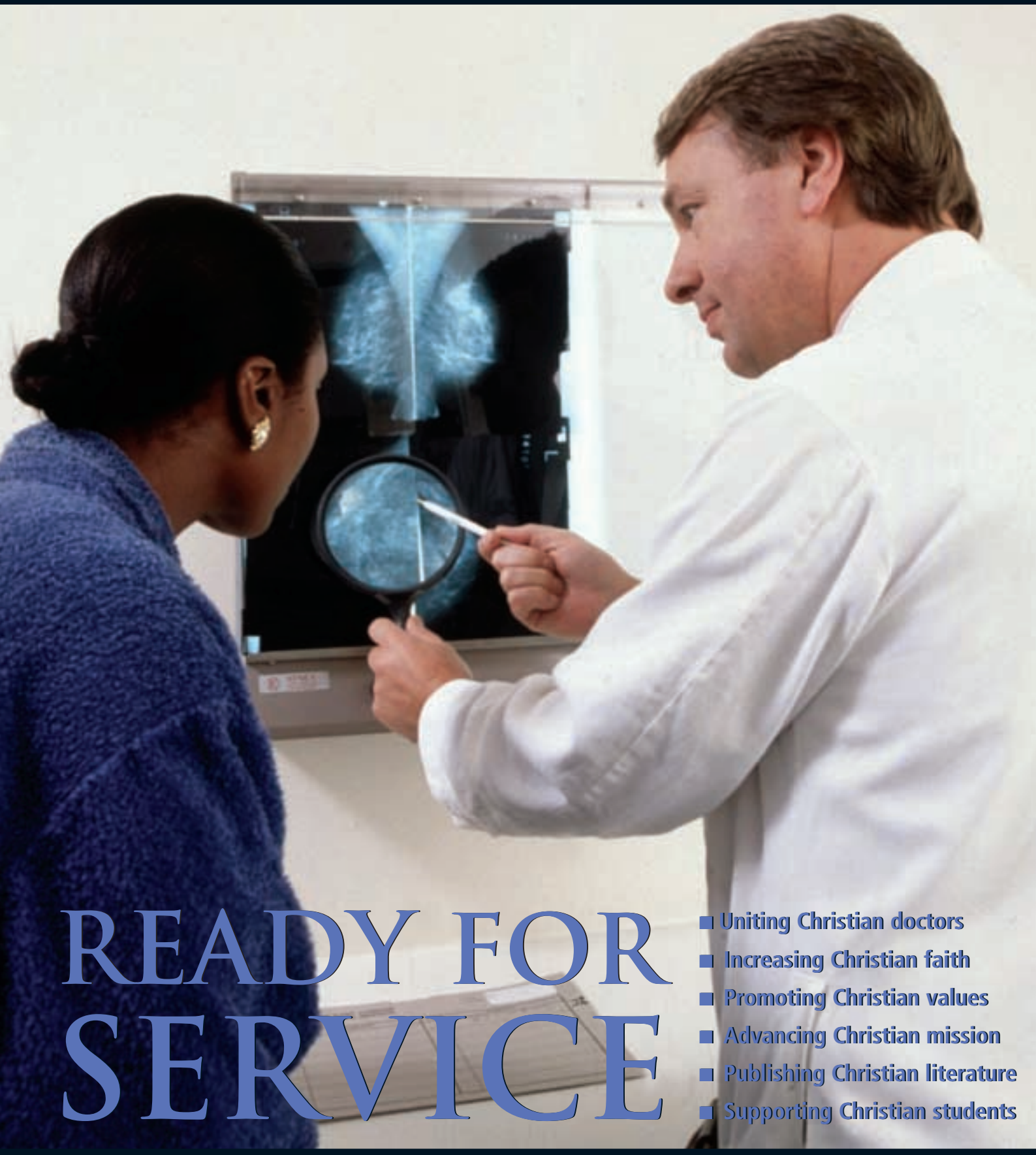
Finally, I was impressed by the fact that despite experiencing such trauma, my patient was still willing to take risks to bring a new life into the world. God asks that we too should be prepared to risk our comfort and even our lives if we are to be fruitful in our service of him. This was a lady who taught me a lot.

Peter Armon is CMF Overseas Support Secretary

References

1. Ezekiel 36:26
2. Romans 5:6
3. 1 Peter 3:10-11

CHRISTIAN MEDICAL FELLOWSHIP



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