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for today's Christian doctor

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Co-belligerence

Compromise or Christian duty?

there is evidence in Scripture of believers willingly working with unbelievers towards a common good

I was personally both stimulated and encouraged by Daniel Strange's recent *Cambridge Paper* on the subject of co-belligerence[1] as it has direct relevance for many of the issues we are facing in Public Policy at CMF.

'Co-belligerence' is a political or military term referring to an alliance of different parties against a common foe; in a Christian context it describes the activity of Christians working together with non-Christians for a common political, economic or cultural cause.[2]

Within evangelicalism, the use of the term was popularised by Francis Schaeffer who emphasised the importance of being both 'in the world' but not 'of the world': 'A co-belligerent is a person with whom I do not agree on all sorts of vital issues, but who, for whatever reasons of their own, is on the same side in a fight for some specific issue of public justice.'[3]

Co-belligerence has recently brought the Christian Institute, the Islamic Human Rights Commission, *The Gay Times* and comedian Rowan Atkinson together in opposing the government's *Racial and Religious Hatred Bill* in the common interest of safeguarding free speech.[4] Similar broad alliances have formed in the UK to combat the Mental Health Bill, counter Sunday trading, protest against the Iraq war and combat world poverty. In the US a collection of strange bedfellows consisting of environmentalists, feminists and evangelicals has waged a successful campaign together against cloning.

More recently in the UK CMF has played a key role in bringing together an alliance of professional groups, human rights groups, healthcare providers and faith groups both to promote palliative care and to oppose the legalisation of euthanasia and assisted suicide.[5] Part of the fruit of these efforts was an open letter to all MPs and Peers signed by nine leaders of the six main world faith groups: Christians, Muslims, Jews, Sikhs, Buddhists and Hindus.[6] It was surprising how easy it was to gain agreement on such a powerful and comprehensive statement from people who would disagree strongly on many fundamental issues of faith. CMF networks similarly with likeminded charities, NGOs and members of other faiths with regard to other ethical issues or in promoting HIV care, developing world health or social justice. And most of us are members of multidisciplinary healthcare teams together with people of all faiths and none, with whom we hold some values and commitments strongly in common.

Some Christians may feel uncomfortable with such joint activity, feeling that it compromises the exclusivity of Christ and dampens enthusiasm for the proclamation of the Gospel. Paul's warning not to 'be yoked together with unbelievers'[7] seems to underline this concern. And did not Jesus himself warn that, 'He who is not with me is against me'[8] and 'No-one can serve two masters'?[9] Co-belligerence certainly does run the risks of dilution, misunderstanding and tension.

And yet at the same time there is evidence in Scripture of believers willingly working with unbelievers towards a common good. Daniel Strange points to Joseph working with Egyptians to alleviate famine,[10] Daniel in Nebuchadnezzar's court,[11] Jeremiah's letter to the exiles to 'seek the peace and prosperity of the city…'[12] and Paul's exhortation to do good to all, especially the family of believers.[13]

The tension here is really that between the Great Commission, to preach the gospel to the ends of the earth, and the Great Commandments of loving God and neighbour in the society in which he has placed us. We are to be both the light of the world, showing the way, and the salt of the earth, flavouring and preserving.

And these two activities of preaching and loving should be complementary; just as we are called to be faithful witnesses to the truth we are also called to be good citizens working to ensure that there is justice, care and equality, that good laws and policies are promoted and bad ones opposed. And in a democratic multi-faith society, that cannot be achieved without working closely together, with others who may not share all our convictions, toward shared goals. Indeed such cooperation should aid our gospel efforts because it will bring us into close relationships with unbelievers we may not otherwise have met, and the conversion of key decision-makers and leaders is one of the most potent ways of bringing about societal transformation.

But we must almost be wise and cautious, as shrewd as snakes and innocent as doves,[14] ensuring that working together with unbelievers does not silence us in our gospel witness or lead us to shrink in speaking truth that might offend in areas of disagreement.

***Peter Saunders** is CMF General Secretary*

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news reviews

The revised Joffe Bill

May run out of time, but we need to remain vigilant

Review by **Peter Saunders**
CMF General Secretary

On 9 November 2005 Lord Joffe re-introduced his *Assisted Dying for the Terminally Ill Bill*,[1] the third 'assisted dying' bill he has tabled in the House of Lords in as many years. If passed it will enable 'an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request'. Put simply it seeks to legalise physician assisted suicide (PAS), but not euthanasia, along the lines of the Oregon *Death with Dignity Act*.[2]

The House of Lords Select Committee Report on Joffe's last Bill,[3] which was the subject of a nine hour debate in the Lords on 10 October,[4] made ten recommendations for a new bill of which Joffe has taken on board only four; this bill is therefore essentially 'more of the same'. The major changes are as follows: The bill applies now only to Wales and England and not Scotland. Although a doctor must still prescribe the lethal drugs, another member of the healthcare team may now 'assist' him in helping the patient to commit suicide (so by implication the doctor need not be present). Terminal illness has now been redefined as 'likely to cause death within six months' rather than 'a few months'. The initial request for assisted suicide must now be made in writing and not just verbally, and dissenting doctors now have no legal obligation to refer the patient requesting PAS to another doctor (but must forward the case notes on request).

This Bill is likely to have its 'second reading', a debate on the principles of the Bill, early in the New Year. By convention there is no vote at second reading debates in the House of Lords. Next is the Committee stage (beginning two weeks or so later) where the House of Lords considers detailed amendments to the Bill. There is then a final report and third reading stage when the Bill, as amended in Committee, can be further amended and is then voted on by the House. This would most likely be in the late Spring of next year.

Even if the Bill were to pass all its stages in the House of Lords, it would still need to go through the House of Commons to become law. But because the Government has effectively taken a neutral position on the Bill, although we must remain vigilant, it seems unlikely that the Bill would be given time to be debated and progress through the House of Commons during the current session of Parliament which will end in the autumn of 2006.

Whatever happens it is imperative that Christian doctors ensure they are fully informed about the bill's progress and well rehearsed in the arguments against the legislation of euthanasia and physician assisted suicide.[5] This is an issue that will run and run and the price of freedom is eternal vigilance.

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WHO three by five initiative

The church is the missing ingredient

Review by **Steve Fouch**
CMF Allied Professions Secretary

In June 2005 the World Health Organisation released its final interim progress report on the 3 by 5 initiative.[1] Set up in 2003, this was an ambitious plan to get at least three million people in developing nations living with HIV & AIDS on to life-saving antiretroviral therapy (ART) by the end of 2005. By June, only 1 million were on treatment. In November 2005, Dr Jim Yong-Kim, the WHO Secretary General publicly apologised that the WHO had fallen so far behind target, admitting they simply had not done well enough.[2]

This is very bad news. Around six million people in the developing world need ART – many of them will die very soon without it, and many more will get ill and need therapy in the coming years. And this need is going to grow, not diminish. This failure has already costs many lives, and many more will die in the coming year.

WHO has increased by more than five times the number of poor people on ART since 2003. Lessons have been learnt, and they are getting better. However, they are a long long way from meeting the very real need that is out there.

The reasons are complex, but a lot is to do with a lack of basic infrastructure. Although more funding is needed for ART, nevertheless, many millions could be on ART now if money alone was the issue. The reality is that there are not enough doctors and nurses to deliver and monitor therapy. There are often not the mechanisms to train staff or volunteers, nor the correct the distribution or storage systems for these highly specialised drugs.

There is, however, a global network of organisations with local, national and international structures, able to help address some of these needs. It is called the Church, and WHO is desperate to engage with it. Churches can deliver drugs to people's homes through teams of trained volunteers, ensuring people are keeping to their regimes, ensuring distribution networks work, linking people to hospitals (especially church run institutions), and acting as advocates for those living with HIV & AIDS. This is already happening, but not nearly enough.

The Body of Christ has a huge potential and the opportunity to save lives, showing the compassionate love of Christ to millions. If the WHO and others can only learn how to work with us, and if we learn how not to distrust or ignore the UN system, this could be one of the greatest opportunities of recent times for the church truly to influence the world. This is a *kairos* moment we can choose to ignore.

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Sarah Gwynne digs beneath the media spin

Photo: Empics

HERCEPTIN

Herceptin is a big issue. Google brings up a staggering one million hits. It features prominently in the media as well as filling the medical literature; but also raises issues that we as Christian doctors need to face. As we enter the increasingly complex days of 21st century healthcare we need to look to the Lord who gives wisdom generously to those who ask for it.[1]

What is Herceptin?

Herceptin (Trastuzumab) is an antibody directed against HER2, a protein over-expressed in approximately 25% of primary breast cancers and associated with a poorer prognosis.[2] Currently licensed (and NICE approved) for use in metastatic disease,[3] the recent media frenzy surrounds the use of Herceptin in early breast cancer, in order to reduce the risk of recurrence. Recent studies have shown up to a 50% reduction in disease recurrence, making Herceptin one of the most significant developments in breast cancer management in recent years.[2]

The major issues with the use of adjuvant Herceptin are cost and concerns over its cardiac tolerability - a factor because HER2 is also expressed in cardiac muscle. It has been estimated that the cost per woman for 12 months treatment with Herceptin will be £21,800.[4] Currently unlicensed, not NICE approved, and not funded on the NHS, those who have succeeded in getting the drug make the headlines. Elaine Barber is one such woman. North Stoke Primary Care Trust initially rejected her appeal to have the drug due to the fact that its safety and cost effectiveness had not yet been confirmed. However the trust reversed its decision after Patricia Hewitt, the Health Secretary intervened.[5]

HER2 testing

The NHS is responsive to demand and does not seek out undisclosed need.[6] It is not yet standard practice to test all new cases of breast cancer for HER2[7] and pathology services are concerned that the funds will not cover routine testing. Many clinicians test only if the patient requests it. However studies have found that nearly 4 out of 10 people with cancer don't know what questions to ask about their treatment options.[8] A recurring theme in the Bible is the defence of the disadvantaged and we should be ensuring equality of care, possibly offering testing to all. As a result of campaigning by cancer charities, it is now routine in England.[9]

Allocation of resources

Some form of rationing exists for almost everyone, either by ability to pay or by queuing for a share of the limited service to which everyone has access.[6] One could take a utilitarian view of resource allocation and argue that spending this much money on a subset of breast cancer patients, only half of whom may benefit, is wrong.[10]

This utilitarian view is the philosophical basis for most economics. The fundamental tenet is that resources should be allocated in the most efficient manner possible, maximising the benefits to society from the resources available. But Jesus seems to have had a different approach. Again and again in his healing ministry he responded to individual pleas for help.

It has been claimed that 'glamorous' specialities, like oncology, are using public support to gain extra funding, and in doing so are actively preventing the equitable distribution of limited resources.[6]

So should doctors get involved in these matters of social policy? Is this the role of administrators and politicians? Apart from our expertise and knowledge being needed we are already making these decisions and it can be argued that we should not be doing so in isolation and away from public scrutiny. Jesus encourages submission to the civil power[11] and we are told to submit to the 'governing authorities'.[12] So maybe we should be accepting directives issued by the government, even when we disagree, as long as it does not contravene explicit biblical commands.[9] On the other hand in a democracy we all have a right and responsibility to express our concerns.

Truth telling

The sick do not come to us in order that we may make all their decisions, or in order that we may run their lives for them. Patients want truthful, accurate information. They want an opportunity to make choices about the various treatment options available and failures in communication about illness and treatment are the most frequent source of patient dissatisfaction.[13] These issues are more pertinent than ever in the case of Herceptin. It is currently unlicensed and we do not have the long-term safety data on the drug, particularly in relation to the cardiac side effects. As Christian doctors we should ensure we are giving our patients both sides of the story.

Jesus said 'I am the Truth'.[14] As Christians we have a right and a responsibility to question the claims made by the media and drug companies. We need to protect the weak and vulnerable, in this case the breast cancer patient.

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Megan Best critiques the current HFE Act Review


Suzi Leather: HFEA Chairman

Photo: Empics

Fertility furore

The *Warnock Report*[1] was written in response to the birth in 1978 of Louise Brown, the first child conceived through in vitro fertilisation. It later became the basis of the *Human Fertilisation and Embryology Act* 1990 (the HFE Act). Assisted reproductive technology (ART) is now involved in over 8,000 British births annually and rapid developments in the field have led to the need for a government review of the Act. The closing date for submissions was 25 November 2005.

Legislation has an educative effect. Experience shows that procedures permitted now, even in limited circumstances, will become socially acceptable under wider circumstances in the future (abortion is an obvious example). This is an important review as it will shape British families and society for years to come.

The scope of the review allows for public comment on the appropriateness and effectiveness of the HFE Act, but the government does not intend to revisit issues that it considers 'widely accepted in our society or which have been recently debated and conclusively resolved in Parliament'.[2] This includes the creation and destruction of human embryos for research, and the prohibition of human reproductive cloning. The government instead continues to rely on the Warnock report to justify human embryo destruction and is not planning to review the moral status of the embryo. This is a pity, because this issue lies at the heart of many of the ethical issues raised by the consultation.

Many consider destructive human embryo research as necessary for advances in ART treatment and medical knowledge. It was first allowed when the HFE Act was passed and then further relaxed in 2001 following advances in stem cell research. But if life begins at conception, then it must follow that any destructive human embryo research is unethical. Biologically, to suggest that human life begins at any point beyond conception is to draw an arbitrary line. Developmental embryology makes it clear that the early human embryo is a genetically unique, self-directed whole. For the Warnock Committee to choose the appearance of the primitive streak (14 days) as the beginning of individual development of the embryo is to rely on obsolete science. The debate deserves a fresh approach.

The *Warnock Report* is out of date yet its assumptions flavour the whole review. When genetic modification of embryos is discussed, it is obvious that some parties do not want barriers to any kind of new technology, even recommending creation of human-animal hybrids and chimeras for research. It is suggested that these and other experimental therapies should be allowed to go ahead 'when they are safe' – completely disregarding how many human embryos will be destroyed in research in the meantime. CMF has already responded to the review and raised its concerns on this matter.[3]

It is encouraging that the government has indicated that both the development and use of ART should continue to be subject to legislation. The current model of regulation under the Human Fertilisation and Embryology Authority (HFEA), however, is held up as a successful one, which may be of some concern to those who have seen its approval of procedures such as cytoplasmic transfer as controversial. However, it is recognised that legislation needs to be more explicit, thereby empowering the Government, rather than the regulator, to debate and amend the law. The HFEA and the Human Tissue Authority will be replaced with a single body with responsibilities across the range of human tissues and cells. Discussion of how the proposed Regulatory Authority for Tissue and Embryos (RATE) will operate is included in the review.[4]

It has always been a mystery to me why such decision-making was placed in the hands of a non-elected, non-representative group of lay people such as the HFEA. Now, with the increased responsibilities falling to RATE, the government plans to continue with substantial lay representation, but has noted that there will need to be either members or consultants with expertise in relevant fields. This is to be welcomed. ART is developing so quickly in terms of clinical requirements and research possibilities, that it requires committee members with some understanding of the area even to be able to ask the correct questions of their advisors. An alternative model is suggested in the CMF submission. It is to be hoped that the current review will consider letting more clinicians help with this aspect of regulation. Should this become a reality, it will be very important that Christians make every effort to become involved and influence the ethical debates that will inevitably arise.

Preimplantation genetic diagnosis (PGD) is currently allowed to avoid inherited genetic disease, sex-linked disease and other chromosomal abnormalities and to permit tissue-typing. The CMF submission argues that embryo screening is a highly discriminatory procedure, as even completely normal embryos may be destroyed if they do not have the desired characteristics. Extension of screening will increase the risk of offspring being considered as a commodity to meet specifications rather than as a gift to be accepted unconditionally.

Other issues covered in the review include the welfare of the child, counselling, data collection, research ethics, surrogacy and parenthood. Christian doctors are encouraged to review the CMF submission and remain alert to further opportunities to influence this important legislation.

Megan Best *is a bioethicist and former Palliative Care Practitioner in London*

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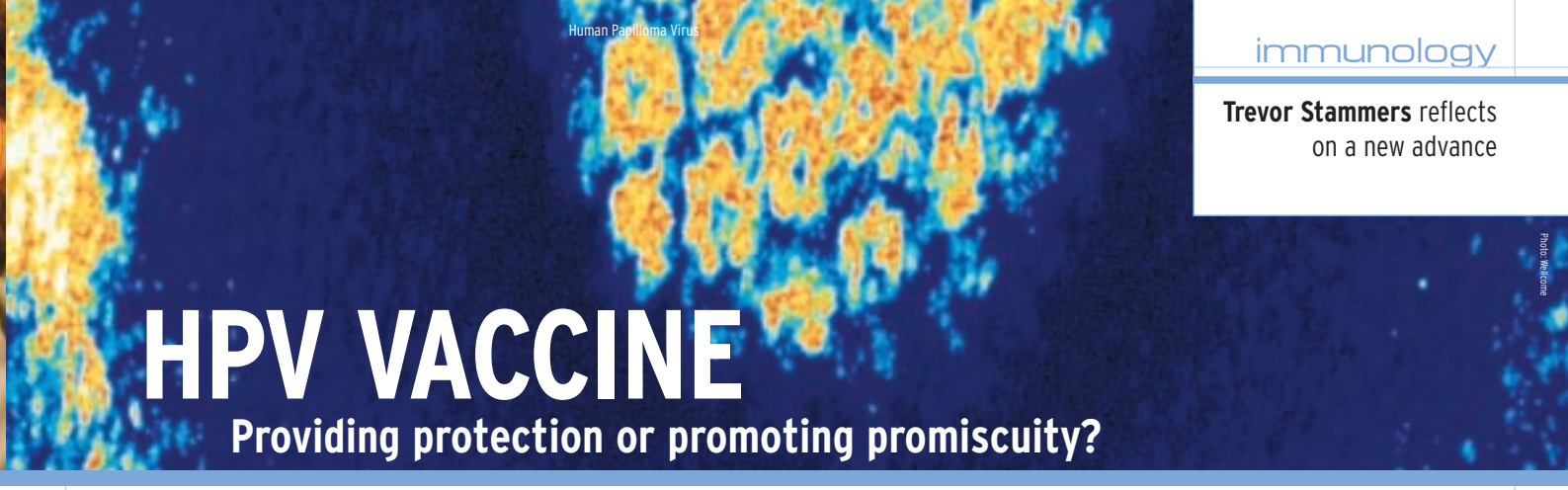

Trevor Stammers reflects on a new advance

Photo: Wellcome

HPV VACCINE

Providing protection or promoting promiscuity?

Cervical cancer is a major cause of disease and death in women worldwide with over 450,000 new cases each year. Though in the UK, there are just over 1,000 deaths annually from cervical cancer, in countries that do not have any cervical screening programme, the death toll is much higher.

Human papillomavirus (HPV) is the main aetiological agent in the development of cervical cancer and now that 'vaccine prospects are bright' [1] for this virus, the next few years will see major promotions by the two companies competing for vaccine sales.

In the hype surrounding what is a major advance in prevention, important messages will tend to be drowned out by the advertising excesses on the one hand and the likely moral backlash against something that could be mistakenly seen as 'promoting promiscuity'.

The first thing to emphasize is that neither vaccine has been proven to prevent cervical cancer. The disease usually takes many years to develop and the trials show that the vaccines are so far 100% effective in reducing HPV 16 and 18 pre-cancer changes. [2] Though these two types of the virus account for around 70% of cervical cancer, this still leaves women at risk from other types and cervical screening will be just as important and must be implemented just as vigilantly after vaccine introduction as before. [1] Even if a vaccine against all types of HPV were introduced tomorrow it is likely that cervical screening would continue for another 20 years. The vaccine is therefore going to be an additional expense to such screening rather than a substitute.

Secondly, the vaccine is not a prophylaxis against promiscuity. Though HPV is the most common viral sexually transmitted infection (STI), it is only one of well over 20 STIs. The two vaccines only protect against two (Cervarix) or four (Gardasil) strains of HPV. Those who have sex with even one partner, let alone more than one, whose sexual history they do not know are still at considerable risk of acquiring an STI even if using condoms [3] and even if they are vaccinated. The need for the 'saved sex' message will not diminish even should HPV vaccination become universal. [4] In fact, the necessity for the vaccine emphasises the importance of the 'saved sex'. Condoms offer little or no protection against HPV transmission and only minimal protection against HPV-related disease, [5] so 'abstinence outside marriage and faithfulness within it' will remain an important sexual health promotion message.

Thirdly, many unknowns will remain for a long time to come. Though no adverse effects attributable to the vaccine have occurred in any trials so far, the MMR debacle and concerns about pertussis vaccine before that, have shown that public perception of vaccine safety cannot be taken for granted. We do not as yet know how long immunity will last and whether booster doses will be needed. The age at which the vaccination should be given has also not been settled, nor whether boys as well as girls should be offered it. And despite the fact that HPV infection simply does not enter into the equation when young teenagers decide to have first sex, many parents will intuitively feel uncomfortable about the idea of their youngster being vaccinated against an STI.

If any Christian doctor feels that he or she must totally denounce the vaccine, they should certainly answer some tough questions first. If an effective HIV vaccine should be developed, there would surely be no grounds for giving it only to haemophiliacs. In which case, why is HPV vaccine any different in principle? HPV infection and cervical cancer isn't always 'the woman's fault' – surely denying women the vaccine implies it is? What of women who are raped? What if they are faithful but their husbands have had lots of partners, with or without their knowledge? Shouldn't we be offering these women a protective vaccine against cervical cancer? And if these women, why not all women?

There are many unhelpful pressures on underage children to engage in premature sex with all its associated risks and it would be tragic if the introduction of this vaccine simply added to that pressure. Jesus' warning about the dire consequences of leading children into harm should always be at the forefront of our minds. [6] Though we have a clear mandate never to 'do evil that good may result', [7] it is always more difficult when others take advantage of our doing good to do evil. Even the coming of Christ led to the slaughter of many innocent children by Herod. [8] Few CMF members will doubt that protection against HPV infection in itself is good. The CMDA, our sister organisation in the US, 'enthusiastically welcomes' the vaccine. [9] In my view, we should do likewise but we also need to pray that in its eventual introduction, others don't exploit the situation by downplaying the many remaining physical, psychological and spiritual health risks to young people of underage sex.

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Steve Fouch outlines a biblical response

Photo: Empics

Global disasters

key points

When global disaster strikes many are tempted to ask, 'how can a God of love let something like this happen?' but a better question for Christian doctors is, 'how can we best respond compassionately and appropriately?'

Often the main need is to support those already working locally, with cash in the first instance and, if those locally request it, by going and using our skills in service of the survivors.

But disasters should also prompt us to put similar effort into tackling such ongoing issues as malaria, AIDS, clean water supplies, maternal health, trade justice and debt relief as we do into tsunami, earthquake and hurricane relief.

The date of 26 December 2004 will stick in people's minds in much the same way that 11 September 2001 has – the images of devastation and suffering, the confused news reports, the gradual unfolding of the scale of the disaster as the days turned to weeks, and the initially slow but suddenly torrential outpouring of aid. Since the Indian Ocean tsunami we have also had Hurricanes Katrina, Rita and Wilma, the famine in Niger and the massive earthquake in Kashmir.

You may also have been surprised (positively or negatively) by the amount of coverage given to different religious responses to these disasters – all starting with different variations on the 'how can a God of love let something like this happen?' question. This strikes one as ironic, as we can sit by and let 150,000 Africans die every month from malaria, but when a disaster unfolds on our TV screens, we are all struck by the fragility of our existence and ask eternal questions. It would appear that until we see it on TV it is not real!

A biblical response

However, despite initial appearances, much of this suffering and loss of life is down to human sin rather than 'acts of God'. The people who suffered most from all last year's disasters were the poor – in substandard housing (most earthquake victims died because buildings fell on them), in areas prone to floods, without the resources to flee cities about to be hit by major storms, etc. Furthermore, complacency that did not prepare for disaster led New Orleans to be built below sea level between two bodies of water prone to flooding and with inadequate levees to withstand a major storm surge. Complacency also ignored all the warning signs from the Sahel region before finally acting too late to avert a major famine. Destruction of mangrove swamps in South and East Asia removed a natural breakwater against tsunami. And (controversially) our tendency to pollute and exploit our environment may be causing global warming that is adding to the ferocity of storms. In short, we need to look to ourselves first for the misery caused by these disasters.

Yet we still ask God why these disasters happen. God's response to this question, asked time and again in scripture, may seem frustrating. Job was never given an answer as to 'why' he suffered; Paul never had the thorn in his flesh removed, despite his fervent prayers.[1] Jesus warned us that '*nation will rise against nation, and kingdom against kingdom. There will be famines and earthquakes in various places. All these are the beginning of birth-pains*'.[2] Paul reiterates this, '*We know that the whole creation has been groaning as in the pains of childbirth right up to the present time*'.[3] Disasters like last year's clutch would seem to be part of a fallen creation, still 'out of sync' with its Creator, awaiting a New Creation.

The Toll of Disasters & Scale of Responses in 2005

South Asian Tsunami – total aid pledged = $13bn
c300,000 lives lost, four million homeless or lost livelihoods.

Hurricane Katrina – total aid pledged = $62bn
Death toll in New Orleans >100, several thousand homeless or with lost livelihoods

Niger Famine – total aid pledged = c$10m
3.5 million at risk of starvation - death toll unknown, but could run into tens of thousands.

Kashmir Earthquake – total aid pledged = $5.4bn
75,000 dead, 750,000 at severe risk of exposure and malnutrition during winter, 3 - 4 million homeless or lost livelihoods.

AIDS Crisis – total aid pledged <$7bn per annum
3 million plus died in 2004, more expected to die in 2005, 40 million plus are HIV+ worldwide, number growing year-on-year

However, struggle as we may to come to terms with the 'why?' question, the gospel leads us to ask another, even more profound question. Not 'why?' but 'what?' 'What should be our response to disaster and suffering?' The disciples were often stumped as to causes of the suffering of those who came to Jesus, but he just got on and healed them [4] – it was a practical not an existential response to suffering that Jesus embodied and modelled.

Our first response then must be to show the attitude of heart and mind of Christ in all situations. [5] If we look through the gospels, we see Jesus time and again reaching out to those who suffered and were in need, to heal, forgive sins, and offer hope. Those rejected by society he accepted, those who were hated he loved, those cast out he welcomed in. [6] In short, where he was presented with a human need, he responded to that need.

Practical response

I am sure the first thing most of us did when we saw last year's disasters was to find out how we could give help. And the main thrust of all the appeals has been for cash, not goods. We have had people ring the CMF office asking if they can donate soon-to-be-out-of-date drugs and medical equipment, most of which was inappropriate or unusable. Aid agencies need cash in a disaster situation, so that they can source the drugs, equipment and materials appropriate to the local situation. In fact, giving goods can do long term damage – it may sound like a compassionate response to send clothes and blankets and equipment, but those items can often be sourced locally, more quickly and cheaply than shipping them halfway around the world by air, and without taking away from the livelihoods of local manufacturers and retailers.

The other response is to ask if we can help in person. This takes wisdom, and I have heard from those working in Kashmir that doctors from the UK and US were turning up offering help, but lacked the appropriate skills, or there were simply no resources for them to do anything – only a couple of operating theatres, not enough medicines or nurses to run them for more than a few hours a day, not enough wards or beds of patients to recover in. A lack of coordination has been a recurrent theme in all of last year's disasters. That is why when people asked CMF about responding, we put them on to agencies already working on the ground that knew the needs, and could say if their skills were needed. In disasters, the needs for medical personnel are often very specific – general help just gets in the way.

Wider Issues

One of the big concerns with disasters is that they divert attention and resources away from other problems. Twenty six million people in other regions of the world need aid just to survive day to day. [7] The Darfur crisis is no nearer a resolution, and the humanitarian needs there and in the famines in Niger and Southern Africa remain enormous. Worldwide there are eighteen million refugees, and a similar number of people displaced within their own country due to war, famine or natural disaster. Meanwhile the long-term issues of fighting poverty and disease simply do not grab the headlines in the same way as wars and disasters, but are causing comparable (if not even greater) levels of human misery and suffering.

Yet if similar levels of aid that have gone into the tsunami, earthquake and hurricane relief efforts went into tackling malaria, AIDS and issues such as clean water supplies and maternal health, the impact would be enormous [*see box*]. Likewise, if issues to do with trade justice and debt relief were addressed, the chances for many hundreds of millions of people worldwide to begin the slow climb out of poverty would be greatly increased. Campaigns like the Micah Challenge (*www.micahchallenge.org*) are chances for us as Christians to influence decision makers to change these situations.

Conclusion

As Christian doctors, the challenge that disasters raise is how to respond compassionately and appropriately. Often the main need is to support those already working locally, with cash in the first instance and, if those locally request it, by going and using our skills in service of the survivors.

And in responding wisely but compassionately, we are witnesses to the love of Christ to people who might otherwise never know of Jesus. Disasters are not to be exploited as a vehicle for proselytising, but they are an opportunity for the Gospel of salvation to be outworked and preached in practice.

CMF has members in most countries of the world, and we can usually get a fair idea of what is needed on the ground fairly quickly, but there are many other Christian and secular agencies that are highly skilled in responding to disasters like this [*see box*]. If this is an area of work that interests you in the longer-term, then talk to the *HealthServe* team at CMF (*healthserve@cmf.org.uk*).

Steve Fouch *is CMF Allied Professions Secretary*


Photo: Empics

Christian Agencies sending medical teams to Disasters, Conflict and Refugee Situations:

Christian Outreach & Development (CORD)
1 New Street, Leamington Spa,
Warwickshire, CV31 1HP, United Kingdom
Tel: 01926 315301
Fax: 01926 885786
Email: *recruitment@cord.org.uk*
Website: *www.cord.org.uk*

Medair
Willow House, 17-23 Willow Place, London,
SW1P 1JH, United Kingdom
Tel: 020 7802 5533
Fax: 020 7802 5501
Email: *info@medair.org.uk*
Website: *www.medair.org*

Information on these and over a hundred other agencies, churches and Christian Hospitals are to be found at *www.healthserve.org*

It was a practical not an existential response to suffering that Jesus embodied and modelled.

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Kevin Vaughan on being a spiritual influence

Five foundations for professional life

key points

We need to pay careful attention to five basic foundations of our professional lives if we hope to have a spiritual impact.

If we want people to pay attention to our faith, we must first be **competent**. But it's not enough to practise good medicine. There must also be something attractive about our **characters**.

Our capacity to show **compassion** to others probably reflects how deeply we ourselves have received the grace of God; while wise **communication** including the ability to listen well may have an enormous influence on a patient's life.

Finally, when it comes to living and speaking for Christ, it takes **courage** to get started and keep going.

How might we recognise spiritual issues in the life of a patient or colleague at work? Would we be competent to help? Might we misuse our powerful position as doctors? Would colleagues consider us out of line? Do politically correct masters exercise control over the way we work? Do we have enough time even to fulfil our basic contractual obligations? These are some of the questions that come to our minds as we wrestle with what it means to be a *Christian* doctor.

Since I started working with CMF last year, I have had conversations with hundreds of Christian doctors in this country and abroad. Many have expressed frustration that they are being squeezed into a 'neutral' mould. Many struggle to see where being a Christian can make a difference in their daily professional lives.

I would suggest that we need to pay careful attention to five basic foundations of our professional lives if we hope to have a spiritual impact.

Competence

If we want people to pay attention to our faith, we must first pay attention to our work. If your own child is seriously ill, you will want the *best* doctor you can find!

Excellence is an important value in the kingdom of God and Paul encourages all of us to pursue it. 'Whatever you do, work at it with all your heart, as working for the Lord, not for men, since you know that you will receive an inheritance from the Lord as a reward. It is the Lord Christ you are serving.'[1]

C Everett Koop, a former Surgeon-General in the USA, advises Christians, 'Almost everything we say is politically incorrect, so make sure you practise good medicine before you open your mouth!'

If, as Christians, we aspire to professional competence, students will need to take their studies seriously and continuing medical education will be welcomed by all of us!

Character

It's not enough to practise good medicine. There must be something attractive about us personally. 'If you don't like the doctor, nothing's going to work,' an elderly patient, with an intractable skin rash, once said to me.

'What would Jesus do?' is a popular question to ask nowadays. However the character of Christ needs to be built into us and find routine expression in the way we behave, as we don't have time to pause and reflect before our every action! How does this happen? We read that 'the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control. Against such things there is no law'.[2] Many of us may find that God begins to forge these characteristics in us as we learn to face our failures and disappointments. Are we allowing him to do that?

Do everything without complaining or arguing, so that you may become pure, children of God without fault in a crooked and depraved generation, in which you shine like stars in the universe as you hold out the word of life.[3]

Compassion

A surgical colleague of mine found that his attitude to young road accident victims on ventilators in intensive care changed when he himself narrowly escaped with his life after making a mistake when driving. Our capacity to show compassion to others probably reflects how deeply we ourselves have received the grace of God. 'Praise be to the Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.'[4] It is likely that we will meet patients and colleagues who have made foolish or even immoral decisions and if we deceive ourselves into thinking that we are safe on the moral high ground, we will probably be unable to help them.

I well remember a day when a woman who had become pregnant by a casual sexual relationship and had an abortion two years previously, consulted me for help with her feelings of guilt, her inability to concentrate on her work and her insomnia. It had taken her two years to summon enough courage to see the doctor and she was desperate and extremely agitated. Had I spoken to her from my 'high horse' I might never have got through to her, but when I pointed out that my need for forgiveness was just as great as hers (and we know that Jesus teaches in the Sermon on the Mount that anger has the same root of sin as murder and looking at a woman lustfully is the same as committing adultery[5]), she relaxed and we had an opportunity to pray together and to share how God is ready to forgive each of us through Christ.

Communication

'The doctor didn't really listen to me.' Sadly this has probably been said about all of us, whether we are aware of it or not. We never reach the end of needing to improve our listening skills, and time and time again we may need a prompt from the Lord to *slow down*. On one occasion as a patient was leaving the room, clearly dissatisfied, a GP I know had the humility to stand up, move to the door, apologise to the patient that the consultation had gone so badly and invite her to sit down and let him try again! Second time round, they did much better.

What we say may get us into even more trouble. If only we'd had the wisdom to ask one more question before wading in, things might have gone much better! Jesus is our model in asking the question that really gets to the vital issue and we know that wise communication from the doctor may have an enormous influence on a patient's life. A word in season may help a patient make a key step in turning their life around.

Be wise in the way you act towards 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]

Courage

What is the biggest temptation for the Christian doctor? Is it money? Is it sex? Is it power? While all these are serious temptations that have tripped up a significant number of doctors, I suggest that the greatest temptation we Christian doctors face is simply to give up, to play safe, to keep our heads below the parapet and look after our own comfort. In our heads we have plenty of excuses to justify this. However let us hear Paul's exhortation, 'Therefore encourage one another and build each other up, just as in fact you are doing.'[7] Let's pray for opportunities to speak for Christ with our colleagues and our patients and ask him for courage to take those opportunities when they come. I am reminded of Jesus words, 'Whoever acknowledges me before men, I will also acknowledge him before my father in heaven. But whoever disowns me before men, I will disown him before my father in heaven.'[8]

It's not enough just to live a good life; people also need a verbal explanation of the relationship with God that inspires our behaviour. When it comes to living and speaking for Christ, it takes courage to get started and it takes more courage to keep going. May the Lord give to each one of us a new heart to love and serve him in our work every day.

But in your hearts set apart Christ as Lord. Always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have. But do this with gentleness and respect.[9]

***Kevin Vaughan** is CMF Associate General Secretary*

When it comes to living and speaking for Christ, it takes courage to get started and it takes more courage to keep going

references

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3. Philippians 2:14-16
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8. Matthew 10:32

Robert Song asks what is driving medical developments?

BIOTECHNOLOGY and theology

key points

The drive for new technologies is driven not primarily by commerce, government or health-related goals but the deep cultural desires and needs that technology fulfils.

This drive has its origin in the 'Baconian project', which considered suffering as pointless and sought to eliminate it by the instrumental control of nature. Medicine thus runs the risk of no longer simply being a response to diseases of body and mind, but a response to a set of consumer demands to eliminate whatever an individual may regard as a burden.

An appropriate Christian response must be based on prayer, an appreciation of grace, putting aside sin, learning to live in love, displaying the fruits of the Spirit and building and modelling therapeutic Christian communities.

The suggestion that technology is constantly outstripping our ability to react ethically and morally has been a frequent refrain in recent decades. This is not a superficial phenomenon, but goes right to the heart of our deepest commitments as inhabitants of modern Western culture. How should Christians think about technology? What does it mean to call ourselves a technological society?

Attitudes to technology

I want to start with three observations about new technologies.

First of all, many of the new technologies we face today potentially have both good and bad consequences: for example, it can't be denied that there must be at least some moral questions about nanotechnology - the manipulation and engineering of minute systems at an atomic level - otherwise we wouldn't need to think about regulating it. Cybernetics, merging living tissue with the mechanical, or ultimately man with machines, certainly helps those with disabilities, but on the other hand there is also the prospect of 'cyborg' human beings.

Sometimes those who discuss technology as a general phenomenon can seem opposed to all technology. But there is something disingenuous, even self-deceiving about such an approach. After all, do we not all benefit from anaesthetics? Do we not all drive cars? The task is rather one of discernment. What should we reject? What should we embrace?

Secondly, it is often quite difficult to discern what is good and what is bad. Consider, for example, the distinction between therapeutic and genetic enhancements. The good and the ethically ambiguous often come from the same source: a prosthesis that might help a person with wasted arm muscles could also be used to confer super-human strength.

Thirdly, there is an underlying sense that technological developments are ultimately unstoppable; they will happen more or less whether we like it or not. This is shared by both those who applaud them and those who fear them. Technology sets the agenda and we have to respond.

Ethical analysis

Modern Western societies have traditionally responded to these three features of technology by what one might call the 'ethics route': we deliberate, then we legislate. When we are faced with a problem such as the morality of germline gene therapy (altering the DNA of sperm or eggs), we typically ask a high-level commission to consider the question, and on that basis recommend legislation or regulation.

I want to suggest that the ethics route is an inadequate response to new technologies, certainly if we are to think through technological phenomena at their deepest level. The most important reason for this is that even if a society enshrines its views in law, laws themselves can change: the fact that we have legislated now tells us nothing about what will happen in the future. In other words we need to understand the underlying dynamics that give rise to the laws in the first place. What are the social, economic and cultural commitments driving technological innovation and development?

A textbook list of influences on technological development might include the needs of commerce, government policy, military demands or the achievement of various social and health related goals. All may fuel policy, although there is also the internal logic of scientific research: the desire for knowledge or perhaps the less healthy desire for scientific prestige, recognition or wealth.

These factors help explain a lot of what drives technological innovation, but fail to capture the most fundamental point: developments are related to our desires for ourselves and our society.

The Baconian project

It is simply inadequate to refer only to the interests of corporations, science and governments. We must seek to understand the desires and needs that are fulfilled by our technologies. These are profoundly influenced by deep cultural commitments that go right back at least to the seventeenth century, to a way of thinking that is sometimes associated with the writings of the philosopher of science Francis Bacon. This way of thinking, which we might call the 'liberal-technological paradigm' or the 'Baconian project', considered suffering as pointless and sought to eliminate it by the instrumental control of nature.

Many characteristic features of modern medicine, and indeed technology more generally, can be attributed to this. For example, we now place enormous faith in technology as the prime means of therapy, and typically marginalize medical disorders that cannot be cured; whilst those health care professions concerned with caring often take second place to those concerned with curing. Alongside this, the human body is increasingly being regarded as infinitely manipulable in accordance with individual tastes and desires, while at the same time more domains of life become medicalised (think for example of Viagra).

Medicine runs the risk of no longer simply being a response to diseases of body and mind, but a response to a set of consumer demands to eliminate whatever an individual may regard as a burden of finitude. Standard modern philosophical bioethics - what one might call the bioethics establishment - is fully bound up with this. It has inherited Kantian and utilitarian ways of thought and, in my view, is thereby rendered incapable of understanding modern technology, or giving the radical critique of it that we need.

It is therefore not surprising that we should find, for example, more research into life extension technologies, or increasing political pressure for euthanasia. In fact, far from being surprised by new technologies, we can actually predict what will happen by identifying the currents within society that will drive the production of new technologies.

A Christian response

Clearly we benefit profoundly from many technologies, but they also shape us, and thus all of us are moulded to some extent by this paradigm. It is precisely because technology has done so much good that it is very difficult to discern where things are adrift.

For this reason our first response should be one of prayer: prayer that God's kingdom will come; prayer that we will be faithful in our discipleship, knowing that we are not justified by scientific, medical, or technological works, but because God is gracious towards us. Together with this comes all the other features of the Christian life that are necessary for good discernment: putting aside sin, learning to live in love, displaying the fruits of the Spirit and so on.

Ultimately the way we act will influence the way we think. If we instinctively regard certain things as morally unacceptable, it is because we have learned to behave in certain ways. If the desire of our contemporaries is to improve themselves cybernetically or genetically, and this is driven by a competitive desire to outdo others, how can Christians witness to a different non-competitive way of living?

What are the communities that will bring about a different way of being? Many members of the 1994 House of Lords Select Committee that examined euthanasia were broadly in favour of it until they heard a presentation from palliative care and hospice staff. In the light of that, they concluded that euthanasia is simply unnecessary. The idea that a different way of living and a different way of dying is possible, demonstrated here through the example of the hospice movement, was what made the difference.

Christian witness is about witnessing to the truth God has given us in Christ. As Dostoyevsky said, 'the whole world will be outweighed by a single word of truth'. The question to us is: what will be the words and the actions that will convey the one word of truth?

Robert Song *is Senior Lecturer in Christian Ethics at the University of Durham, and author of Human Genetics: Fabricating the Future (London: Darton, Longman and Todd, 2002).*

Based on a CMF/CIS Day Conference address in October 2004


Photo: Empics

When medicine becomes a response to a set of consumer needs, it is not surprising that we should find more research into life extension technologies, or increasing political pressure for euthanasia

How two very different CMF members are serving people in dire need in Pakistan's earthquake zone. **John Martin** reports

Balakot... eight homes in 10 destroyed.

Love + service

key points

The Kashmir earthquake on 8 October killed over 85,000 people and left more than 4 million others directly affected. Winter snows are now meaning further casualties through hypothemia and pneumonia.

Two Christian hospitals in the heart of the earthquake zone were left virtually untouched and CMF members working there have been able to play a major part in responding compassionately to the pratical and health needs of a largely Muslim community.

With the help of an on-line appeal which raised over £75,000 from UK members, CMF has been able to support these efforts to provide tents, blankets, household items and medical care to families devastated by the disaster.

Every day since 8 October people waiting at the outpatients entrance of Kunhar Christian Hospital read a sign bearing words from Psalm 46:'God is our refuge and strength, an ever-present help in trouble. Therefore we will not fear, though the earth give way and the mountains fall into the heart of the sea.'

Kunhar is the closest Christian hospital to the epicentre of the 7.6 Kashmir earthquake, a disaster much greater than the Asian tsunami. The Pakistani government's official death toll was 87,350. Some estimate it could reach over 100,000. Reuters reported at least 74,500 people dead. The UN says more than 4 million people are directly affected and winter snows mean certain casualties through hypothemia and pneumonia.

For Dr Haroon Lal Din, CMF member and founder-director of Kunhar and his staff, Psalm 46 has become a huge source of encouragement and inspiration. On 8 October it was fulfilled in their ears. Remarkably, while outbuildings were damaged the main Kunhar Hospital complex stands intact with just

Response to the crisis

In response to what we were seeing in the news and hearing from two of our members in the area (see article above), we felt that we should respond specifically to the Kashmir disaster and channel what help we could through the hospitals at which our members were working. Bach and Kunhar hospitals in the heart of Pakistani administered Kashmir, the most affected region, had miraculously withstood the earthquake, while all around had been devastated, and were working at beyond full capacity to deal with the huge number of injuries. However, they were also finding nowhere to discharge patients to, so were also trying to get people settled with tents, food, and recently with more durable, winter worthy shelters.

CMF put out an appeal to its membership to support this work on 24 October. Using the *GivenGain* website that we were using on a trial basis at the time, we sent out an appeal to all members for whom we had email addresses. (some 4,300 in total of which about 1,000 bounced!). The initial response was huge, and within ten days more than £30,000 had been donated online or through cheques and charity vouchers. Online giving eventually came to nearly £40,000. With other giving, and Gift Aid to be reclaimed the total raised currently stands in excess of £70,000.

a few cracks. All around are scenes of devastation. Tent villages beyond the Kunhar perimeter fence are home to hundreds of displaced persons waiting with trepidation for the onset of winter. Balakot town 12 miles away is a pile of rubble.

Earthquake over Haroon, who qualified in Pakistan and later studied at Liverpool School of Tropical Medicine, made a quick inspection and gathered staff on the roof of the main building. To the sounds of drums the Kunhar community, all of them Christians, repeatedly sang Psalm 46 in public witness to the deliverance of God.

15 minutes later the first casualties began to appear at the gates. It was 36 hours before Haroon could return to his house to snatch a rest. A month on he was still working 12-hour days and hadn't taken a day off. Outpatient numbers have shrunk to 200 a day, still twice Kunhar's normal workload. In an overwhelmingly Muslim district Kunhar is proof positive that Christians care.

Yet less than three months ago the future of this Christian hospital was under a cloud. In early June a woman died there during childbirth. Her Muslim husband who had been far too long seeking medical help blamed Haroon. He stirred up local mosques with misinformation and circulated petitions to the government to try to get Kunhar closed. Clean water is very scarce in the region. Haroon's response was to arrange for a well to be dug in the man's village. It's one of five wells he's recently provided as part of Kunhar's outreach.

Kunhar was founded 17 years ago with a vision to be an indigenous medical mission. Haroon sees 8 October as an important turning point in its life. 'The whole atmosphere has changed. It's certainly true of local relations, including the man who wished Kunhar so much ill. Now the Christian churches of Pakistan are realising that they need to be partners in our work and outreach.' The hospital compound has become a distribution point for tents, food and utensils donated by Christians from all over Pakistan.

It was Sean Connery who immortalised the words 'never say never again', but at Bach Hospital further away from the epicentre Ruth Coggan OBE is cheerfully reflecting on an a resolution she once made along these lines. She worked as a surgeon at Bach from 1992-9 as part of 29 years' service to medical mission in the north-west frontier region with the Church Mission Society. Returning to Britain she resolved to give up medicine completely. She even gave away her stethoscope and gave donations to CMF in lieu of her membership subscription.

An answerphone message from a Swedish friend on route to the disaster area prompted Ruth to wonder if, after all, she might contribute something worthwhile. She got a huge encouragement when applying for a visa. The First Secretary at the High Commission in London knew of Ruth and her work. He issued a multi-entry visa free and wrote a long letter that said how wonderful it was to have people like her helping his country.

Equipped with a borrowed purple stethoscope Ruth's day starts at 5.30am with prayers and breakfast, with ward rounds at 7am. 'I'm loving it though I'm aware of my limitations', she says. 'Things have moved on in medicine since 1999. I wait for something that's up my street. If I get a call from obstetrics I leap at it. So far I've done 14 caesarean sections and this frees up the senior surgeons for more complex work.

'Bach needs people,' she explains. 'Ideally they need to speak the language and they need to be able to do a specific job.'

Luke Cutherall is head surgeon and CEO at Bach. It's assembled a small emergency team that supplies a package including tents, utensils and food rations. 'It's not like a war. All the damage was done in 90 seconds. In the acute phase we treated people for immediate injuries, but continuing care is needed. We found we quickly needed to focus. We are a hospital, not a relief agency, but we're here for the long haul.'

***John Martin** is Head of Communication at the Church Mission Society and Associate Editor of Triple Helix*

Photos: John Martin

Dr Haroon

God is our refuge and strength, an ever-present help in trouble. Therefore we will not fear, though the earth give way and the mountains fall into the heart of the sea.

Psalm 46:1-2

By the start of December 2005 we had been able to wire some £35,000 directly to the hospitals and/or their support agencies, and by the time you read this we will have sent £35,000 more. This money has already helped to save lives.

The two hospitals have raised shelters and semi-permanent structures for people. Using local knowledge and resources, they have been meeting the wider needs of the community, as well as providing top rate medical care where few other facilities have been left intact.

In addition to such generous financial support, CMF's members have been generous with their time, and we have had nearly forty enquiries from members wanting to offer their time and skills. Our main channel to send people out has been SIM UK, and a number of our members have gone with their teams.

There is much to thank God for – the confluence of the right people in the right place at the right time, the miraculous survival of two hospitals (and their staff) when all around was destroyed, having access to web-based systems that enabled an appeal to be set up and sent out in matter of two or three days, the generosity of our members in money time, and service, and the fact that through all of this Christians are showing the love of Christ in a practical, sacrificial way that speaks louder than any words.

Please continue to pray for all those involved. And a very big thank you to all our members who have shown such great generosity of sprit.

***Steven Fouch** is CMF Allied Professions Secretary*

showing the love of Christ in a practical, sacrificial way

Ian McColl on the amazing story of Mercy Ships

Hope and healing AFLOAT

Crisis hit the crew of Mercy Ships a year after the launch of the charity's first ship MV Anastasis 26 years ago. The crew found themselves short of food. Then a miracle happened. Suddenly 8,301 herring leapt out of the sea on to the shore. It was enough to feed the ship's company for a year.

Mercy Ships is a Christian charity that runs a fleet of hospital ships that visit the poorest countries in the world and carry out operations not available to their people. It all began with the purchase of the Anastasis for $1 million, all of which was borrowed.

The vessel was transformed into a hospital ship over a period of three years in a port near Athens. It was a prolonged and difficult time. Even so the spirits of the team remained high. When an earthquake occurred nearby the crew were able to go to the assistance of those stricken. But the miracle of the great draft of herring set the keynote for the work. Gradually smaller ships were added and they sailed to ports in the Caribbean, South America, the Philippines and South Korea.

Stories of lives changed are legion. A little girl called Edoh, aged seven, appeared at the back of a queue of five thousand people waiting for many hours to be seen. She had a huge tumour of her jaw that was occluding her airway. Naturally, all the patients wanted to be seen first but when they saw that this little girl they immediately transferred her overhead up to the front of the queue and over the closed gates. She required an immediate tracheostomy and then had her tumour removed successfully. Years later she came to the ship to announce that she was going to take up nursing. Perhaps one day she will join the crew.

Mercy Ships only visit countries that invite them. This can sometimes present difficulties. Once, just three weeks before they were due to arrive in Ghana, the country's President cancelled the trip. Being a resilient organisation Mercy Ships quickly arranged to go to nearby Togo.

The ship had not been there for more than a few weeks, operating on many patients and helping with various projects on land, when they noticed that secret police from Ghana were surveying their work. Eventually the President of Ghana came to the ship and apologised for the last minute cancellation. Informants in Europe had told him the ship was a Trojan horse full of armed soldiers dressed up as surgeons - their mission to stage a coup. After a three-month stay in Togo the ship went on to Ghana for a most worthwhile visit.

As well as requiring an invitation Mercy Ships insist on a written contract specifying what activities will be carried out and requiring close liaison with local doctors and hospitals.

A Mercy Ships anaesthetist went to visit a local hospital and found a young lady in a coma and dying. When he enquired he was told that she was in obstructed labour, needed a caesarean section, but could not afford it. When he enquired as to the cost of the operation, the answer was £70, which he quickly paid.

The lady had her caesarean section and both mother and daughter survived. Seven years later, when he again visited that country, the anaesthetist was greeted at the airport by a large sign 'Thank you for saving our lives.' Here was the mother and the seven-year-old girl.

The story of Mercy Ships is replete with tragedies and trauma. Equally there is a more than fair share of amusing incidents

The story of Mercy Ships is replete with tragedies and trauma. Equally there is a more than fair share of amusing incidents. Like when a Jewish eye surgeon was told that his first patient was a blind Muslim mullah who needed removal of cataracts so he could once again teach the Koran. The Jewish surgeon was none too certain about this. He said 'I have given up thousands of dollars in private practice, I have had to pay my own fare here, I have left my family behind, I have to pay for my food and keep on board and now they tell me my first patient is a Muslim mullah.'

Meanwhile, when the mullah was informed by the nurses about his Jewish surgeon: he was none too pleased either. When they met, however, all was well and the operation was a great success.

Here is an amazing story of the love of Christ in action in all those ports where Mercy Ships visit, bringing hope and healing to the outcasts of society.

***Lord McColl** is Emeritus Professor of Surgery at Guy's Hospital*

The story of Mercy Ships is chronicled in Ships of Mercy by Don Stephens with Lynda R. Stephenson published by Hodder & Stoughton, 2005.

John Martin recounts an amazing partnership

Pictures making a difference

Here is a story of two people:[1] a visionary innovator and a courageous implementer. David Morley's heart began to be stirred with a concern to address poverty and health in the 1950s. The chance arose for a rare opportunity to undertake research on children growing up in the Nigerian village of Imesi Ile. Quickly, the practical priorities of developing world medicine became very clear for David.

On leaving West Africa he took up a post as lecturer in the London school of Hygiene and Tropical Medicine where his collection of colour slides quickly proved to be a powerful learning tool. So the head of department suggested they should be made available as teaching sets with a detailed interactive script for students to take home. This is how TALC (Teaching-aids At Low Cost) was born.

Now meet Edwin Mapara, a young doctor with strong Christian convictions. We pick up his story many years after David's return to London. Edwin was working at Athlone, a 175-bed district hospital in the Lobatse region of Southern Botswana where his experiences confirmed TALC's belief in the power of colour pictures in teaching.

In his spare time, with a group of other health workers, Edwin started to run discussion groups on the threat of HIV/AIDS. This was early on in the epidemic and many asked to see cases like those he spoke of. Edwin obtained colour pictures of the effects of the disease from TALC.

For his audience to discuss and understand the fundamentals of transmission he found it necessary to show explicit pictures including an ulcer on a penis and in a female perineum. These pictures were highly effective in creating discussion and a real understanding of the disease.[2] However, they also produced a strong reaction.

Older people walked out of the discussions. Edwin was reported and fined by the local chiefs. There was an outcry from the churches and a strong reprimand from the health ministry. However he persisted and over 10 years ran over a hundred workshops at all levels. Even departments of Government came to accept the approach and support it.

Edwin received requests to run discussion groups from the police, local communities, schools and churches. He even received a request from a church to show his pictures from their pulpit. But perhaps the most striking response came from the same community members who had resisted the teaching in the early days. Words spoken publicly by a community leader who once firmly resisted Edwin's message show both an amazing change of heart and a stark challenge:

'You doctors are to blame for what has happened to us and particularly our children in Africa. You should have done this ten years ago before a third of our population became infected? The blood of our children who have died rests on your heads.'

It's a comment that witnesses to the impact of TALC on lives in many parts of Africa and beyond. Thanks to TALC's approach in Botswana, a diagnosis of AIDS has less stigma associated with it compared with many other South African countries.

Wider recognition of the work followed. In 2000, the United Nations Development Programme declared Athlone Hospital's initiative as one of the 'best practices' in Botswana,[3] and it is being replicated nationwide.

TALC remains a small NGO but has now been providing information for health workers in the Southern hemisphere for forty years. For the first 20 years TALC's approach remained the same: simple but effective slides, with detailed interactive scripts. TALC sent out over seven million of these mostly to Africa.

Recent technological advances heralded change. In 2000 the UK government provided a three year grant to create free CD-ROMs on Health Development. The first went out in 2001 and since then 4,000 go out about twice a year with 100 new addresses received each month.

TALC is heightening emphasis on overcoming poverty and improving health care. The majority of health care workers in less privileged countries are starved of up to date reliable information to continue their education and provide health care. Where a health worker has access to computers a free CD-ROM proves to be a great benefit.

***John Martin** is Associate Editor of Triple Helix*

TALC Resources

The regular production and growing demand for the TALC free CD-ROMs is both encouraging and problematic. Producing the CD-ROMs is expensive and demands time over and above normal duty. From the start it was recognised the CD-ROM had to be available free. Additionally, selecting the right material to meet the wide requirements of district hospital and community levels is demanding. The BMJ, Lancet, RCP Journal of Clinical Medicine, Cochrane Abstracts and Tear Fund are just some of the organisations generously providing material.

TALC is looking for people with recent experience of health care in the developing world to select suitable material. There are plenty of opportunities to support the work of TALC by volunteering and through regular prayer. Donations are very welcome
Contact: Teaching-aids at Low Cost (TALC) OOB 49, St Albans, Herts AL1 5TX. Tel: +44(0) 1727853869 Email: *info@talcuk.org*
Website: *www.talcuk.org*

references

1. David Morley is the founder and president of Teaching-aids At Low Cost (TALC), based in St Albans, UK. Edwin Mapara is a postgraduate student studying for an MSc in infectious diseases at the London School of Hygiene and Tropical Medicine, UK
2. Mapara E, Morley D. Picturing AIDS: Using mages to raise community Awareness. *PLOS Medicine* 2004; 1 issue 3 e43 *http://medicine.plosjournals.org/archive/1549-1676/1/3/pdf/10.1371_journal.pmed.0010043-S.pdf*
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Philip Hacking and **Dr Mark Houghton** share their ten-point tool kit for helping people prepare for this life's final journey

Our final duty

It is a great privilege to be physicians and pastors to the bodies and souls of people. At every phase of life are ways for pastors and doctors to share their faith. There are, however, special opportunities when patients enter life's final journey and we need to be prepared for both our medical and spiritual duties.

The principle is well established in the history and practice of palliative care. Moreover the General Medical Council has clearly left the way open for the appropriate sharing of faith with patients at every stage, provided it is with sensitivity:

'The profession of personal opinions of faith is not of itself improper…doctors who caused patients distress by the insensitive expression of their religious views would not be providing the care which patients are entitled to.' (*GMC Annual Report; 1993:4*)

Therefore our medical responsibilities provide a framework for opportunities to share our faith appropriately. In practice, however, we face a double dilemma. On the one hand there is far less home visiting by the caring professions and pastors. On the other there is a vastly increased ignorance of the Christian message, even among elderly patients.

Even hospice chaplains can find it surprisingly difficult to move from small talk to the spiritual. This means that Christian doctors often find that the first opportunity to bring up spiritual issues presents itself to them. So however pressured we are we must be ready for the task.

Using this ten point tool kit will equip both doctors and pastors for those opportunities to share our faith that arise with people who are beginning their final journey:

1. Confidence: We need to be confident about the theological basics. Much depends on whether we accept the clear New Testament teaching on heaven and hell. If we believe that finally all will go to heaven clearly it will take away the need and the urgency to prepare a person to face the ultimate. The New Testament teaching, not least from the lips of Jesus, (Mark 9:42-49), on the realities of hell should concentrate our minds. Confidence on this issue can help us to seize opportunities.

2. Opportunities: We should not expect that opportunities will come out of the blue. Most of the time they are the result of a long process in a person's life. We see only a part of it. Most of our witness is non-verbal and arises from a consistent Christian life but it will help if the patient has gathered that your faith is important to you. There are many ways this can be done such as mentioning a conversation at church at the weekend. A sound relationship with the patient, backed by caring compassion, wins trust.

3. Know the Good News: In order to introduce the dying to Christ we need a good grasp of how to explain the way of salvation. CMF has excellent resources to help such as *Confident Christianity* and *Saline Solution*. (See *www.cmf.org.uk*)

4. Excellence in medical care. There is nothing so damaging to a doctor's spiritual effectiveness than weakness in some other area of medical practice. As physicians to the dying we must ensure that the whole team is working together well; controlling distressing symptoms and supporting the family. Leave no opportunity for the comment, 'She may be a good Christian but she is a rubbish doctor!'

5. Value people. Having set in motion the best available holistic care, try not to neglect individuals in the midst of the busyness of the job. It is nurturing relationships that builds trust and earns the right to probe into the spiritual heart. Time may reveal a causal 'I'm fine thanks', to be a suppression of deeper issues.

6. Pray beforehand. Remember Paul's advice to 'pray in the spirit on all occasions.' Our job is not to force doors open but to be in step as the Holy Spirit opens doors. We may need a little courage to walk through and prayer helps.

7. Be alert to the prompting of the Lord. As you continue to care for every area of the patients life, be ready for that God-prepared opportunity in the dying person. Look for that moment. It may come very close to the end, even when one feels that perhaps the chance was missed. In the same way as one palpates for signs of tenderness, so when appropriate one can probe with words for areas of spiritual tenderness. The timing and depth of this probing takes faith, sensitivity and experience. Questions can be helpful in letting people open up. It can be helpful to ask open questions such as, 'What place does faith have in your life?' or direct questions such as 'Would you like me to pray with you? I often do at times like this.'

8. Obstacles. We are dealing with someone's eternal destiny and our Enemy has a fixed agenda to prevent us if he can. (Ephesians 6: 11, 12.) We need just as much humility and prayer to speak with one person as we do with a thousand. Prayer and praying friends will promote many encouragements.

9. Mistakes. We are all human and make mistakes. If we offend in some sensitive area, be ready to apologise quickly.

10. Keep confidences. Seek the patient's permission before involving the pastor.

We all battle against pressures of time and accusations from the Devil. So it is important and healthy to remember that we cannot do all this on our own. We need the ever-present help of the Spirit and other Christians in the background. But the rewards of seeing someone find peace at the end are out of this world.

Philip Hacking *was formerly vicar of Christ Church, Fulwood, Sheffield and chairman of the Keswick Convention.*
Mark Houghton *is a part-time GP in Sheffield*

eutychus

Spirituality and health across the Atlantic

More than half of the medical schools in the United States now offer courses on 'spirituality and health', up from just three a decade ago, largely because patients are demanding 'more spiritual care'. According to a *Newsweek* Poll, 72 percent of Americans say they would welcome a conversation with their physician about faith; the same number say they believe that praying to God can cure someone, even if science says the person doesn't stand a chance. To make sense of the morass of data, the NIH commissioned a series of papers, published earlier this year, in which scientists attempted to definitively assess the state of the faith-and-health research. Lynda H. Powell, an epidemiologist at Rush University Medical Center in Chicago, reviewed about 150 papers, throwing out dozens that had flaws, those that failed to account for age and ethnicity, for example, which usually affect religiosity. In one respect, her findings were not surprising: while faith provides comfort in times of illness, it does not significantly slow cancer growth or improve recovery from acute illness. However people who regularly attend church have a 25 percent reduction in mortality compared with non-churchgoers. This is true even after controlling for variables intrinsically linked to Sundays in the pew, like social support and healthy lifestyle. (*Newsweek* 2005; 10 November, *http://msnbc.msn.com/id/3339654/*)

Scottish euthanasia move fails

MSP Jeremy Purvis has been campaigning for the legalisation of euthanasia in Scotland through a 'Dying with Dignity' Consultation. On 25 October 2005 he lodged a proposal for a bill 'to allow for a mentally capable, terminally ill adult the right to receive medical assistance to die'. Under the rules that regulate Members' Bills, a proposal of this kind had to attract 18 supporters within one month if it was to continue through the legislative process. However it attracted only five supporters within the allotted time period. This means that his proposed *Right to Die for the Terminally Ill Bill* will not proceed.

GP charged over late abortion

A GP from Birmingham has been charged with sending a woman to another country to have a late abortion. Dr Saroj Adlakha, 59, is accused of arranging the termination in Spain two years ago for Shilpa Abrol who was alleged to be 31 weeks pregnant. Miss Abrol, now 20, and Dr Adlakha were both charged on Wednesday night of conspiracy to commit an offence against a person outside the United Kingdom. (*BBC News* 2005: 15 December)

New parliamentary group promotes palliative care

An All-Party Parliamentary Group on Dying Well has been formed. Its purpose is educational - to address current misconceptions about end-of-life care, including the role, use and misuse of different drugs, the nature of euthanasia or assisted suicide, the present state of UK law in this matter, the ethical constraints within which doctors operate, and how these would be affected if the law were to be changed in the light of experience of countries which have gone down this road. It plans to produce briefing material and to hold open lectures by specialists in their fields. This will provide some opposition to the VES-sponsored All-Party Group on Compassion in Dying. Frank Field MP is Chairman.

Majority of UK doctors oppose euthanasia

The internet discussion forum *www.doctors.net.uk* (dnuk), to which over 110,000 UK doctors belong, has conducted an on-line poll on a variation of the September RCGP statement, 'With current advances in palliative care a change in the law to allow euthanasia or physician-assisted suicide is not necessary.' Of over 2,000 who responded (the largest response on record for dnuk) 69% voted in favour and 31% against. This is yet further confirmation that the majority of doctors on the frontline are opposed to a change in the law.

Christian doctor wins discrimination case

An eye specialist has accepted undisclosed damages after claiming that Muslim colleagues forced him out of his job. Joseph Erian took the United Lincolnshire Hospitals Trust to an employment tribunal, stating that he was made to resign from the ophthalmology department of Pilgrim Hospital, Boston, after staff there discovered that he was a Christian. The tribunal ended when the trust offered an out-of-court settlement and admitted that the problems surrounding Dr Erian's case 'were not his fault'. Dr Erian pursued his claim privately after the British Medical Association refused to back the case. He brought his case under the Employment Equality (Religion or Belief) Regulations 2003, which make it illegal to discriminate against someone on the grounds of their religion or beliefs. (*Times on Line* 2005; 30 November)

Stem cells for spinal cord injury

The director of the Spinal Repair Unit at University College, London, has announced trials of a new treatment for patients with spinal cord injuries. Ten patients will be treated at the National Hospital for Neurology and Neurosurgery in London using stem cells taken from the lining of their noses. Professor Geoffrey Raisman warned that patients with spinal injuries should not get their hopes up but the trial raises the possibility that adult stem cell transplants could allow patients to recover sensation, movement and other functions in the future. (*The Telegraph* 2005; 30 November)

Alpha feeds spiritual hunger

The Alpha course, which teaches the basics of Christianity, has enjoyed a resurgence. The course originated in London's Holy Trinity Brompton more than 20 years ago and now, according to organisers, there are now some 30,000 Alpha courses running around the world. Sessions are held in prisons, workplaces, schools, colleges and military establishments. Around 7,000 UK churches are signed up, many running several courses a year, but the number of converts still does not match the tide of Christians leaving the church. (*BBC News* 2005; 4 August)

More women buy morning after pill

The number of women buying the morning-after pill from chemists has nearly doubled in a year. Over-the-counter purchases rose from 27% in 2003/04 to 50% in 2004/05, the Office for National Statistics found. Fewer women asked their GP for a prescription for the emergency contraceptive in the same time period. However, the percentage of women using it remained the same - about 7% of women aged 16-49 using the morning after pill every year. (*BBC News Online* 2005; 28 October)

Making it in British Medicine

Essential Guidance For International Doctors
Graeme Catto, Peter Cross & Sobina Dosani

- Radcliffe Medical Press 2004
- £21.95 Pb 184 pp
- ISBN: 1 85775 8757

Author Sabina Dosani was staffing a BMA stand at a careers fair when she was overwhelmed by enquiries from International Medical Graduates (IMGs). She responded by co-authoring this book which is crammed with succinct information for both recently arrived graduates and doctors contemplating a move to the UK. The expected information re IELTS and PLAB 1&2 is full and in the case of the IELTS language test most informative and well researched. The authors follow the route of the IMG from the stage when he/she is contemplating moving to UK through to arrival and settling in and exploring the openings in the NHS, including negotiating PLAB and job searching. Throughout the writing is marked by both empathy and sensitivity. Some paragraphs are an excellent example of conveying a great deal with few words, eg. the passage on clinical governance.

What makes this book live are the comments from overseas doctors at many different stages, feedback and advice from Dr Yong Lok Ong (overseas doctors Dean, London Deanery) and Professor Michael Carmi (North London GP, whose surname is incorrectly spelt throughout the book) . Additionally there are comments from PLAB examiners, IELTS assessors and the examiners from the Royal Colleges. It is this leavening of the loaf with anecdotes, advice and wisdom that gives this book a special appeal. The retrospective view of the NHS, annotating the major changes since 1948, is a superb summary and a reminder of the constant change that professionals within the NHS have grown to cope with.

As a GP I would have preferred a longer chapter about general practice and a greater exposition of the new contract, with emphasis on the necessity of being computer literate. However the first experience of the NHS that these doctors will encounter is in the hospital. Therefore advice re clinical attachments and the role of the SHO within the district hospital setting is essential. Judicious use of flow charts and diagrams aids explanation of the acute trust organisation. There is excellent advice on teamwork and inter-professional relationships. There is advice on how to cope with homesickness, exam failure and personal health issues, including stress. There are lists of helping agencies, both professional and illness orientated. The proper role of the GP in personal health care is clarified and applied. A most informative chapter on the British way of life is called living in Britain. This is a mine of information as to the idiosyncrasies of the infra structure which those born in the UK take for granted.

Finally the book provides four pages of acronyms commonly used in UK medicine from A&E to WBC. This is most useful and not surprisingly there were some I had not encountered or fully understood. A book worth reading and recommending to our colleagues from overseas, it is also a useful exercise for UK graduates to see our profession as overseas colleagues experience it. This is a well produced and planned book of advice and information.

Geoffrey Norris *is a General Practitioner and course organiser of the clinical experience scheme, International Unit, London Deanery*

Life in our hands:

Christian perspective on genetics & cloning
John Bryant & John Searle

- Inter-Varsity Press 2004
- £9.99 Hb 191 pp
- ISBN: 0 85111 7953

Barely a month goes by without an announcement of a new development in biotechnology. The challenge for Christians is to keep abreast of such advances and respond biblically. In *Life in our hands*, biological scientist John Bryant and doctor/pastor John Searle attempt to outline some of the issues at stake, and explore how Christians can make balanced ethical decisions.

The book is based on the London Lectures in Contemporary Christianity, given by Bryant in 2002, and seeks to tackle a huge range of topics related to biotechnology: from genetically modified crops to the Human Genome Project, and prenatal diagnosis to the genetic enhancement of embryos. In each case, they provide an extensive and helpful overview of the science, then a brief review of the ethical literature - both Christian and secular - before formulating a Christian response.

The authors also include several useful chapters at the beginning of the book exploring the state of contemporary bioethics, particularly Christian ethical decision-making, and whether or not the use of biotechnology falls within the our remit as stewards of God's creation. The biblical concept of man being made in the image of God (see Genesis 1:26-27) is fundamental to the Christian perspective on many of these technologies, as Bryant and Searle point out. However, their detailed explanation and defence of evolutionary theory rather detracts from their exploration of this important theme.

Many of the ethical principles discussed in *Life in our hands* have been debated at length, both within the Christian community, and more widely, and the authors expound a few views – particularly regarding the beginning of life and the status of the embryo – which may not sit comfortably with some CMF members. However, the book provides a useful overview of biotechnology as it stands today, whilst the authors repeatedly make reference the lack of biblical proof texts to apply to many of these technologies. Instead they, write:

'All these questions represent real human dilemmas. Even if we believe that we know what we would do, we must not assume that other people – even those who share our faith – will reach the same answer. The church community needs to support in a non-judgemental manner those who are dealing with such dilemmas: listening and, if asked, providing advice.' (p131)

Helen Barratt *is a surgical house officer at Wexham Park Hospital in Slough, Berkshire*

The Hospital by the River

A story of Hope
Dr Catherine Hamlin with John Little

- Monarch Books 2004
- £7.99 Pb 304pp
- ISBN: 1 85424 673 9

Many of those who have worked in Africa and who have come face to face with the desperate, despairing young woman with a vesico-vaginal fistula caused by obstructed labour and have faced the daunting prospect of trying to repair it, will know the name Hamlin and know of the fistula hospital in Ethiopia. Not all will know their story but it makes enthralling reading.

Catherine and her husband Reg set off for Ethiopia, on a short-term contract, in 1959. Some 45 years later, Catherine is still there and still at work. Her husband sadly died in 1993. Their original calling had been to establish a midwifery training school. Overwhelmed by the needs of the women who had suffered the appalling consequences of prolonged obstructed labour, the 'fistula pilgrims' as Reg called them, because of the tremendous journeys that some of them had undertaken to reach help, they set about teaching themselves how to repair such fistulae.

Catherine has successfully operated on over 25,000 fistula patients and trained many doctors from all over the world to do likewise. The hospital they have set up has many ex patients amongst both its nursing and medical staff. This book tells not only the Hamlin's story but provides glimpses into the lives of many patients and the problems faced by those living in extreme poverty.

The Hamlins have lived through good times and bad, respected and supported by the Emperor and his family.

They saw many of their Ethiopian friends imprisoned and killed by the communist regime. Throughout the book, Catherine speaks honestly about the joys, dangers and sorrows of missionary life, of difficulties faced bringing up children in a country which is not your own, where missionary parents can so easily become too busy and miss out on the needs of their children. Never willing to turn a fistula patient away, they were often inundated by needy patients and at the end of a busy day they had the additional labour of raising funds for their fistula work.

In a story full of heartbreak and miracles, Catherine's love for God and for her patients shines through, showing itself in the way in which she so often goes the extra mile that her saviour taught her. Honoured by many prestigious institutions and governments around the world, the establishment of a purpose built fistula hospital, where the techniques they have so successfully pioneered continue to be taught to others, stands as an even more fitting testimony to their life long commitment to God's calling on their lives.

A challenging and readable book but it should carry a 'watch out God might speak to you through it' warning. Such needs still exist in many of the resource poor countries of the world even in the 21st century.

***Peter Armon** is CMF Overseas Support Secretary*

Keeping the Vision Alive

The Story of Barnardo's
Winston Fletcher

- Barnardo's 2005
- £14.99 Pb 156pp
- ISBN: 1 904659 11 x

We grow great by dreams... Some of us let these great dreams die, but others nourish and protect them; nurse them through bad days till they bring them to the sunshine and light which comes always to those who sincerely hope that their dreams will come true.

Woodrow Wilson,
28th US President

Great visions require great people to carry them forward, but all too often, the adage that we die and our dreams die with us is true. *The Story of Barnardo's* shows that this need not be the case. 'Dr' Thomas Barnardo never qualified as a doctor, wherein lies a tale of intrigue and deception, yet was a man of vision with a charismatic personality. He had a passion for the vulnerable that enabled him to found a charity that has become a world-leader, helping over 100,000 disadvantaged children each year. However, Barnardo was also plainly human, and in spite of a strong evangelical faith could be intolerant, ill tempered and untruthful. Perhaps this was not too different from many Old Testament characters on whom the vision of a chosen people and Promised Land was built.

I have great admiration for the author for undertaking what seems an impossible task of writing an entertaining, informative and inspiring biography of an organisation. I read this book with high expectations; as a paediatrician, I was aware of Barnardo's work but knew little about the organisation and its founder. Whilst I have learnt much, it was a struggle to do so. Apart from the great photos, this book is not easy bedtime reading. Indeed, I am unclear at whom it is targeted.

Fletcher starts with a useful sociological study of the nature of charitable giving and historical changes in welfare provision. He then supplies a brief biography of Barnardo, followed by the history of his organisation from 1905 to 2005, set in the context of the changes of the 20th and early 21st centuries. As with the man himself, the organisation has not been without fault, but has grown and adapted to changing needs and perceptions to maintain its focus on helping vulnerable children.

In the light of the Victoria Climbie inquiry, the Children Act 2004 and the Green Paper *Every Child Matters*, the book finishes with a look to the future and Barnardo's UK Agenda. Reflecting back on the nature of welfare provision through the charitable sector, the author leaves us with rather a frustrating set of questions that are aimed in part at Barnardo's, and in part at government and other agencies. Perhaps one purpose of this book is to raise these questions. In that spirit, I shall leave you with a few:

- Where should the balance between state and charity provision of welfare services lie?
- Are there too many children's charities?
- Can the slow decrease in the total number of people in Britain giving to charity be reversed?
- How should Barnardo's (or any other charity) divide its resources between front line childcare, political and social campaigning, and research?

***Peter Sidebotham** is a Consultant Paediatrician in Bristol*

news from abroad

Well done SIM

It was a privilege to sit in on a debriefing session with a team of young doctors, led by a CMF member and including several other CMF members, who had recently returned from SIM's first 'Mission Exposure Trip'. The participants had spent a couple of weeks in a Government District Hospital in South Africa.

Each one had been challenged by what they had experienced and had their eyes opened both to the needs and the difficulties; the joys and the sorrows of working overseas. Common threads running through their shared experiences included the overwhelming impact of AIDS on medical practice, the difficulties of being called upon to be a generalist when UK training has become so 'specialist' orientated and the need to adapt to a more 'hands on', low tech approach.

It is to be hoped that SIM will organise further such trips on a regular basis. This was very much in line with the vision of CMF to do likewise. We hope to be able to be able to utilise the experience and opportunities offered by SIM, rather than re-invent the wheel.

CMF capacity building trips

We are continuing to work on a response to needs mentioned by some of our members working overseas. Requests have come from Malawi, Benin, Ecuador and Pakistan. There is also the possibility of linking into a work in Uganda and another in India. There will be ongoing needs in the earthquake-affected area of northern Pakistan/Kashmir.

The needs for both specialists and generalists in Kashmir are overwhelming. The request from Benin is for a team to assist with Eye work and from Ecuador, for a palliative care team. Apart from the ongoing disaster response needs in Pakistan, the primary needs are for those who are willing to teach and pass on their skills to others.

If you are interested in being a part of any response that CMF might make in any one of these areas, please let me know (*peter.armon@cmf.org.uk*).

Some snippets from members currently working overseas

What are we here for?

A member writes of the incredible privilege of attending the funeral of a friend's 21 yr old niece. 'You hear so much negative stuff about Africa's future but if you could have seen the hundreds of young people (many in white coats, she was a 3rd year medical student) all praising God and wanting to proclaim that he is good and faithful even in their grief. She was part of an amazing dance group. Their worship through movement, dance and music was so powerful. I didn't know her but, from what was shared, she had touched so many lives with unconditional love and is remembered for her unswerving devotion to Christ – Wow what will they say about me? More importantly, 'Is it well with my soul?'

Another writes

'This year Ramadan coincided with the Hindu festival of Durga Puja, which was celebrated last week. I was returning from a shopping trip to the town when we were caught up in the final evening's celebrations. A carnival of idols snaked down the road while hundreds of people lined the riverbank waiting for the symbolic throwing of the idols into the water. Young men with painted faces and staring eyes danced wildly. Pungent incense filled the air.

It is a little overwhelming when the darkness is so explicit and widespread. Yet I am also reminded of the truth and light of our Lord, and the reality of the growth of his kingdom. As the yeast spreads through the dough, and as the mustard seed grows into the tree.... imperceptible to us, but we can trust in his power and purposes.

I looked for a man among them who would build up the wall and stand before me in the gap on behalf of the land so I would not have to destroy it, but I found none. (Ezekiel 22:30)

Whom shall I send? And who will go for us? (Isaiah 6:8)

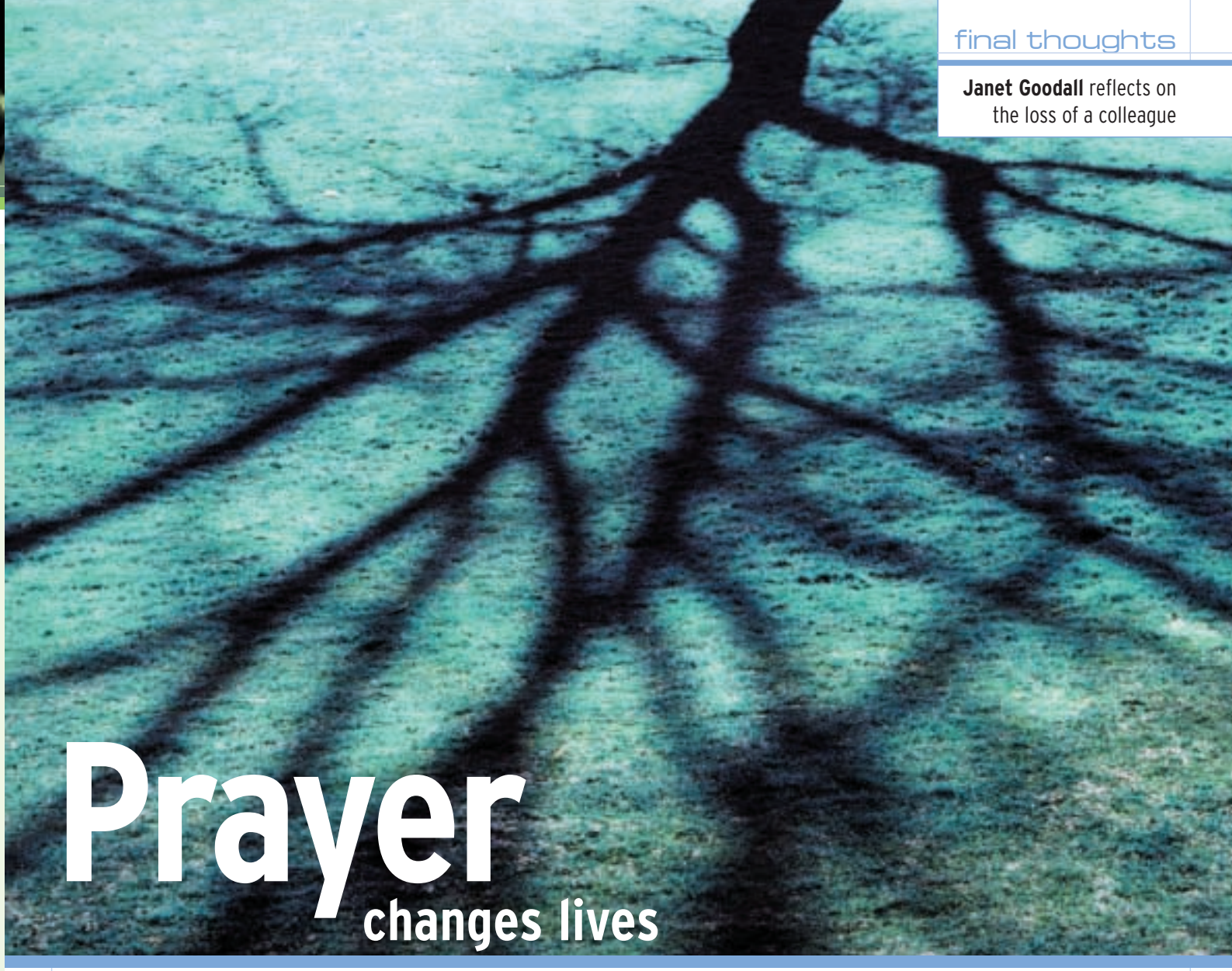
Peter Armon *is CMF Overseas Support Secretary*

Overseas Vacancies currently advertised on the Opportunities pages of our Overseas Website include:

- Doctor for Rumginae Rural Hospital, Papua New Guinea
- Medical Director for Harpur Memorial Hospital, Egypt
- Director of Education and a Director of Distance Learning Diploma required at Hospice Uganda
- Doctors needed to join a Medical/Needs Assessment team that International China Concern are sending to China in September 2006
- Anaesthetist for the Beit Trust Cure International Hospital, Malawi for 6-12 months duration
- Ophthalmologist needed to work in an eye clinic in Mali
- GP, Paediatrician and a Physician/Internal Medicine specialist needed at Chogoria Hospital, Kenya
- Experienced Gynaecologist and an Ophthalmologist, to join two local doctors at a mother and child clinic in Aden
- Executive Director needed for LAMB project in NW Bangladesh, starting around 1 January 2007

For fuller information and job descriptions please visit *www.healthserve.org* or contact Laura at CMF office, *laura.risdale@cmf.org.uk*

Janet Goodall reflects on the loss of a colleague



Prayer changes lives

Son of a South African pastor, Richard Johanson was born in South Africa. His mother's obstetrician was Paul Bremer, an old friend of CMF, so much prayer must have surrounded him from the start. We met in 1984 when Richard joined our hospital team as a junior doctor, by now married to Charlotte. They occasionally visited my home, then years passed and paths diverged. In retirement I heard that Richard and Charlotte were back at our local hospital, she as an anaesthetist and he as a highly respected perinatologist. By now they had three children, lives were full and we did not meet up again , although his work was becoming internationally acclaimed. I was therefore shocked to hear of Richard's early death from a malignant melanoma in 2002. It is no surprise to note the affection with which he is remembered, or that an obstetric prize now bears his name.

Yet our tenuous connection did not end there. Not long ago our church family was blessed by the arrival of Linda, a research worker, and Paul, a lecturer in computer technology. Paul willingly came to my rescue over some teaching material I was trying to prepare and, after our technical discussion, I asked him how he and Linda had come to faith.

'It was through Richard and Charlotte,' he replied.

It emerged that Linda had been Richard's research assistant, and the two couples had been friends for six years before Richard's diagnosis. 'We thought they were great,' said Paul, 'except they were Christians, which we found a bit weird. We had a lot of discussions, though. Then we heard the awful news, and I got as far as saying, "OK, God, I'll believe if you'll heal Richard." But he only got worse – from the start he'd only been given a few weeks to live. There was, though, a great sense of excitement and serenity about him which we couldn't understand.'

The 'few weeks' were extended to five months – a crucial extension. One memorable day, Richard invited Paul and Linda to take a walk with him through the woods.

'I do this every day,' he told them,' I sit on a log and look out over the countryside.' Sure enough, there was the log and they sat down together to admire the view.

'What I do here is pray,' said Richard,' and that's what I'd like to do now.'

'In his prayer he mentioned our names, and that did it,' said Paul, still a little choked.

'We just said to God that we gave in, and it was up to him what happened to Richard.'

Three weeks later, as very new Christians, they attended Richard's funeral.

'In spite of the sadness,' said Linda,'there was such a sense of peace.'

Someone at the service directed them to our church, and so we met. Soon I hope to meet Charlotte again. Despite the great loss Richard's early death means to her and their children, and to friends and colleagues worldwide, we can surely thank God for answering those perinatal – and subsequent – prayers.

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