TRIPLE HELIX

Winter 2005

For today's Christian doctor

SMACKING CHILDREN

SMOKING

EUTHANASIA

SEXUAL HEALTH

EUGENICS

STEM CELLS

AFRICAN STAFF EXODUS

ADDRESSING SPIRITUAL NEEDS

TRUSTING IN CHARIOTS

CHIROPRACTIC

SPIRITUAL HISTORIES

OVERSEAS OPPORTUNITIES

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EDITORIALS

Banning smoking

A welcome proposal

Smoking could be banned in offices and factories, restaurants and most pubs within four years under plans unveiled by the government. The plans form part of Health Secretary John Reid's White Paper on Public Health, and are expected to become part of the government's manifesto for next year's general election. The government is to be praised for adopting a bold and controversial position for the sake of potentially huge public health gains.

If the ban progresses as planned, government departments and the NHS will be smoke free by the end of 2006 and by 2008 the ban will be enforced in all workplaces, restaurants, cafes and pubs that serve food (currently 70% of the total). The ban has received a mixed response. Anti-smoking campaigners have complained that limiting the ban to pubs that serve food will lead to disputes over the definition of prepared meals, and mean that working class people who tend to drink in pubs that don't serve food will go on smoking while the middle classes are encouraged not to smoke. However, perhaps current perception of the response of bar landlords is questionable. Certainly after Ireland's ban, not only were profits not affected, but also more non-smokers ventured into pubs (*BBC News*, 31 May). And as far as who might quit, laws have never been the prime motivator for quitting, whereas societal taboos are. 'Redefinition of the unacceptable' has always been a powerful motivator for behavioural change. Perhaps a culture increasingly intolerant of smoking will be the biggest incentive for all smokers to quit. Observations on American trends illustrate this; smoking is increasingly perceived as socially unacceptable where bans are in force (*Tobacco Control*, December).

The announcements have also led to renewed claims from libertarians that Labour is 'nannying' the public. The Christian worldview, however, holds that the purpose of the state is to encourage what is right and to punish the wrongdoer (1 Peter 2:14; Romans 13:3-4), and so would naturally encourage the enforcement of the good in spite of public reticence. While smoking per se is arguably morally neutral (presuming one can do it without jeopardising the welfare of anyone else), addiction is certainly not, since anything that vies for dominance in our thoughts and desires with God is at best unhelpful and at worst idolatry. The potential health benefits are of course huge with billions spent each year on smoking related diseases.

As Polly Toynbee points out in the *Guardian* (17 November), with the once reviled seat belt laws, what once seemed a preposterous imposition, soon becomes accepted as common practice. And it may well prove that the most affected individuals are largely on side, since 70% of smokers want to give up anyway. Perhaps today's outrageous directive will prove to be tomorrow's shrewd decision.

Jason O'Neale Roach is on the editorial board of Triple Helix

The euthanasia bandwagon

Propelled by medical fence-sitting and indifference

The *Mental Capacity Bill*,[1] which gives full statutory force to advance refusals of food and fluids, passed its third reading in the House of Commons on 14 December 2004 by a majority of 354 to 118 amidst huge controversy about it bringing in 'back-door euthanasia'.[2] The government employed a three-line whip and the vast majority of supporting MPs did not attend the debate. 34 Labour MPs voted against the government and 100 abstained on grounds that they should have been allowed a conscience vote on such an important life and death matter. The bill now passes to the House of Lords. The medical profession has been largely silent throughout the proceedings.

Meanwhile, the Lords' Select Committee considering Lord Joffe's *Assisted Dying for the Terminally Ill Bill*,[3] has been hearing evidence and, according to sources close to proceedings, is now divided 8-5 in favour of the Bill. It will recommend a course of action to the House of Lords early in the New Year.

Both the Royal College of Physicians (RCP)[4] and the Royal College of General Practitioners (RCGP)[5] have chosen not to oppose the Bill in giving evidence to the Select committee. Furthermore the RCP spoke out on behalf of the Academy of Medical Royal Colleges apparently without actually consulting those colleges or its own membership. It is largely because of this that members of the Select Committee now believe that the medical profession is not opposed to the Bill.

This is despite the fact that the BMA, GMC, Royal College of Nursing (RCN), the Association of Palliative Care Specialists and CMF[6] all opposed the bill - although ironically three (unelected) members of the BMA Ethics committee - John Harris, Sheila McLean and Evan Harris - all appeared before the Select Committee representing the Voluntary Euthanasia Society which was supporting the bill.

The decision as to whether euthanasia becomes law is now poised on a knife-edge. It is imperative that Christian doctors protest to the Presidents of their own Royal Colleges[7] urging them to make clear their positions and to oppose the Bill.

In urging that doctors will rise up in protest I am reminded of the judgment of the War Crimes Tribunal in 1949:

'Had the profession taken a strong stand against the mass killing of sick Germans before the war, it is conceivable that the entire idea and technique of death factories for genocide would not have materialized... but far from opposing the Nazi state militantly, part of the medical profession co-operated consciously and even willingly, while the remainder acquiesced in silence. Therefore our regretful but inevitable judgement must be that the responsibility for the inhumane perpetrations of Dr Brandt...and others, rests in large measure upon the bulk of the medical profession; because the profession without vigorous protest, permitted itself to be ruled by such men.'

Peter Saunders is General Secretary of Christian Medical Fellowship

1 Treloar A. The Mental Capacity Bill. *Triple Helix* 2004; Autumn:6-7
2 *The Times* 2004; 15 December
3 *www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.pdf*
4 *www.rcplondon.ac.uk/college/statements/statements_assisted_dying.htm*
5 *www.rcgp.org.uk/press/2004/9506.asp*
6 See CMF Website on *www.cmf.org.uk* for full review
7 Addresses can be found at *www.aomrc.org.uk/pages/members.html*

Business as usual on the IAG

A report not to be mindlessly swallowed

The latest annual report of the Government's *Independent Advisory Group on Sexual Health*[1] was published in October 2004. The group was set up to monitor progress and advise the Government on the implementation of its sexual health strategy. It is chaired by the Labour peer Baroness Gould of Potternewton who is also the current president of the FPA (Family Planning Association). The vice-chair is Anne Weyman, the FPA's Chief Executive. Ian Jones, the Chief Executive of BPAS (British Pregnancy Advisory Service) is on the committee as 'abortion advisor' and Jan Barlow, the Chief Executive of Brook is also a member.

There are also eminent medical members of the committee, such as Dr Kevin Fenton, who have frequently stated that they consider that abstinence education has a part to play in good sex education. It is therefore disappointing to see that, along with some very helpful recommendations such as acceleration of the rolling out of the national chlamydia screening programme, the final 'groupthink' in the document contains much spin, distortion and patent lies about the role of abstinence. Early on the report states, 'there is clear evidence that abstinence-only education is ineffective. Abstinence-only approaches do not equip young people adequately to negotiate positive relationships… (they are) at higher risk of STIs and unplanned pregnancy because they have had little or no information about contraception and safer sex'. This assertion is unreferenced and untrue. The only research (as yet unpublished) to which this paragraph inaccurately alludes, is that of Bearman et al whose data[2] shows a very different picture from that painted in the report. This study examines the effect of pledging, not school-based abstinence education, and the pledging group were not at greater risk of STIs.

Having dismissed out-of-hand the possibly of changing primary sexual behaviours such as delaying first intercourse, the report falls back on the usual well-worn suggestions that confidentiality must be heightened so as not to frighten young people from accessing services (they do not mention the fact that 93% of girls with unplanned pregnancies have accessed services[3]) and that there should be an expansion of availability of free condoms through the NHS. No mention is made of the fact that Douglas Kirby, one of the doyens of sex education in the USA, considers that the 'jury is still out' on the effectiveness of condoms in schools.[4]

With regard to abortion, the only negative comment is about GPs who do not 'make their position clear on abortion and delay referral' (again unreferenced). They recommend that the NHS should carry out 90% of abortions. Perhaps this is just as well as the recent investigation of BPAS by the CMO must dent confidence in the probity of their service.

This report is as independent as one on passive smoking prepared by British American Tobacco and like the 'spring bubbling up with both fresh and bitter water'[5] should not be mindlessly swallowed.

Trevor Stammers is a General Practitioner in West London

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4. Kirby D. Making condoms available in schools. *West J Med* 2000; 172:149-151
5. James 3:11

'Choosing' our genetic future

A specious euphemism for prenatal eugenics?

The Human Genetics Commission's consultation *Choosing the Future: Genetics and reproductive decision-making*[1] closed on 15 November 2004. The consultation covers a variety of issues including designer babies, preimplantation diagnosis, prenatal screening and genetic counselling.

The HGC will report to ministers in 'late 2005'.[2]

CMF's full submission is available on our website.[3] The key points we made are as follows:

1. All people with congenital disability, genetic or otherwise, should be treated with the utmost respect at all stages of development. Resources for their treatment, care and support should be a top healthcare priority. Any policy that has the effect of identifying and eradicating groups of individuals with certain conditions from our community, whether based on expectation, coercion or free choice, is essentially eugenic.
2. Screening of embryos and fetuses as a prelude to disposal or termination, if it is to be allowed at all, should only be carried out for disorders qualifying under section 1(1)(d) of the Abortion Act 1967 (ie. 'there is a substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped'). In addition 'serious handicap' must be objectively defined.
3. Provision of screening tests for termination for any given condition should never be carried out at the expense of providing proper treatment, support and palliation for existing individuals with that condition.
4. No screening for any given condition should be offered unless there is proper provision for all parents being screened to give fully informed consent to screening, to discuss with a fully trained genetic counsellor the implications of the diagnosis, prognosis and intervention/treatment options, and to have the time and support to consider available options and come to a decision.
5. We believe that most antenatal screening currently being carried out in General practice and in antenatal clinics is being done without fully informed consent or adequate counselling and that a conveyor belt system of 'prenatal eugenics' already operates. This needs to be urgently addressed before genetic screening is made available for more parents or for a broader range of conditions.
6. We are gravely concerned that widely available prenatal screening for termination will lead to the eradication of whole categories of people with specific genetic disorders from our community and subsequent stigmatisation, discrimination against and inadequate support for individuals and families who are perceived as 'escaping through the net' and thereby creating an intolerable burden for society.
7. Primary prevention (ie. genetic screening of sperm and eggs or advising parents not to have children), encouragement of adoption, and tertiary prevention (treatment of handicapped individuals prenatally or postnatally) are ethical alternatives to so-called secondary prevention (prenatal diagnosis and disposal/abortion) that should be vigorously promoted and adequately resourced.

Peter Saunders is General Secretary of Christian Medical Fellowship

1. *www.hgc.gov.uk/choosingthefuture/index.htm*
2. *www.hgc.gov.uk/choosingthefuture/ChooseFuturefull.pdf*
3. *www.cmf.org.uk/ethics/submissions/hgc_nov04.htm*

Peter Saunders reviews the latest developments

Stem Cells

The battle over stem cells intensified throughout 2004 becoming a major issue in the US election won by Republican George Bush on 4 November. Much of the controversy centred around different views on the status of the human embryo, and the fact that embryos have to be created and destroyed to produce stem cells. Bush's policy was to restrict federal funding to research on the 78 embryo stem cell lines in existence since 9 August 2001, banning both the use of all new human embryos and the creation of cloned human embryos through cell nuclear replacement. Democrat candidate John Kerry supported funding the use of embryo stem cells, cloned and otherwise, to develop treatments for heart disease, Alzheimer's, Diabetes and Parkinson's.[1]

The emotional intensity of the debate was raised considerably by the involvement of celebrities who threw their weight behind Kerry. *Back to the Future* star Michael J Fox, who has Parkinson's disease, made a television advert supporting Kerry's campaign in October.[2] *Superman* actor Christopher Reeve, who was paralysed in 1995 after falling from a horse, campaigned tirelessly for the Democrat candidate, believing that his only hope also lay with embryo stem cells. He died just before the election on 10 October.[3] Nancy Reagan claimed that the life of her husband former US president Ronald Reagan, who died in June from Alzheimer's, could have been saved by embryo stem cell research. The *Washington Post* hailed this 'Reagan-inspired tidal wave of enthusiasm' as 'an example of how easily a modest line of scientific inquiry can grow in the public mind to monumental proportions'.[4] Ironically Alzheimer's, in contrast to spinal injuries and Parkinson's, involves widespread diffuse neuronal and synaptic loss, and is most unlikely to benefit from stem cell treatment.

The scientific community on both sides of the Atlantic have not been quick to dispel the myths or counter the claims. In the UK, the British media and public have been consistently misled into seeing cloned embryos as a panacea for treating degenerative diseases through the Government's failure or unwillingness to highlight the dangers and to rectify misconceptions about the properties of the more ethical alternative of adult stem cells propagated in the now seriously dated 2000 Donaldson report *Stem Cell Research*. Such selective interpretation and presentation of scientific data is both irresponsible and dangerous because it falsely raises the hopes of vulnerable people. Honest and balanced reporting of the facts should always take precedence over the prestige and profit motives of the government and biotech industry.[5]

Over 2,000 colleagues in CMF's US sister organisation CMDA signed a letter to Congress and the President on 30 July 2004 urging investment in *adult* stem cell research and warning that *embryo* stem cell research is likely to prove both expensive and non-productive.[6] In a three year review of research since Bush's original 2001 decision (and post Donaldson) they concluded that 'verified accomplishments of *adult* (non-embryonic) stem cell research are already providing hope and therapy for patients suffering from heart muscle injury, diabetes and brain damage from stroke with realistic promise for treating other diseases on the horizon. The government needs to put taxpayers' money into ethical research that will get us the most affordable cures for our patients in the quickest time.'

Assessing the peer-reviewed evidence catalogued in great detail on the CMDA website[7] they conclude that:

1. Embryonic stem cells have yielded only very limited and/or questionable success in animal models and no therapeutic application whatsoever in human beings:

- Human embryonic stem cells are difficult to obtain, develop and maintain and are unstable and mutate in culture.
- Differentiation protocols for many cell types have not been developed and cell types that have been differentiated often act abnormally.
- When embryonic-derived cells have been placed in animals, cancerous tumours have formed.
- Cloned cells, used to address the problem of immune rejection, are not normal.
- At a cost of over $200,000 per patient, only the very wealthy could afford the procedure.

2. Adult stem cells are ethically obtainable from multiple sources in human beings and research over the last three years has made great strides:

- 'Adult' (non-embryonic) stem cells have been found in cord blood, placenta, bone marrow, fat, teeth and other sources.
- Adult stem cells found in one type of tissue can repair damage in another tissue type and can be harvested from each patient, multiplied in culture and transplanted back into the patient.
- Since adult stem cells require limited, if any, manipulation, and are readily available from a number of sources, the cost for their clinical application will be far less.
- There are no ethical concerns in their use, making them acceptable to virtually all patients and healthcare providers.
- Adult stem cells are already providing cures in animals and clinical human trials.

From October to December 2004 three independent reports of patients showing recovery from spinal injuries after *adult* stem cell transplants surfaced in Russia,[8] Korea[9] and Portugal[10] respectively; and a group in Innsbruck have reported success in using the same technology to treat stress incontinence.[11] We will have to wait and see if these so-far small studies are confirmed; but it seems that Christopher Reeve's hope may have been misplaced. Either way we will get far more answers through following the biblical injunction to 'enquire, probe and investigate'[12] than we will through the enthusing of ill-informed celebrities and politically motivated media spin.

Peter Saunders is Managing Editor of Triple Helix

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12. Deuteronomy 13:14

Kevin Vaughan reflects on our assessment of the spiritual needs of patients

Taking a Spiritual History

KEY POINTS

There is a growing awareness of the link between spirituality and health, but most doctors are completely untrained in taking a spiritual history and many are unaware of the substantial evidence demonstrating that faith has a positive impact on illness prevention, coping with illness, recovering from surgery and treatment outcomes. Taking a spiritual history at the appropriate time may be one way of opening a door for further conversation or prayer and it can certainly help the medical team manage patients more appropriately. There are several effective models but all should enquire about belief, practice and support from a faith community.

There is 'increasing emphasis on spirituality as a factor contributing to wellbeing and coping strategies' said Speck and colleagues in a recent *BMJ* editorial.[1] A team from the Royal Free Hospital, London, has also discovered in a study of acute admissions to that hospital that 71% of people have an important spiritual belief even though many do not express it in a religious way.[2] Further, spiritual needs are an issue for trust managers. Sarah Mullally, Chief Nursing Officer and the Department of Health's lead director on public and patient involvement, argues that faced with a choice between a trust geared up to caring for patients in a holistic way and another which treats them like a series of clinical episodes, patients will vote with their feet. She goes on to say that healthcare professionals and the organisations in which they work 'need to recognise that in healthcare we join people on their life journey and for a time we travel with them. We need to understand better who they are and how we can work with them as partners on that journey. Central to this is understanding them as individuals who have many dimensions including a spiritual one'.[3]

Remembering motives

Many doctors, even Christians, are surprised by these recent developments in our NHS and do not know how to respond. Most of us are completely untrained in taking a spiritual history and many are unaware of the substantial evidence demonstrating that faith has a positive impact on illness prevention, coping with illness, recovering from surgery and treatment outcomes.[4,5] As clinicians we will want to do our part in helping our patients and their families deal with their presenting complaints and associated issues. However as Christians we may also long that our lives would express the Gospel in such a way that those we meet may be drawn to know God personally. Paul writes to the Colossians: 'Be wise in the way you act toward outsiders; make the most of every opportunity. Let your conversation be always full of grace, seasoned with salt, so that you may know how to answer everyone.'[6]

How do we find appropriate words to get started in conversation, particularly in the clinical context? Taking a spiritual history may be one way of opening a door for further conversation and it can certainly help the medical team manage patients more appropriately. It is encouraging to see that in a medical school in New South Wales, Australia, which serves a population of mixed ethnic origin and religious belief, spiritual history-taking has been integrated into the regular student curriculum, through the influence of one palliative care physician. As in taking any medical history, we will need to approach our patients with 'gentleness and respect' in the spirit of 1 Peter 3:15.

Examining models

Various models for spiritual history-taking have evolved and all contain three key components:

Belief, Practice and Faith Community. Many of us are afraid that time constraints will prevent us from getting involved in this area, but it only takes three simple questions to gain the basic information. The words used may depend on the style of the individual questioner and whether the questions are part of a formal history for admission/health maintenance or coming up naturally in the course of conversation. Typical questions which may be asked are:

Belief: 'Do you have a faith which helps you (in a time like this)?' 'Do you have a personal faith?' 'What is important to you?'
Practice: 'How does it affect your life?' 'Have you ever prayed about your situation?'
Faith Community: 'Do you belong to a faith community?' 'Who gives you support?' 'What keeps you going?'

There may be a particularly good opportunity to take a spiritual history:

1. When someone is suffering from major illness, terminal disease or dying
2. In the perioperative period
3. At registration or health maintenance check
4. In a social crisis or time of loss

It may be best to ask only one question at a time and to gather the information incrementally over several consultations, or it may even be possible for an assistant to take a history at routine registration. It is not necessary to follow up the information immediately, but it is available when required for a subsequent occasion. Working in the context of General Practice I have found the questions 'Do you have a faith that helps you?', 'Have you ever prayed about your situation?' and 'Who gives you support?' can often be asked quite naturally during the consultation. Elizabeth Croton has helpfully written in a similar vein from the hospital context, in previous editions of *Triple Helix*.[7,8]

It is surprising how often a door to further conversation or an opportunity to pray with a patient may develop. However, even if a patient appears to respond negatively, that in itself is valuable information. A positive response of allegiance to another faith such as Judaism, Islam or Jehovah's Witnesses (or the knowledge that our patient's main support comes from fellow-members of the local amateur dramatic society), will help us in providing appropriate care to our patients.

Restoring meaning

Nowadays many people struggle to know where to turn for help on spiritual issues as they have no regular contact with the church and may feel it is not accessible or relevant. On the other hand, most people do have contact with healthcare professionals at some time, but again they may feel that this is not the right arena to raise spiritual issues as the professionals are busy coping with 'a series of clinical episodes'.[9] However those professionals who are willing to take a small initiative in asking a gentle question may have great opportunities to offer help. A recent research article in *Palliative Medicine* which states that spiritual care is about helping people whose sense of meaning, purpose and worth is challenged by illness, found, after conducting 149 in-depth interviews, that '*Many patients and carers were uneasy about turning to health and social services for spiritual support, although if they did find professionals who were able and willing to discuss such needs, this was much valued*'.[10]

Let us pray that with courage and the help of God, we professionals may be able to help our patients in this area and so fulfill a vital element in our vocation.

Kevin Vaughan is CMF Associate General Secretary

A CMF member who has recently started taking spiritual histories writes:

'I have come to realise that even on a bad day and despite time constraints, there are simple things that you can do and say which may have quite an impact. One of the things that I've found most helpful is the simple question, 'Do you have a faith that helps you?' It's a non-threatening question that can be slipped into a consultation quite easily.

Two weeks ago, I was seeing one of my regular patients, who has recently lost her husband and is suffering with profound depression. I asked her this question and she looked rather taken aback and then said 'I used to be a Catholic'. I didn't feel it was right to go any further and so left it there. She came back today and quite spontaneously said, 'I believe in God. Do you think he can help me?'. We then went on to have a wonderful conversation about the power of prayer and how helpful it can be in times of need. She then expressed concern that she was under pressure from her neighbour and her sister to become a Jehovah's Witness and she thought their religion might not be true. I agreed with her and we briefly discussed some of the differences between Christianity and the Jehovah's Witnesses. I also suggested that she try the local Anglican church.

This lady had come in with her head down, looking deeply unhappy, but as she left, she had a big smile on her face and said, 'I'm going to start praying!' I've been caring for this lady for two years and this topic of conversation has never come up before, so I can only assume that it was the result of my initial question two weeks ago that opened the door. I was really encouraged and look forward to exploring all this further with her in future consultations!

IT ONLY TAKES THREE SIMPLE QUESTIONS TO GAIN THE BASIC INFORMATION

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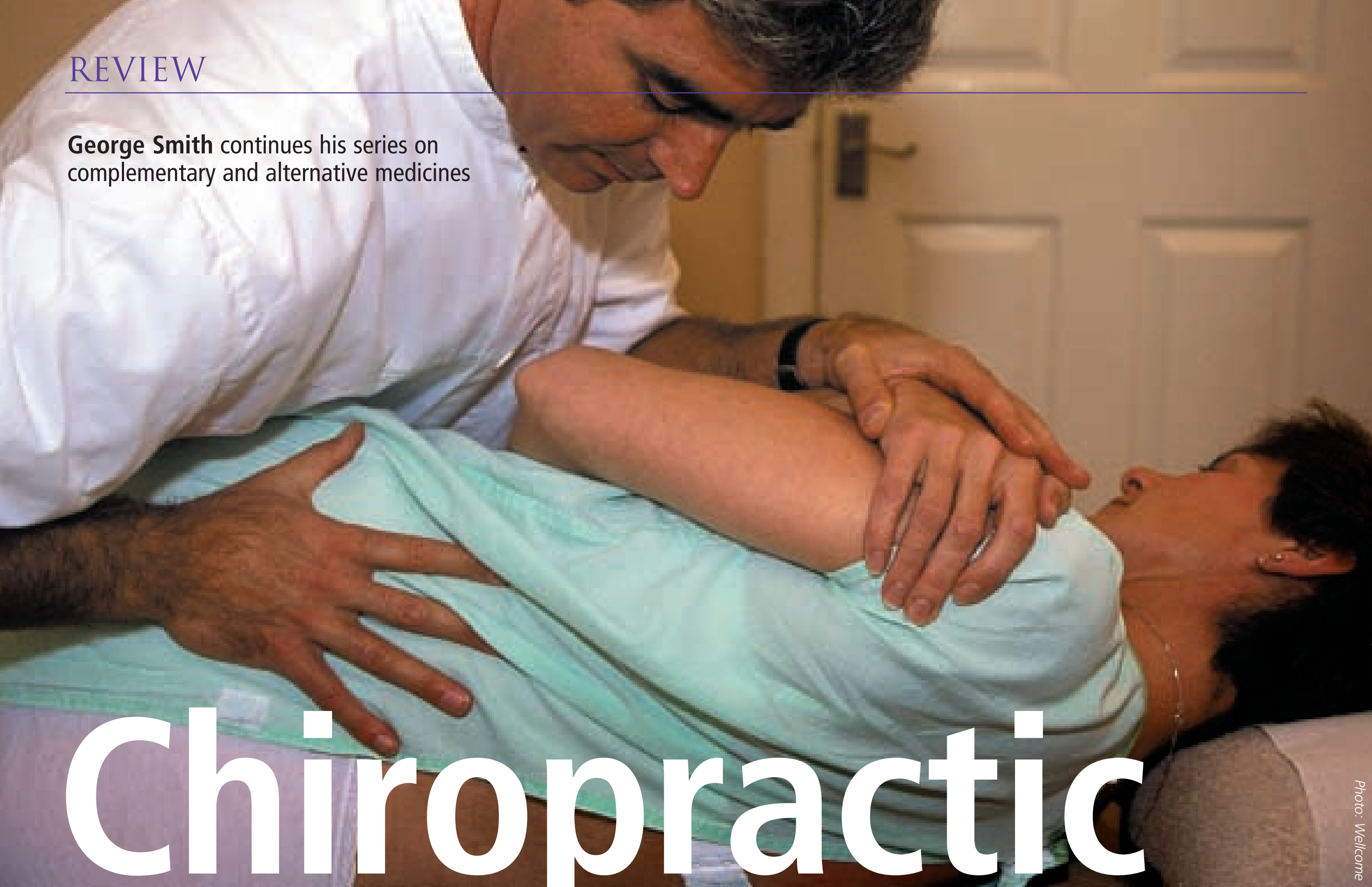
George Smith continues his series on complementary and alternative medicines



Chiropractic

Photo: Wellcome

KEY POINTS

Chiropractic is an alternative system of healthcare and healing based on manipulation of the spine. Its founder, Canadian grocer DD Palmer, believed that maladjusted or displaced vertebra pressed on nerves, interfering with the flow of 'Innate Intelligence' and resulting in defective function and poor health which could be alleviated by chiropractic adjustment. Consistency and reliability of specific chiropractic diagnostic methods, and a credible and verifiable scientific basis have not been shown, and in controlled trials results are inconsistent for back pain, and not demonstrable for other disease. Its basis in a non-Christian belief system and safety factors raise additional concerns.

Chiropractic is one of the most widely used systems of alternative health care available today. It is particularly popular in Canada and the USA, its country of origin, where there are over 50,000 practitioners. It is also available in many other countries around the globe. It was rather slower to take off in the UK, lagging behind osteopathy, but is now increasingly popular with some 4,500 practitioners on the current Register of Chiropractors.

There is a wide variation in claims, application and scope of chiropractic today. The majority of consultations are for musculo-skeletal problems, particularly of the back, neck and shoulder. However, chiropractic as set out by its founder was believed to be an effective treatment for a wide range of diseases including asthma, cardiac problems, digestive disorders, migraine and infantile colic; this is despite no evidence of these conditions having spinal origins.

Definitions

The term chiropractic derives from two Greek words, *chiro* (*kheiro*) meaning hand and *practicos* meaning practical - the practical use of hands. Concisely, it can be defined as a system of healthcare and healing based on manipulation of the spine.

In 1999 the World Federation of Chiropractors defined chiropractic as 'a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculo-skeletal system and the effect of these disorders on the function of the nervous system and on general good health. There is an emphasis on manual treatment including spinal manipulation or adjustment'.

The General Chiropractic Council defines chiropractors as 'autonomous primary care practitioners who take an integrated and holistic approach to the health needs of their patients considering physical, psychological and social aspects'.

Origins

Manipulative techniques can be identified in ancient Egyptian, Hindu, Chinese, Babylonian and Assyrian civilizations. Hippocrates (460-370 BC) advised Greek physicians to 'look well to the spine for the cause of disease'. Bone setters have practised throughout history, being particularly popular in the nineteenth century. It cannot be assumed, however, that any of these groups were forerunners of the specific philosophy and techniques practised by DD Palmer, the founder of chiropractic.

David Daniel Palmer (1845-1913), a Canadian grocer, originally became interested in magnetic healing and mesmerism (hypnosis). He studied anatomy and physiology and was a student of AT Still, the founder of osteopathy. His interest in manipulative treatment began when he noticed that his janitor, Harvey Lilliard, had a swelling on the back of his neck. Believing that this was a displaced vertebra, Palmer manipulated it into place with a noticeable pop. Amazingly, the janitor's deafness of 17 year's duration appeared to have been cured. Although this pivotal event is recorded in all accounts of the founding of chiropractic, no corroborative evidence is offered.

Palmer apparently achieved remarkable successes with asthma and heart disease. He came to believe that 90 percent of disease was associated with spinal

problems, which could be alleviated by chiropractic adjustment. A patient, Rev Samuel Weed, first coined the term chiropractic. The Palmer Infirmary and Institute of Chiropractic was opened in Iowa, USA in 1895. Palmer's son, BJ Palmer, developed and expanded this new therapy.

A small volume called *The Chiropractor* contains original lectures by Palmer on the principles, science, art and philosophy of chiropractic.[1] He passionately believed that the exercise of chiropractic was a moral and religious duty. He also believed that the spirit in man is part of the Innate Universal Intelligence, which is present in and controls our whole body. He identified this as being known to Christians as God, but it can clearly be equated to the Universal Cosmic Energy or Vital Force of many Eastern religions and alternative therapies with New Age associations. He believed that a maladjusted or displaced vertebra – subluxation – pressed on nerves, interfering with the flow of Innate Intelligence, so resulting in defective function and poor health.

Present practice

Diagnosis

Following a medical history, chiropractic examination concentrates on posture, inspection and palpation of the spinal column. This includes motion palpation and nerve tracing as specific chiropractic techniques (possibly with an intuitive element) together with tests for musculo-skeletal function to identify vertebral maladjustments (luxations or subluxations). These are said to press on nerves (by impingement, pinching or constriction), blocking the free flow of energy within them. X-rays may be taken to exclude organic disease or injury but do not necessarily indicate specific evidence of subluxations. Although Palmer did not use them, laboratory investigations are sometimes ordered today.

Specific chiropractic diagnostic techniques have been tested for reliability but showed poor accuracy.[2,3] A larger group of diagnostic methods used by chiropractors – visual postural analysis, pain description, lumbar X-rays, leg length discrepancy, neurological and orthopaedic tests, plus motion palpation – have revealed only moderate inter-examiner agreement. It was concluded that these diagnostic tests were not reproducible.[4] Consistency and reliability of specific chiropractic diagnostic methods have not been demonstrated.

Treatment

Advice regarding posture, exercise and lifestyle is given but the characteristic element of chiropractic treatment is manipulation of the spine and its associated joints, usually by high velocity/low amplitude thrusting techniques, together with massage and manipulation on specially designed tables. Vertebral adjustment by these techniques is designed to restore normal positioning and proper function. There may be an audible crack, said to be the sound of gas bubbles bursting under pressure rather than bones cracking.[5] This claim appears to be speculative.

Treatment by manipulation and massage has by no means been neglected by orthodox doctors and physiotherapists; it is not the prerogative of chiropractors and osteopaths. Manipulation has been advocated by physical medical specialists (especially Doctors Cyriax and Maitland) and orthopaedic surgeons, but for clearly defined and scientifically verifiable conditions. Terminology varies but doctors and physiotherapists usually define manipulation as high velocity/low amplitude techniques and describe other manipulations as manual therapy.[6]

Regulation

Unlike most alternative therapies, chiropractic is well regulated. The British Chiropractic Association was formed in 1925. The Chiropractic Act of 1994 set up the General Chiropractic Council (GCC) to maintain a register of all qualified chiropractors and regulate teaching and qualifications. A four year internationally accredited degree course is available at the Anglo-European College of Chiropractic in Bournemouth or the McTimoney College of Chiropractic in Oxford, leading to a BSc Chiropractic or Diploma in Chiropractic.

POPULARITY AND REGULATION DO NOT, OF THEMSELVES, GUARANTEE EFFICACY AND SAFETY

Medical checklist

Does it have a rational scientific basis?

A credible and verifiable scientific basis has not been established. Palmer's original cures lack confirmation and explanation. As hearing depends on the VIII *cranial* nerve, vertebral adjustment of a spinal nerve is most unlikely to restore hearing. Neither X-rays nor post mortem examinations have shown reliable evidence of subluxations or their pressure effects on nerves.[7] No verifiable scientific evidence has been produced confirming subluxations to be the cause of general medical disease. Innate Intelligence is a spiritual or metaphysical concept, not verifiable scientifically.

Does it work?

Hundreds of studies and more than 50 systematic reviews of published papers have been used to investigate chiropractic. Most investigations have focused on back pain and neck problems with far from convincing results. Professor Ernst, of the Department of Research into Complementary Medicine at Peninsular University, commented: 'None of these systematic reviews demonstrate beyond reasonable doubt that chiropractic interventions are effective in treating these conditions or that they are superior to other treatments – for example, physiotherapy or drugs'.[8]

Whilst some past trials suggested that chiropractic treatment might be efficacious for low back pain, two recent investigations have not confirmed this.[9,10] Most studies for other conditions including migraine were not of high quality. Manipulation

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and massage may benefit muscle spasm, tension and pain, but this is not exclusive to chiropractic. There is no convincing evidence of significant benefit in general disease, including cardiovascular, gastro-intestinal and respiratory diseases, migraine or cancer.

Is it safe?

Systematic reviews reveal considerable evidence of both minor and serious complications, including stroke, spinal injury, thrombosis and joint dislocations, although these are relatively uncommon in relation to the total number of consultations. Recent studies suggest that half the patients suffered some side effects, albeit not serious. A further study reported 177 severe complications after cervical spine treatments and 295 complications of all spinal treatments with 32 fatalities.[11] *Chiropractic: The Victims' Perspective* reported 20 serious complications.[12]

In his book *Back Pain*, Professor Ernst states: 'Contrary to what is often said, spinal manipulation is by no means free of risk. In particular, upper spinal manipulation has been associated with serious complications'.[13] He suggests that complications are under reported. Chiropractic should be avoided in the elderly, osteoporotic or those with malignant or spinal inflammatory disease and those on anticoagulants. Overuse of X-rays is a further potential danger.

Christian checklist

Can it be recommended with integrity?

Claims that chiropractic is safe and effective have not been substantiated. Popularity and regulation do not, of themselves, guarantee efficacy and safety. Exclusive use of an unproven alternative therapy may lead to delay in diagnosis and subsequent effective orthodox treatment, sometimes with serious results.

What are its roots?

Palmer's concept of Innate Intelligence clearly underpins his philosophy of chiropractic. It is akin to the New Age pantheistic view of God, quite unlike the Christian belief in a personal Father God. Whilst this concept has been discarded by some modern chiropractors, it was endorsed by John Thie, a prominent Pasadena chiropractor: 'The chiropractic believes that the Innate Intelligence that runs the body is connected to the Universal Intelligence that runs the world, so each person is plugged into the Universal Intelligence throughout the nervous system. It is the job of the chiropractor to help this communicating system to ensure that the body will function'.[14]

Is it harmful?

Observations in *Complementary Medicine – an Objective Appraisal* are salutary, particularly for Christians: 'The Innate Intelligence of chiropractic, the qi of acupuncture and the vital spiritual force of homeopathy have persuasive theoretical effects'. It continues, '…a full participant in chiropractic, acupuncture or homeopathy is having more than their spine adjusted with hands, their meridians opened with acupuncture needles and their spiritualised life force finally connected to its dematerialised counterpart'. Or as Oths said, '…in essence, the chiropractor first manipulates a patient's belief structure before manipulating his or her physical structure'.[15]

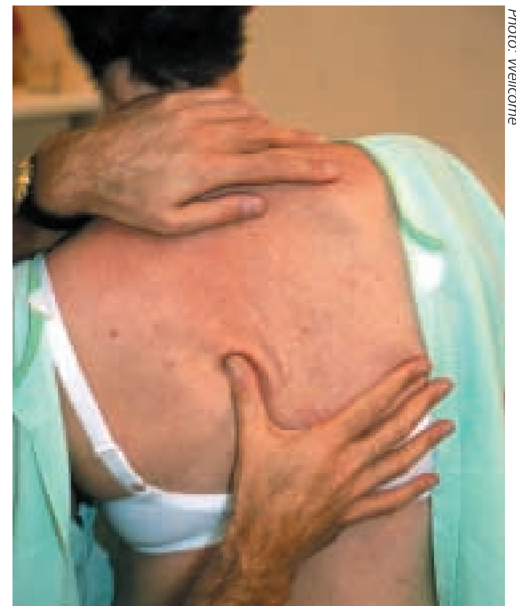
Photo: Wellcome

In assessing the validity of any alternative therapy, a Christian carer needs to exercise spiritual discernment. Contact or involvement with dubious alternative therapies or New Age practises may lead to spiritual ill health, manifested as anxiety, depression, fear, lack of Christian assurance or interference with prayer life and Bible reading.

Conclusion

The popular view that chiropractic is a proven and safe manipulative treatment, particularly for back and neck problems, is not confirmed by detailed investigation. There is confusing and unconvincing scientific evidence for its effectiveness and serious concerns about its safety. The philosophy of chiropractic is clearly based on a non-Christian belief system, which raises important additional spiritual concerns for Christians. I believe there are convincing reasons for this therapy to be avoided.

Ye should do that which is honest. (2 Corinthians 13:7 KJV)

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Fiona Underhill reflects on the opportunities and responsibilities of General Practice

Addressing spiritual needs

As a GP I come into contact with more spiritually needy people during the course of one day in my surgery than many ministers do in a month. As doctors in general, and GPs in particular, we can often build long-term relationships with patients, leading to both great opportunities and great responsibilities.

HALF OF THE CONSULTATIONS I HAVE IN AN AVERAGE DAY ARE FOR NON-MEDICAL PROBLEMS

Great opportunities

1. Opportunities because people respect us

Someone told me recently that the medical profession is among the few remaining professions that still retain widespread public respect and trust. Of course we cannot take this for granted and need to earn that respect by being the best possible doctors we can, combining excellence in medical care with a compassionate and caring approach. Yet considering our patients' spiritual needs is part of practising good medicine: the holistic approach demonstrates our belief that people are not just mind and body, but have a spiritual dimension as well. If patients respect us as good doctors, they often ask for advice on other issues and may be ready to listen to spiritual counsel.

2. Opportunities because people come to us with all sorts of needs

I would estimate that up to half of the consultations I have in an average day are for non-medical problems, from relationship problems and dealing with difficult teenagers, to unemployment and work stresses. There can be few jobs where there are greater opportunities to share the Gospel! Of course this must always be done sensitively, offering Christ but never forcing him on people, listening first to where our patients are at on their spiritual journey, and never abusing our position. In nearly 20 years as a GP I have never had a single complaint from a patient that resulted from me sharing my faith or talking about Jesus. There are so many ways we can do this, some more direct than others: posters on the surgery wall; a Gideon Bible in the waiting room; appropriate Christian literature; invitations to an *Alpha* or *Christianity Explored* course; as well as simply taking opportunities in conversation to talk about the Lord or offer prayer for the patient.

3. Opportunities because we know the one who can help

A man consulted me recently because he was consumed by guilt after a one-night stand: he had never cheated on his wife before, but their marriage was fraught with difficulties and he had drunk too much that night. What does a non-Christian GP have to offer in this situation? What a privilege it was to show him 1 John 1:9 and share with him the truth that God is able to forgive all sin through the death of his Son. We know that only Jesus can deal with guilt and fear of death, as well as giving meaning to life. How can we not share this when asked?

4. Opportunities because we have a network to refer to

Recently I have been able to refer a drug addict to a wonderful Christian rehabilitation centre, a family struggling with debt to an excellent Christian debt counselling agency, a lonely elderly man to a retired man in our church for friendship, and a couple having marriage difficulties to a marriage course at our church. We are privileged to have access to other Christians who can help us in our ministry, as well as pray for us.

Great responsibilities

With great opportunity comes great responsibility. Ezekiel was told in chapters 3 and 33 that if he did not warn the people of Israel about God's coming judgement, he would be held responsible for their death. If we know that people without Christ lack hope, and we have the opportunity to warn them and point them to Jesus, how can we not do this? I fear that when we waste time worrying about what people might think, or whether we might possibly offend someone, we have lost sight of the urgency of their plight. A South African bishop reportedly instructed the clergy under his oversight to write 'Lost people are headed for Hell' across the top of their diaries. 'Now organise your time around this priority,' he told them.

However good we are as doctors, all of our patients will die one day and face the judgement of God. The greatest thing we can do for them is to help them be prepared for that.

Fiona Underhill is a GP in Essex

Gabriel Toma looks at this emerging medical manpower crisis

African Healthcare Exodus

KEY POINTS

Sub-Sahara Africa needs another one million workers to fight HIV, AIDS, malaria and TB. But this shortfall has been created by migration of trained doctors and nurses to richer nations, rather than an inadequate supply of locally trained personnel. Migration is fuelled by a desire for better working conditions and training, better wages, prestige and the desire to help family. It is potentiated by the lack of good role models, poor handover to nationals and a 'poor mentality'. Shining out from this gloomy picture are some inspiring best-practice models. Solutions are achievable, but results will come only when Africans mobilise their resources with all support possible from the worldwide church.

As the continent with the most poor people, Sub-Sahara Africa is a place of great need. More than 350 million (out of a population of 765 million) people live on less than a dollar a day; and, unlike other poverty-stricken continents, this proportion is rising.[1]

In 2000 Africa's debt stood at 334 billion dollars. Every year, eight billion dollars are repaid but another five to six billion dollars of debt are simply rescheduled. Tanzania alone spends nine times more on debt repayment than on healthcare.

How is this debt to be repaid? Africa is home to 70% of the world's HIV positive population and 87.5% of HIV positive children.[2] So, as AIDS ravages African life expectancy, there are fewer and fewer people fit enough to work, boost economies and repay debt. Continuing political instability and corrupt governments eat further into the meagre money-pots.[3] Under these circumstances, there is no chance of Sub-Sahara Africa ever being debt free.

Staffing crisis

Africa is staggering under the world's heaviest disease burden but has the lowest health care professional:patient ratio; for example, Uganda's doctor:patient ratio is 1:24,700.[4]

There is an unprecedented exodus of African healthcare professionals and it is worsening by the day. Of the 600 Zambian doctors trained since independence, only 50 are said to have remained in the country.[5] Ghana has lost more than 12,000 health professionals since 1993.[6]

My own survey of Nigerian medical students showed that at least 60 percent want to add to this brain drain. Of the 40 percent who may remain, less than 20 percent plan to make decisions based on the needs around them or stay in rural regions.

So, where have these departing professionals gone and how severe is the resulting shortage? A recent study by the Joint Learning Initiative, which includes the World Health Organization, concluded that Sub-Sahara Africa needs another one million workers to fight HIV, AIDS, malaria and TB. Rich nations poaching African doctors and nurses was identified as the major factor in this shortage.[7] A Canadian survey revealed that 23 percent of practising physicians were trained abroad. More than twenty percent of American physicians graduate overseas.[8]

Self-actualisation

Most African health facilities do not have adequate infrastructure. There is never enough up-to-date equipment. Very few Sub-Sahara post-graduate educational programmes provide a level of training that provides self-actualisation for most physicians. Having turned to the developed world for such training, beneficiaries find it hard to return to their former conditions.

Advantageous positions

Medical training is very costly for an African family. Financial sacrifices are made in the hope that the doctor-to-be will one day help his/her extended family. Such a doctor who then goes on to complete developed world educational programmes is generally regarded highly, having achieved economic empowerment and influence. There is a lot of pressure to stay put in their host country and benefit the extended family.[9]

Many of us think of ourselves first. Our family and circumstances inform our choices and decisions. We are less concerned about the needs around us, or our Lord's wishes.

Westernisation

There are areas of Africa where the Christian influence of early missionaries is difficult to differentiate from westernisation. This has made it difficult for many Africans to return to their

home countries or villages; the conditions there no longer match what they have come to embrace as *the* way of life.

Missionary transition

Some mission societies have done very well in handing over mission leadership to local nationals. Still, how much preparation was given to the nationals before they were handed such responsibilities? Do national leaders now truly own the missionary vision? It should be noted that, in some situations, leadership transitions were forced by political circumstances.

Poor mentality

Most Africans see themselves as poor; indeed, most are poor. Yet, even worse than being poor is the possession of a *poor mentality* - wallowing in self pity and blaming every ill on poverty. Such an attitude of dependence on outside help causes individuals to be so absorbed with their own needs that they are not able to see the needs of others, let alone consider helping them.

Role models

There are very few examples of strong African leadership in healthcare missions. In part, this may be due to a lack of vision, a failure to be burdened for the lost. Strong leadership commands respect, and could be a great influence on the decisions of the next generation of African doctors.

Churches

Lack of church support has contributed significantly to the dearth of healthcare workers. Very few churches have demonstrated commitment to healthcare missions in their finances, or in spiritual, emotional and social support of missionaries. Worse still, corruption amongst some church and mission leaderships has discouraged and disillusioned many sincere young healthcare professionals. People hate to see their sacrifices enriching leaders' pockets.

Materialism

The worldwide trend for materialism has captured African societies. Throughout developing Africa there is a strong craving for wealth, pleasure and personal convenience. Yet it is so much easier to satisfy these cravings in the developed world.

Specialist training

Western medical training and expertise encourages specialisation and sub-specialisation. So often western-trained African doctors find it difficult to fit back into their original rural communities. Much western medical technology is unavailable anywhere within a whole African country, let alone in individual rural communities. It becomes frustrating for such highly-trained people to remain in rural set-ups. The natural trend is to move to centres where the challenges of modern facilities exist.

Shining examples

Shining out from this gloomy picture are some inspiring examples.

In Nigeria, the Baptist Medical Centre and ECWA Evangel Hospital have established themselves as credible high quality training centres for family medicine. Many of their doctors accept good training in place of high salaries. This has provided a steady stream of physicians for these institutions. Many graduates stay on as the high quality care they are able to offer fulfils them more than money.

The SIM Hospital in Galmi has a slightly different arrangement. It has forged a cooperation with Evangel Hospital and the Christian Medical and Dental Association of Nigeria, and provides itself with a steady stream of physicians. As Niger shares borders with Nigeria, travelling distances for Nigerian doctors are relatively short; cultural and language differences are not so marked so culture shock is minimised. The hospital is also considering starting a family medicine training programme.

The Haggai Institutes in Singapore and Maui, Hawaii, have remained committed to training indigenous missionaries since 1969. So far, over 48,000 Asian, Latin American and African leaders have returned to their societies, identified the resources that God has placed there, and used them to reach their own peoples. They have remained in business, and are still growing because their methods have been effective. A good percentage of their graduates are Africans who have remained in Africa to provide leadership for evangelism.

There are also good Indian models. The Emmanuel Hospital Associations have been able to retain their medical staff by training and exposing them to missions from undergraduate level.

What can we do?

The thrust of health care mission in Sub-Sahara Africa must be to get Africans to mobilise their own resources. The worldwide Church needs to recognise this and support it in every way. It is not just an African problem. It is a problem for the whole Church. What can we do?

- Discuss the issues.
- Provide role models.
- Share examples of training models.
- Devise fulfilling careers for the younger generation.
- Encourage character development.
- Provide strong emotional, social and spiritual support.

Above all, we must pray. Only God can give a vision to African healthcare professionals, one so bright that personal concerns fade away. Only he can enable Africans to own the vision of reaching our own people for him.

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THIS IS NOT JUST AN AFRICAN PROBLEM. IT IS A PROBLEM FOR THE WHOLE CHURCH

Photo: Wellcome

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Steve Fouch asks questions about Christian participation in global health strategies

Photo: Empics

Trusting in CHARIOTS

KEY POINTS

Top-down healthcare strategies from big secular donors are often applied in developing countries without proper consultation and without real knowledge of the local situation. By contrast one of the great strengths of most Christian healthcare is that it is locally led, responsive to immediate needs, and supported by the worldwide Christian community. In the last two or three years the World Health Organisation, UNAIDS and others have increasingly recognised the role played in healthcare by Christian groups. Working together with international organisations has biblical precedent and provides creative opportunities for the Christian community provided we are wise in our dealings and compromise of ethos or integrity.

Christians have been at the forefront of providing care for the sick and the marginalised since the time of Jesus.[1] His command to 'preach and heal'[2] has been central to the calling of Christian missionaries down the centuries. Though modern medical mission has only arrived in its current form in the last hundred and fifty years, nonetheless it is rooted in the same call to bring the gospel of reconciliation and healing to all humanity.[3]

However, healthcare mission is in a state of rapid change. Mission hospitals were often seen as, at the very least, a necessary evil by colonial governments. After independence some were taken into government control, while others continued as Christian institutions. But the role of the Christian hospital is now primarily in ministering to the poorest and most marginalised of communities.

Meanwhile, in the latter part of the twentieth century Christian groups, in Africa in particular, began to respond to the challenge of HIV and AIDS, by developing care programmes, supporting orphans and vulnerable children, and running prevention programmes. Historically, the international health community has not taken much interest in this work. However, in the last two or three years the World Health Organisation, UNAIDS and others have recognised the role played by Christian and other faith based groups, and are beating paths to our doors.[4] Should Christian organisations welcome this as an opportunity or view it as a threat? To answer this we first need to understand the way that global health strategies are being set and implemented, and what their strengths and weaknesses are. Secondly we need to understand the strengths and weaknesses of Christian healthcare mission.

Global health strategies

Recent decades have seen a range of global strategies coming from the World Health Organisation and other bodies: *Health For All by 2000; Roll Back Malaria; the Millennium Development Goals.* These have been funded by the major donor nations – in particular the US President's Emergency Plan for AIDS Relief (PEPFAR), and the initiatives of private charities such as the Bill & Melinda Gates Foundation and the Clinton Foundation.

All such strategies set agendas from the top down for how local and national strategies in health are to be tackled. Many are disease specific (eg PEPFAR); some are nation specific, and some specific to a particular health sector (eg Health For All, which focused on primary healthcare). The strength of such initiatives that they mobilise resources to which the poorest countries and communities could never normally hope to gain access.

The downside is that the agendas are being set in the West by those with varying degrees of knowledge and contact with what is happening on the ground. In some cases there has been little or no consultation at local level before introducing initiatives. This also happens at the smallest philanthropic level –such as mission hospitals being saddled with vast quantities of drugs or equipment that are of no use to them by a well meaning donor in the West.[5]

At a national level it is even more of an issue. For example, the government of Mozambique recently found itself on the receiving end of PEPFAR funding with no prior consultation. It was being expected to use US approved and funded anti-retroviral drugs when it already had agreements with generic pharmaceutical manufacturers and the Global Fund to treat its HIV positive population with cheaper generic versions of the same drugs.

Furthermore, the US programme would have put considerable funds into employing foreign consultants rather than into local services.[6]

Anecdotal reports reveal poorly staffed and equipped hospitals that have a brand new, hi-tech, well resourced research and treatment centre in the grounds (usually paid for by a European or North American University or government). This is demotivating for the hospital staff, who can see their colleagues with better resources and with better pay working at the foreign research establishment, while they struggle to care for their many patients with few resources and inadequate pay.

Furthermore, the focus of funding and policy on major illnesses such as HIV/AIDS may lead to disinvestments in other initiatives that have been reducing significant, if non-fatal causes of morbidity among the poor. This is ironic, as programmes that tackle common infections and parasitic conditions often achieve greater health benefits, and are also cheaper and more cost effective. Linking together such programmes can increase the effectiveness of both (eg connecting measles vaccination programmes with the distribution of insecticide treated bed nets for malaria prevention).[7,8]

Christian healthcare mission

One of the great strengths of most Christian healthcare is that it is locally led, responsive to immediate needs, and supported by the worldwide Christian community. That is not to say that we get it right all the time, or that we have all the funding we need, but we are often closer to the grass roots needs of the poor, more flexible and less bureaucratic. Indeed, often the Christian poor themselves initiate the health work. The response to AIDS has been huge in many parts of Africa – as much as 60% of care responses, especially to the terminally ill and to AIDS orphans, have come from local churches with few resources. The danger for these initiatives, and larger mission and church hospitals, is that international donors will wish to set agendas different to those which motivated the work in the first place, forcing small agencies and hospitals into areas of care in which they have no skills, simply to attract funding. Furthermore, this funding requires extensive administration, monitoring and feedback, increasing bureaucracy and diverting energy from front line work.

Trusting chariots

Scripture warns us about relying too heavily on the world. For example, Isaiah 31:1 cries:

'Woe to those who go down to Egypt for help,
who rely on horses, who trust in the multitude of their chariots and in the great strength of their horsemen,
but do not look to the Holy One of Israel, or seek help from the LORD.'

There is a very real danger that too close a relationship between Christian and secular organisations might make us lose our way, becoming less distinctively Christ-focused in our motivation, ethos, and practice as a consequence of trusting in the 'chariots' of the WHO, UNAIDS, PEPFAR and the Global Fund, rather than in God.

On the other hand God is Sovereign over the whole world. Might he not therefore use secular organisations to further his ends in the same way that he used the Persian king Cyrus?

'I will raise up Cyrus in my righteousness… He will rebuild my city and set my exiles free' (Isaiah 45:13)

Nehemiah also asked Artaxerxes King of Persia for permission and provisions to rebuild the wall of Jerusalem (Nehemiah 2:4-9). Should we therefore automatically discount secular sources of funding? There may be ways of avoiding bureaucratisation, for instance by working as syndicates, with larger agencies acting as local hubs administering the money to smaller initiatives. Rather than avoid big donors, we need to look at how we work with them creatively without compromising our ethos and integrity.

Another issue is whether these global health strategies actually work. *Health For All* has failed,[9] the *Millennium Development Goals* look to be nearly dead in the starting blocks,[10] while the WHO's plan to get three million poor people on HIV anti-retroviral therapy by the end of 2005 (the 3 by 5 Initiative) was not even 25% complete by mid 2004.[11] One of the reasons these initiatives have failed in the past is that they were not based on local consultation. However, this is changing and where we have a voice to influence policy makers we should use it to help set international health strategies.

Another reason for failure is that national governments in both the rich and poor nations have had other issues on their agendas, and have either failed to put health initiatives into practice or have been seduced by glamorous, expensive initiatives that benefit only the elite.[12] Christians worldwide should be raising their voices to challenge this complacency.

I would argue therefore that turning to the international community to fund and resource our work may provide an opportunity for Christians to be a voice for the poor and a challenge to those in influence. The Bible exhorts us to be involved in this kind of work, Isaiah 1:17 encouraging us to seek justice and encourage the oppressed, and Proverbs 31:8-9 to speak up for those who cannot speak for themselves and defend the rights of the needy.

While international bodies are open to work with Christians, we should be prepared to take the opportunity to be a voice for the poor and vulnerable, and to be advocates for change. But we need to be wise as serpents and innocent as doves[13] in our dealings with these bodies if we are not to find the gospel imperatives that we work from lost underneath a welter of well-meaning but ill-conceived initiatives.

Steve Fouch is CMF Allied Professions Secretary

Photo: Empics

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HEAD T

Paul Burgess and Rhona Knight debate this timely issue

Should Christian doctors suppo

'Yes!' **Paul Burgess** is a GP in Southampton

For a long time we parents have been hoodwinked into believing that smacking can be a useful and even necessary part of child discipline. We have been hoaxed into accepting that the Bible supports such a bogus and empty method of teaching right and wrong.

Coping with defiant, exasperating or dangerous behaviour tests our parenting skills to the limit; we need to be patient, not slip into using methods that are often regretted and will have to be abandoned sooner or later. We can always walk away from potentially confrontational situations. There is no need for short, sharp shocks - learning is a life-long process. Children watch their parents' behaviour acutely and respond best to the positive reinforcement and affirmation they rightly crave.

Smacking as such is not mentioned in the Bible but it can guide us in disciplining children. Some biblical references to corporal punishment are literal;[1] others are usually read as metaphorical.[2] Proverbs exhort us to seek our Lord's wisdom, knowledge and discipline. The metaphorical rods of discipline and correction are mentioned.[3] 'He who spares the rod hates his son'.[4] Those who believe this rod to be a literal device for physical punishment should note that it is also to be used for foolish *adults*.[5] As Christians today do not advocate corporal punishment of adults, we should be consistent and refuse to apply it to children. Violence is a sign of unfaithfulness.[6] Verbal aggression is a sign of godlessness.[7] When considered alongside Jesus' example, these rods are almost certainly metaphorical.

Ephesians refers to child discipline: '…obey your parents in the Lord for this is right'.[8] 'Fathers, do not exasperate your children'.[9] The Good News translation says, 'Parents, do not treat your children in such a way as to make them angry'. J B Phillips interprets it as, '…don't over-correct'. Similarly, 'Parents don't come down too hard on your children or you'll crush their spirits'.[10]

Children under six are too young for smacking to be contemplated. Babies and toddlers are extremely distressed by pain. Terrified and emotionally overloaded, they learn only fear. Small children are physically and mentally vulnerable; we can sometimes forget our adult strength. In the tragic case of Victoria Climbie, the physical abuse that eventually led to her death began as what some would consider normal smacking.[11]

Children of six and over are rapidly becoming thinking young adults and should be treated as such. They are learning to manage their own behaviour and social skills and their parents' example is paramount. Any physical punishment is humiliating, demeaning, negative and rejecting. It may also result in children smacking their younger siblings, copying their parents' behaviour.

A change in the law is the quickest way to bring about positive and necessary changes in social attitudes. It will need to be accompanied by a huge publicity campaign, as in Sweden. Only then will we be able to look back on the legality of smacking children in the same way as we view defunct laws that permitted husbands to hit their wives, and institutions to use corporal punishment.

Ordinary, loving parents have nothing to fear as minor lapses will not result in prosecution. We can learn the skills necessary to guide and discipline children without smacking, so imitating our Heavenly Father who is slow to anger, abounding in love and faithfulness.[12]

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2. Psalms 23:4, Isaiah 11:4
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6. Proverbs 13:2
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15. Psalms 139: 13-16

Timeline

- **1860** – *legal limit of chastisement laid down*
- **1933** – *Children's and Young Person's Act enshrines 'reasonable chastisement'*
- **1979** – *Other European countries begin to ban smacking*
- **1986** – *Education Act abolishes corporal punishment in state schools*
- **1998** – *European Court of Human Rights rules that UK law doesn't adequately protect children from parental assault*
- **1999** – *Independent schools abolish corporal punishment*
- **2001** – *Victoria Climbie case and inquiry*

rt a ban on smacking children

'No!' **Rhona Knight** is a GP in Peterborough

I believe in child-centred discipline based on biblical values, rather than state-dictated discipline based on non evidence-based transient ideologies. The methods of discipline used by parents in the upbringing of their children need to be tailored to the age, stage and nature of the child concerned. And as always, God wants to help us.

We have been given a special task in bringing up our children to be men and women of God. [13] We are not to exasperate them and we are to desire good for them. This does not preclude physical discipline. [14] Just as our Heavenly Father treats us as unique individuals, so we should treat our children. [15]

As parents of three boys, my husband and I have aimed to use positive forms of discipline. Saying, 'Thank-you, that was very generous' to one of our children resulted in him almost glowing with pleasure. A small present for another who had worked especially hard at a difficult area of school work likewise affirmed him. The third likes nothing better than to snuggle during reading or being read to. All three of our children have responded to time as a family. We have used all these forms of positive discipline in many different ways, adapting them to meet the needs of our children at different times. They have all helped in our task of guiding them in the way they should go. First and foremost, *positive discipline* is worth striving for.

We also have used *negative discipline*. The feedback to our son on the lack of violin practice resulted in increased self-motivation. Time out, aided by an egg timer, helped another son calm down and reflect. The withdrawal of computer privileges was a punishment to be feared by all three; loss of a promised treat or pocket money really was next to ineffective! More drastically, the removal of a child from a party for bad behaviour never had to be repeated. We have also smacked our children, although with the youngest now eight this seems a long time ago. We smacked our preschool children, after verbal warnings, for things we deemed dangerous - like approaching an open fire. It was not long until 'One, Two, Three!' resulted in safe behaviour. As we were able to use a smack, they learned at an early age (when reasoning was not possible due to their still developing linguistic skills) that fires were not to be played with. The other situation in which we would use a smack was extreme naughtiness. With our children this was not biting or hitting others (as some of our friends have had to contend with); it was more often defiance or loss of control. Smacking in these situations makes a point that a certain behaviour is either dangerous or unacceptable. The smack is over quickly, the behaviour stops rapidly and, depending on the age of the child, a cuddle plus/minus a discussion can follow. In either case, relationships are renewed.

As a GP and mum, I have witnessed many forms of parental discipline. Effective parents seem able to be flexible in their approach to discipline. *Positive discipline*, whether it be star charts, special treats, affirmation or a cuddle, is always preferred to *negative discipline*. However, *negative discipline*, including smacking, also has a place – the right place at the right time for the right child. I recall a friend who had twins, one of whom loved running away, whether onto a road, into a shop or out of the open front door. When my friend was not up to being the perfect parent and allowed one of these escapes to occur, how should she have reacted? I believe her smacks to have been appropriate. Knowing that particular child at that stage of his life, only a strait jacket would have worked any better!

A ban on smacking will prevent responsible parents from having the flexibility needed to discipline their children. I believe that a state-dictated ban on smacking will result in our children being exposed to more physical and emotional danger. Instead, as Christians, we need to empower parents to use child-centred discipline, to meet their children's individual needs. Each one is special and unique.

2002 – *UK urged to embrace UN Convention on The Rights of the Child*	**2003** – *NSPCC report that smacking laws abroad have not led to prosecution of parents for minor incidents*	**2004 July** – *The Children's Bill in the Lords – a complete ban rejected in favour of Lord Lester's compromise amendment, which removes the 'reasonable chastisement' defence but permits mild smacking*	**2004 October** – *At report stage in the Commons, the compromise position is supported*

Information

- Children's Rights Alliance for England - *www.crae.org.uk*
- Children and Young People's Unit - *www.cypu.gov.uk*
- 4 Nations Child Policy Network - *www.childpolicy.org.uk*
- UN Committee on The Rights of The Child - *www.unhchr.ch*
- Families First - *www.familiesfirst.org*
- *www.childrenareunbeatable .org.uk*
- *www.endcorporal punishment.org*

What position do you take? Is there a particular issue that you would like featured in Head to Head?

Write in to **rachael.pickering@ cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head to Head.

EUTYCHUS

UK egg bank opened

The UK's first 'human egg bank' has opened, according to an article published in the *Mail on Sunday*. The bank has been set up by Mohammed Taranissi, director of the Assisted Reproduction and Gynaecology Centre in London, and will store more than 1,500 frozen eggs. He has built up the store of eggs over five years, using donations from women attending his clinic for fertility treatments. Twenty-two UK clinics are licensed to freeze eggs, but donated eggs are scarce. The GMC said that not enough was known about the procedure, or about human development, to be assured that 'a potential health time bomb was not being produced'. The success rate with fresh eggs is significantly greater than with frozen. (*Mail on Sunday* 2004; 28 November)

Threat to AIDS drugs for developing countries

Antiretroviral treatment for AIDS patients in developing countries is set to become more expensive. As from 1 January 2005 members of the World Trade Organisation must grant 20-year patents to new pharmaceuticals. Some existing medicines are to be reviewed for patent protection. *Médecins Sans Frontières* has expressed concern that supplies of affordable, generic medicines will fall. Generic preparations have succeeded in giving people longer, healthier lives. In addition, where first line treatment is failing the charity has to buy patented medicines at much greater cost. MSF estimates that 5.5 million people in developing countries need antiretroviral treatment now if they are to expect to survive two years, but only 440,000 are receiving it. (*BMJ* 2004; 329:1308, 4 December)

Cybersuicide

Cybersuicide - suicides or suicide attempts influenced by the Internet - has resulted in the deaths of nine people in two suicide pacts in Japan in October 2004. Unusually, these pacts seem to have been arranged between strangers who met over the Internet and planned the tragedy through suicide websites. An editorial in the *BMJ* contrasts these with traditional suicide pacts, in which the victims are people with close relationships. The websites describe suicide methods, including details of medication that would be fatal in overdose. Such websites are thought possibly to trigger suicidal behaviour in predisposed individuals, particularly adolescents. Little information exists about the Internet and suicide pacts. (*BMJ* 2004;329:1298-1299,4 December)

High Court rules that babies should not be resuscitated

The High Court has given permission to doctors in separate cases to withhold life-saving resuscitation from two babies. Luke Winston-Jones, a nine-month old with Edwards' syndrome, has since died. Charlotte Wyatt, born at 26 weeks and suffering from severe lung disease of prematurity, is still alive in neonatal intensive care. Both sets of parents took their cases to the court asking that the babies receive full resuscitation if needed, but the judges ruled that this would not be in their best interests. Margaret Brazier, professor of law at Manchester University, said the question arose as to how much these babies should be treated given that the means to do so is now available. Currently, doctors make decisions regarding newborn resuscitation on the 'viability' of the baby. (*bbc.co.uk* 2004; 12 November, *Times* 2004; 8 October, *Independent* 2004; 8 October)

Genetic slippery slopes

The Human Fertilisation and Embryology Authority (HFEA) has granted a licence to a London clinic to screen embryos for familial adenomatous polyposis (FAP). Four couples have had pre-implantation genetic diagnosis (PGD) for the condition. FAP causes multiple rectal and colonic polyps, leading to malignant tumours in most affected people. Prophylactic colectomy is commonly performed during teenage years. In principle, any condition with a known genetic marker could now be screened for. Up until now screening has only been allowed for conditions such as Huntington's chorea and cystic fibrosis. Meanwhile a press release from the Cystic Fibrosis Trust in November 2004 stated that almost a third of CF patients face problems obtaining life saving drugs and the specialist centres are seriously underfunded.
(*BMJ* 2004;329:1061, *Guardian* 2004; 2 November)

High Court refuses to stop suicide tourism

A 66-year-old British woman with cerebellar ataxia has died in Zurich following physician-assisted suicide. The local council caring for Mrs Z brought the case to court requesting a ban to prevent her travelling to Switzerland. She was too ill to travel there alone, and needed her husband to accompany her. The High Court ruled that it could not prevent her from travelling there: 'The court should not frustrate indirectly the rights of Mrs Z. The role of Mr Z is now a matter for the criminal justice agencies,' said Justice Mark Hedley in his ruling. Assisting suicide is a criminal offence with a maximum jail term of 14 years. Physician-assisted suicide is legal in Finland, Sweden, The Netherlands, Oregon (USA) and Switzerland. The Swiss authorities are concerned at the number of euthanasia tourists: there were over 90 such visitors in 2003 compared with three in 2000. (*bbc.co.uk* 2004; 6 December, *Guardian* 2004; 4 December)

BPAS refer women to Spain for late terminations

The British Pregnancy Advisory Service (BPAS) has been criticised for referring women to Spain for late terminations. Spain's laws on late abortion are actually stricter than the UK: after 22 weeks it is only legal where the mother's health is in grave danger. Staff at the Spanish clinic admitted to a reporter that they 'play with the laws a little bit'. BPAS have defended themselves against the allegations, comparing it with Irish women who travel to England for terminations. BPAS see it as part of their service to provide women with access to abortion whenever they can. Health Secretary John Reid has launched an investigation into the actions of BPAS. (*Telegraph* 2004; 10 October, *Guardian* 2004; 25 November)

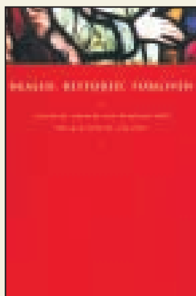
Malaria vaccine trial

A promising new malaria vaccine has shown encouraging results in a trial on 2,000 children in Mozambique. The research (published in *The Lancet* on 15 October) showed a reduction in incidence of severe disease of 58% and of new infections of 45%. The vaccine causes the immune system to attack the malaria parasites before they reach the liver. Developed by *GlaxoSmithKline Biologicals* in collaboration with the Malaria Vaccine Initiative, it is to undergo further trials. The Bill and Melinda Gates Foundation has contributed $150 million (£84 million) to the programme. (*Times* 2004; 15 October)

BOOKS

Healed, restored, forgiven

Liturgies, prayers and readings for the ministry of healing



Written and compiled by John Gunstone
Canterbury Press 2004
£12.99 Pb 117pp
ISBN 1 85311 587 8

In 2000, the Church of England produced its monumental report *A Time to Heal*. This book draws from that report, and is a valuable collection of material for use in connection with healing prayer. It is a resource not just for Anglicans but for all Christians everywhere.

There are sets of personal and responsive prayers, prayers for intercessors, ministry teams, preparation, thanksgiving and a general selection. There are liturgies for healing services that include anointing and laying on of hands, and the Eucharist. The ministry of reconciliation (confession to a priest with absolution) is also covered. The book ends with a relevant and representative selection of Bible readings from Old and New Testaments, and with helpful readings from some twentieth century writers.

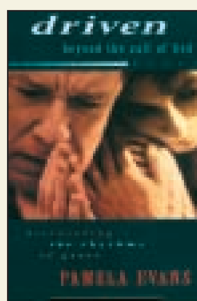
The Christian healing world has long been indebted to John Gunstone and this collection increases that debt. He has composed much of the material and compiled the rest from other sources, mainly Anglican but occasionally Roman Catholic and Orthodox. There are frequent cross-references to the exhortations in *A Time to Heal* and this book therefore functions as a supplement. Gunstone uses Scripture well throughout, and the only quote from Ecclesiasticus (38:1-2) is the well known: 'Honour physicians for their services, for the Lord created them; for their gift of healing comes from the most high'. Some might be uncomfortable with repeated references to Mary as the 'Mother of Christ', always in capitals.

All those who pray for healing in church contexts, no matter their denomination, will want this to hand. But do busy health professionals need it? I think so. There were insights, profound in their simplicity, which I found illuminating as I reflected on my own lot, and on that of many whom I have attended professionally and in prayer. You might even consider using sections with carefully selected patients.

Andrew Fergusson is Chairman of the Acorn Christian Foundation

Driven beyond the call of God

Discovering the rhythms of grace



Pamela Evans
The Bible Reading Fellowship 1999
£7.99 Pb 224 pp
ISBN 1 84101 054 5

Are you a driven person? Do you think you drive yourself too much? This book will help you answer these questions and do something about it. Pamela Evans is a doctor who is also a counsellor, and investigates some of the reasons behind spiritual 'drivenness' and 'workaholism'. 'Anything that's used to alter our mood or block out troublesome feelings is potentially addictive', she writes, and gives the example that some people can be 'addicted' to helping others in the church. She helpfully warns against co-dependency where someone's whole life is focused on the needs of others. Such people's helpful manner, she suggests, attempts to cover up their own deep needs. She warns against religious activity becoming an end in itself; people can easily get trapped on a treadmill of compulsive church activity at the expense of a vibrant relationship with the living God.

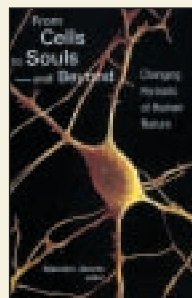
The title of the book derives from Jesus' words: 'Are you tired? Worn out? Burned out on religion? Come to me. Get away with me and you'll recover your life. I'll show you how to take a real rest. Walk with me – watch how I do it. Learn the unforced rhythms of grace. I won't lay anything heavy or ill-fitting on you. Keep company with me and you'll learn to live freely and lightly' (Matthew 11:28-30, *The Message*). Evans sees learning the rhythms of grace as keeping in step with God as he directs our path, rather than following a set of instructions. She gives examples from her own experience of how easy it is to 'put on a show' rather than to be honest with ourselves and with God. She encourages us to do the latter so that we can become more mature in Christ.

This is a challenging book. It is well written in a lively style and with many examples from daily life. I definitely recommend it for anyone in the caring professions, very busy in the church or who thinks that they may be doing too much.

Dominic Beer is a Consultant Psychiatrist in London

From cells to souls

Changing portraits of human nature.



Malcolm Jeeves (Ed)
Eerdmans Publishing 2004
£19.99 Pb 250pp
ISBN 0 80280 985 5

The Psalmist's question 'What is man that you are mindful of him?' has never been more relevant than today. The Christian understanding of man is now under particular pressure from neo-Darwinians such as Dennett and Singer who look at our biology and morality, and from neuroscientists who challenge our concept of consciousness and of free will.

This book, written from a clearly Christian perspective, examines the current debate about the nature of human personhood. Its contributors are philosophers, theologians, psychiatrists, neuroscientists and biologists. Malcolm Jeeves, the editor, deliberately skews the mix towards a clearer understanding of the implications of current science. This is helpful, as it ensures the debate is as well informed and as contemporary as possible.

Inevitably a multi-author book will have its stronger and weaker parts, and my opinion will differ from yours as to which bit is which. Some of the book, such as its consideration of cloning or the definition of personhood, goes over well worn ground, but this will help those who have never considered the issues before. The standard of contributions is high. It is easy to read bit by bit, as the chapters naturally stand alone, as a series of separate articles around a theme.

BOOKS

For me the important core of the book is in its consideration of the nature of consciousness and an understanding of human agency. I enjoyed the contributions of Alan Torrance, a theologian, and Diogenes Allen, a philosopher. They point out the paradox of scientists, clearly *acting* as agents yet at the same time questioning the nature of agency as a plausible concept.

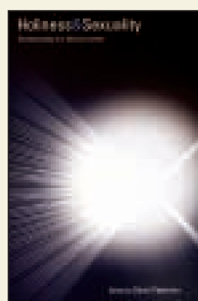
Another theme of the book is that man is defined by relationships. It explores the relationship between mind and brain and body, and calls for an integrative view of man, rejecting both a dualistic and reductionist view of man's nature. Glen Weaver describes man's nature as 'embodied spirituality', a helpful concept. The book also explores our nature in terms of our own relationships, not least our potential for relationship with God.

This is a rewarding and useful book. It could have been even better if it had an index and suggestions for further reading. It makes me realise just how much we don't yet know about ourselves - how much basic theory is still being played with on the drawing board. The philosophy and theology of neuroscience will be a hefty issue for the church of the 21st century. Reading this book is an excellent introduction.

David Misselbrook is a General Practitioner in London

Holiness and sexuality

Homosexuality in a biblical context



David Peterson
Paternoster Press
2004
£7.99 Pb 212pp
ISBN 1 84227 269 1

There are so many books available exploring both theological and personal Christian perspectives on homosexuality that any new addition to the field should offer fresh insights. This one does. The chapters were all originally papers given at a symposium at Oak Hill Theological College in April 2003. Although the chapters by Oak Hill Principal David Peterson on interpreting the biblical texts, and Peter Saunders on the origins of homosexuality are models of lucid, well-referenced synopses of current understanding, this or similar material is available elsewhere.

In his chapter charting his personal journey as a Christian gay man, Martin Hallett offers some profound insights, not least that 'Perhaps one of the reasons why we deal so badly with the issue of sexuality in the church is that we expect total transformation of the present. Sex demands so much of out attention because it connects with so many other fundamental issues'. However Martin's life story *I am Learning to Love* has recently been republished and tells his story in much greater and therefore more helpful detail.

It is the two chapters by David Field on the nature of sexual sin that make this book essential reading for all those interested in the theology of sex. They are not an easy read in their style, content or implications. However, I have not previously read anything on this topic that has given me such deep insights into God's heart and how sin in all its forms affects our relationship with him. Under headings such as 'Sin is suicidal and deicidal', 'Sin is the contradiction of life, love and truth and the embrace of death, loathing and falsehood' and 'Sin is one and many', Field explores practical issues such as gay men and the love of the father, how the concept of 'homosexualities' may offer a better framework for understanding than 'homosexuality', and the relationship between sexual orientation, sexual behaviour and sin. Though requiring careful study to avoid misunderstanding, there are parts of these chapters that will cause discomfort to the reader who understands, 'Inordinate horror at sin is not excessive horror – for no horror at sin can be excessive. It is rather the horror that discriminates in my favour and other's disfavour. Horror not at the sinfulness of an action, but at its strangeness. It is the horror of offended taste rather than offended holiness. This is particularly pertinent in matters of sexuality.'
This is a sobering and necessary book.

Trevor Stammers is a General Practitioner in West London

Children and bereavement

Wendy Duffy
Church House Publishing
2003
£6.95 Pb 74pp
ISBN 0 71514 998 9

Wendy Duffy, previously a hospice nurse, is now a bereavement counsellor. She is also a pastoral assistant in her local parish church and writes from many years' experience of supporting children and families through the bereavement process. Her short book is easily readable and is targeted at parents, teachers, clergy and others involved with helping children or teenagers come to terms with a death.

The book is a mixture of information and stories from her experience. It includes sections on suicide, sudden death and the role of the school in helping to support a community of children after a tragic event such as 9/11, or an individual child after a personal loss. That many young teachers may not have suffered any form of bereavement themselves and may struggle with their own reactions was a point well made. There is also a useful chapter on resource organisations and appropriate books for children, teenagers and adults who help them.

The chapter on children's perception of death at different ages is very brief. I felt that it lacked a clear explanation of the difference between the concrete thinking of children under seven years of age, and older ones who are developing an ability to grasp more abstract ideas. Tailoring explanations to children's age and understanding of the world is crucial to minimise confusion. The quotes from the children themselves would have had more power if the interpretations had been expanded.

Many of us will come into contact with bereaved children either professionally or in our personal circles. Indeed, we may be asked to be involved in explanations or support for children of friends or of church families because of our medical training, and we may feel inadequate for the task. For my own purposes the book was too

brief but it could be useful for a local church leader or a teacher. For more detailed coverage of how children think and react to death, dying and bereavement, I would recommend a book by a past President of CMF and retired consultant paediatrician, Janet Goodall: *Children and Grieving*, Scripture Union 1995. This book has helped me immensely over the years.

Liz Walker is a General Practitioner in Farnborough

In a strange land…
People with dementia and the local church

Malcolm Goldsmith
4M Publications 2004
£14.95 Pb 239pp
ISBN 0 95304 946 9

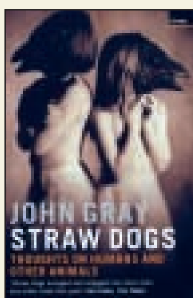
This book offers a compassionate and well-informed look at the world of dementia. The author is an Anglican minister with many years' experience in pastoral ministry in this area. He paints a realistic and forthright picture of the problems of dementia, and talks straightforwardly about the difficulties and opportunities of reaching out through visiting and 'alongside' ministries to both sufferers from dementia and their carers. He is a passionate advocate of the personhood of people with dementia, and feels strongly that the church should be a community of 'loving defiance' to the values of the world. There are many more questions than answers, which is the nature of things and not a defect of the book.

I do confess to getting a little lost in Goldsmith's description of spirituality without faith, and I suppose I cannot go along with all of that. But it is clear that he is trying to grapple with difficult issues, and to explore how people with a very limited capacity for coherent thought can experience transcendence, and be all that they can be.

I was much more moved by one of his quotes from a Christian lady with early dementia: 'I refuse to be a victim, to succumb to the lie of dementia, that as my cognition fades, so must my spirituality. I will trust in the Holy Spirit within me, and the fellowship of the body of Christ around me, to help me as I make this journey.' Now, that's faith! Overall, this is a highly useful introduction to the ministry of caring for these people, and should be required reading for all ministers and elders.

Mark Cheesman is a Geriatrician in Bristol

Straw dogs
Thoughts on humans and other animals



John Gray
Granta 2002
£8.99 Pb 246pp
ISBN 1 86207 596 4

We have become used to modernism, and got the hang of post-modernism but what comes next? Perhaps post-humanism? Christians and humanists mostly get along. We share a broadly similar and liberal vision of what is good for society because we both believe that being human is special and valuable. To a humanist we are special because we possess a high degree of reason, self awareness and moral agency. As Christians we see ourselves as special because in addition, God created us in his own image, with the capacity to relate to him. But can you imagine a world where humans no longer see themselves as special but as just another animal? A world where we do not see ourselves as free or responsible? A world where we do not see any point or purpose to our lives?

Gray writes off both the Enlightenment and its progeny humanism as a blind alley. He follows Schopenhauer in his view that humanism is just Christianity with God left out, and that without God it is unsustainable. But if the 21st century does indeed leave humanism behind as a pseudo-Christian hangover, then what is left? According to Gray, only a bleak mixture of nihilism, Eastern philosophy and a dash of neuroscience.

This book is horribly readable. It paints a vividly accurate picture of how this world would be without God. What value our ethics if humans have no special place? What value beauty if there is no meaning? What value my personhood or my relationships with those around me if consciousness is just a cosmic accident and 'free will is a trick of perspective'? According to one reviewer 'nobody can hope to understand the times in which we live unless they have read Straw Dogs'.

Gray may be a prophet for the 21st century. He joins the likes of Dawkins, Dennett and Singer in seeing only a world without God. But as CS Lewis pointed out, if you abolish God then the abolition of man as a free and worthwhile being is not far behind. It remains to be seen whether people will really accept Gray's despairing message. If the 21st century world does indeed become bleaker and more futile, then the treasure we possess in knowing the living God through Jesus his son should shine all the more brightly. Read this book – you will be glad you are a Christian.

David Misselbrook is a General Practitioner in London

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OPPORTUNITIES ABROAD

Please note that this page carries a health warning.

Stepping out of your comfort zone involves a risk but r-i-s-k is an alternative spelling for faith and if you want to walk on the water you have to get out of the boat.

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The vacancies listed on this page are only a small part of available openings. Visit our website at www.healthserve.org for a larger list and log on to some of the agencies listed for even more! Agencies offering short term 'experience' trips can also be found on the Healthserve Pages on the site.

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Agencies usually require you to be a UK based national with your own financial and prayer support. The contact details given are to enable you to research the post.

Bangladesh

Administrator/Manager with at least 5 years experience in health development at a senior management level is required by the **Leprosy Mission International (TLMI)** to co-ordinate the management of their programmes in Bangladesh. Based in Dhaka, responsibilities will include maintaining effective standards in their current work, developing new projects and the strategic leadership of programmes in conjunction with the Field Director of SE Asia. Four year term with 2 months home leave after the first two years. The appointee will be required to learn Bengali.

TLMI provides a living allowance and work-related travel expenses, medical insurance and pension contributions. Accommodation and flights provided.

For more details visit their website at *www.leprosymission.org*

Contact: Personnel Department, TLMI, 80 Windmill Road, Brentford, Middlesex, TW8 0QH Tel: 020 8326 6754 Fax: 020 8326 6777 Email: *jobs@tlmint.org*

China

Jian Hua Foundation requires a **Director of Medical Services**. The role will need leadership and organisational skills together with experience in business and people management. A sound working knowledge of public health and current challenges facing the Chinese medical system is preferred together with a sufficient experience to command respect in academic circles both within and outside China. Fluency in English and Mandarin is required and a commitment to a minimum of 5 years with the possibility of an extension to 10 years.

Contact: Martin Thorman, Director of Personnel and Administration, The Jian Hua Foundation, PO Box 71675, Kowloon CPO, Hong Kong Tel: +852 2336 5312 Fax: +852 2337 2965 Email: *martin.thorman@jhf-hk.org* Web: *www.jhf-hk.org*

India

There are still vacancies on a **BMS World Mission** multidisciplinary medical team going to the Christian Hospital at Chandraghona in Bangladesh from 12-27 February 2005 (possibly another in Autumn 2005).
A **General Surgeon, Anaesthetist, Orthopaedic, Ophthalmic & Plastic Surgeons** and **Obstetricians & Gynaecologist** are needed. Cost is likely to be approximately £1,000 per person

Contact: Ruth Robinson, Volunteer Programme Organiser, BMS World Mission, PO Box 49, Didcot, Oxfordshire, OX11 8XA.
Tel: 01235 517654
Email: *rrobinson@bmsworldmission.org*
Web: *www.bmsworldmission.org*

Malawi

Beit Trust Cure International Hospital is still looking for an **Orthopaedic Surgeon** with experience in paediatric orthopaedics, a vision for mission, a commitment to training and a willingness to undertake private work to generate income, to join a team of one FT and 2 PT surgeons. There is a possibility of a trauma commitment in a local government hospital. Ideally a long term commitment but short term considered

Contact: Mr Peter Kyalo
Email: *kyalo@malawi.net*

Nigeria

Action Partners require **Doctors at Vom Hospital**, to assist in the upgrading and restructuring of the Hospital and to be involved in the training of local doctors. The hospital has a new focus on **Paediatrics, O&G and Surgery**. Two year contracts are preferred, but shorter periods are possible. Self financing but accommodation provided.

Contact: Personnel Dept, Action Partners, Bawtry Hall, Bawtry, Doncaster, DN10 6JH
Email: *info@actionpartners.org.uk*
Web: *www.actionpartners.org.uk*

Southern Africa

AIM has many openings for doctors, mainly in rural government medical institutions. Two year contracts are offered. Assignments will depend on the qualifications, experience and interests of each candidate. Local salary and housing is provided and automatic registration for UK trained doctors.

Contact: Associate Overseas Personnel Director, AIM International, Halifax Place, Nottingham, NG1 1QN. Tel: 0115 983 8120
Email: *personnel.support@aimeurope.net*
Web: *www.aimeurope.net*

Uganda

A Doctor is required at **Rugarama Health Centre** on a 2-3 year contract. He/she would be required to head a team of 39 medical and 29 non-medical staff assisted by 4 Clinical Officers (nurse practitioners). Requirements include 5 years post-graduate experience, preferably with GP training and some tropical medicine and surgical experience. The present Doctor-in-Charge will be leaving in June 2005, and it is hoped that a replacement will be in place by March 2005 for a good hand-over.

The Church of Uganda will provide a suitable house free of charge, but utilities will be paid for by the occupant. It is hoped that an expatriate doctor would be able to raise their own funds from supporting church and individuals.

For further details, visit the *Healthserve* website or contact: Dr Rachelle Sanderson, Rugarama Health Centre, Diocese of Kigezi, P.O Box 3, Kabale, Uganda.
Tel: +256 77 333 580
Email: *sanderson@infocom.co.ug*

United Arab Emirates

The Oasis Hospital requires a female & male GP / Family Practitioner, Paediatrician with Neo-Natal experience, Anaesthetist, A&E Specialist and a female Radiologist

Further details about the hospital and posts can be found on their website at *www.oasishospital.org* or by contacting: Lamis Abdo, P.O.Box 1016, Al Ain, Abu Dabi, UAE.
Tel: +971 3 722 1251 Fax: +971 3 722 2007
Email: *labdo@oasis.smart.net*

John Martin reflects on a blind ministry he encountered in India

Good news for the invisible blind

JESUS ALLOWS THE MAN THE DIGNITY OF SPEAKING OF HIS NEED IN HIS OWN WORDS

The story of Jesus and the blind beggar of Jericho (Luke 18: 35-43) offers interesting insights into blindness and the complexities of ministry to blind persons, especially in places where they are ignored or treated as invisible. A blind person by instinct will resist cross conversation or being pushed aside.

So in Luke, when the blind man hears that Jesus is coming, he shouts at the top of his voice in hope of getting Jesus' attention. The crowd tell him to shut up but that's merely a trigger for him to shout 'all the more' (v 39). Then we see how Jesus does not assume that he knows for sure what the man wants. Jesus allows the man the dignity of speaking of his need in his own words (v 41).

This story has been very much on my mind following an all-too-brief visit to India where in the process I met the blind Pastor Pushparat and learnt of his Bangalore-based ministry, *New Vision*, that is giving hope and a quality of life to people who are treated as invisible.

'I lost my sight at the age of two following typhoid,' Pushparat told us. 'Typhoid is very contagious and at the time there was no treatment for it. What is more, Hindus are taught to be resigned to fate and there was little practical help or advice.' His parents, Hindu farmers, unable to read or write, could not agree what should be done and eventually they handed him over to a Catholic orphanage.

A security guard took an interest in Pushparat. They would read the Bible together and the guard taught him to pray to Jesus. He was musical and had a good singing voice so he took to begging in the streets. Then another Christian started to take an interest in him. He made a personal commitment of faith and embarked on theological studies.

We heard the testimonies of several of the blind persons sitting on the floor. Most were from Hindu backgrounds. Gospel accounts of Jesus' dealings with blind persons form a large part of their reflection and songs. One said: 'In this world we have no silver, no gold. But by the blood of Jesus we have been bought.' Another song was based on John 9 where Jesus is asked whether it was the sin of the parents or the man himself that caused him to be born blind.

Pushparat explained: 'Healing in the story is not the most important thing. Jesus said this happened "so that the work of God might be displayed in his life."' That is Pushparat's testimony too. 'I was a beggar. I used to collect a few coins by singing. Jesus has given a quality of life to me through the Cross.'

India, the biggest democracy in the world, is home to 1.2 billion people. They encompass vast extremes of wealth and poverty and speak 652 languages. No less than 427 tribal groups live on the social and geographic margins. In contrast 100 million of its people are middle class (that's twice the population of Britain) and the pundits are right about their capability for competing for European jobs.

What is clear, too, is that India is home to a flowering of indigenous Christian missions, propelled by revival and reaching out to the tribal areas. Through people like Pastor Pushparat it is also ministering to those who others would leave by the wayside, just as the crowd in Jericho would have done had Jesus not intervened.

John Martin is Associate Editor of Triple Helix

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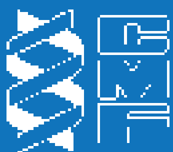

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