Winter 2007

for today's Christian doctor

triple helix

Cannabis

confessing christ, abortion, aids, stem cells, alzheimer's, alan johnson, international child health, bereavement, crisis pregnancy counselling, obituaries, reviews, news from abroad

ISSN 1460-2253

Triple Helix is the quarterly journal of the
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A registered charity no 1039823

Subscriptions
Triple Helix is sent to all members of CMF as part of the benefits of membership, but individual subscriptions are available to non-members at £3 a copy including postage (UK only).

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

Authors have reasonable freedom of expression of opinion in so far as their material is consonant with the Christian faith as recorded in the Bible. Views expressed are not necessarily those of the publishers.

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Design S2 Design & Advertising 020 8677 2788

Cover Photo MedioImages

CMF
Christian Medical Fellowship

No.38 Winter 2007

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Confessing Christ today

Standing up for unpopular truth

If I profess with the loudest voice and clearest exposition every portion of the Word of God except precisely that little point which the world and the devil are at that moment attacking, I am not confessing Christ, however boldly I may be professing Him. Where the battle rages there the loyalty of the soldier is proved; and to be steady on all the battle front besides, is mere flight and disgrace if he flinches at that point. (Luther's Works. Weimar Edition. Briefwechsel [Correspondence], vol. 3, pp. 81f.)

As Christians we are fighting in a spiritual battle, but Martin Luther argued that not all God's truth is under attack at once. In any culture and generation there are certain truths which are more under attack than others. As Christian doctors in the 21st century we need to be aware of which truth is most under attack, and ensure that we are faithful in standing for that truth. It is 'mere flight and disgrace' only to stand for truth which is not being currently targeted.

Most people are very accepting of Christian doctors who mind their own business and just quietly minister to people's needs with niceness, tolerance, decency and compassion. But Scripture is very clear that persecution is part and parcel of the Christian life, and its absence should give us pause for thought about how faithful to God we are being in the truth that we stand for.[1]

It is tempting to imagine that if we are being good and faithful Christians everyone will like us, but Jesus said exactly the opposite.[2] Often in the Christian walk opposition is a sign that we are doing a good job rather than a bad job.[3] Many people hated Jesus simply because he spoke the truth – that is precisely why he was crucified. Likewise when we speak the truth some people will hate us.[4] Persecution began for the early church when Peter, John and Stephen opened their mouths and started to speak unpalatable truth! We must of course speak the truth in love,[5] but how often do we use 'sensitivity' simply as an excuse for cowardice, when our real underlying motive is to avoid being persecuted for the cross of Christ?[6]

Several events over the last few months have led me to reflect on what truths are under attack in this generation. CMF came under attack for playing a role in the reversal of the BMA's neutral stance on euthanasia last June[7] despite the fact that our influence was exaggerated in an attempt to sideline all opposition as religious.[8] Dignity in Dying (formerly the Voluntary Euthanasia Society (VES)) and critics like Liberal Democrat MP Evan Harris continue to blame CMF for the defeat in the Lords last May of Lord Joffe's *Assisted Dying for the Terminally Ill Bill*.[9] Former VES chairman Michael Irwin suggested recently on the National Secular Society (NSS) website the setting up of a group affiliated to the NSS to challenge CMF and 'the religious lobby' 'on issues such as abortion, doctor-assisted suicide, stem-cell research, and voluntary euthanasia'. Perhaps, he hoped, a 'Secular Medical Fellowship' might emerge.[10] In the same article Irwin ridicules CMF members for accepting 'the Bible as the supreme authority in matters of faith and conduct'.

The Times gave front page coverage in November to four UK universities where Christians currently face discrimination.[11] In Exeter, Edinburgh, Birmingham and Herriot Watt Universities Christians Unions have come under attack by Student Unions either for restricting their leadership to Bible believing Christians or for teaching a biblical view on sex to their members. Bank accounts have been frozen and access to university facilities has been denied. In Exeter the Christian Union had its name changed by the SU to the 'Evangelical Union' on the grounds that it was not 'inclusive' enough to be called Christian. In these cases the staunchest opposition has come from those who take exception to the exclusive claims of Christ or to the biblical view that sex between two people of the same sex, or indeed sex in any context outside marriage, is wrong. At the time of writing one Christian medical student group is attempting to regain access to a campus from which it has been excluded.

Christian doctors and medical students in this generation need to stand for the views that abortion and euthanasia are wrong, sex is for marriage, the Bible is God's Word and Jesus is the only way to God. These truths are under attack. These views will not make us popular – but if we shrink from standing for them – I would suggest that we are not confessing Christ.

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

...in the Christian walk opposition is often a sign that we are doing a good job

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news reviews

World AIDS Day

A glimmer of hope on a dark plain

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

Another World AIDS Day passed on 1 December: but amidst the usual flurry of news stories and updates on the epidemic, and the predictable tables of statistics showing the mounting scale of the problem, there was a glimmer of hope.

At Saddleback Church in California, Rick Warren, author of *The Purpose Driven Life*, convened a second Global HIV Summit for church leaders at the end of November.[1] Warren emphasises that AIDS is a *kairos* opportunity for the church to re-engage with the world and show the love and mercy of God to a hurting creation.[2] Using the scriptural template laid down in Mark 10 and Luke 10, he advocates the engagement of ordinary Christians where they are and with what they have to bring Christ's hope and healing.

That he was also able to draw in people such as the head of the Global Fund and Senator Barack Obama is a sign of how influential Warren has become. But his profile does not detract from his central plea – for the church to get out and get its hands dirty.

Anglican Archbishop Rowan Williams also raised his voice on World AIDS Day,[3] echoing Warren's call for engagement, but reminding the worldwide church to look at the problem of AIDS not just in communities overseas, but also in our own, local communities, and even more, within our own churches. AIDS is not an 'out there' problem – it affects people inside and outside of the church, but we fear even to talk about it, let alone take action.

At the same time, ICMDA launched its HIV Initiative with an inaugural award for Christian clinicians that have pioneered work in fighting AIDS.[4] This year's winner is Dr Biangtung Langkham of Emmanuel Hospital Association in India, who was recognised for his pioneering work in prevention and treatment in several rural and urban communities over the last 20 years.[5]

There are increasing signs that the church is waking up and engaging more and more with the pandemic. There are some, like Dr Langkham, who have been working away quietly for decades, and others like Rick Warren who seem to have just woken to the challenge. There are many other ordinary Christians who have been involved in different ways and at different times in whatever manner they can, especially in Africa, a land replete with unsung heroines and heroes of faith.

AIDS is not the only scourge afflicting our world, but it is one of the biggest. It is also one where Christians have already contributed a huge amount, but we have so much more yet to give.

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Stem cells

Positive research outcomes show how useful adult stem cells could be

Review by **Rachael Pickering**
Triple Helix Associate Editor

The last few months have yielded much good news on the adult stem cell front. Several ground-breaking research projects have announced successful results.

There is hopeful news for diabetics. In New Orleans, human bone marrow stem cells have been shown to repair defective insulin-producing pancreatic cells in diabetic mice.[1] Three weeks after injection, the treated mice had lower blood sugar and were producing more insulin than untreated mice. Furthermore, glomerular damage in their kidneys was halted. The research team leader is optimistic that their success in using human stem cells to cure research mice can be successfully transferred to human diabetics. Dr Wilson, research director of Diabetes UK, said, 'This is interesting work…Theoretically, pancreatic beta cells produced from a patient's own bone marrow could be used to treat diabetes, overcoming the requirement for immunosuppression following islet transplantation'.

Funded by the Medical Research Council, a team from University College London and Moorfields Eye Hospital has successfully transplanted precursor cells (a type of more developed stem cell), taken from the retinas of three day old mice, into the eyes of partially sighted mice.[2] Once treated, these animals (which mimic human conditions such as age-related macular degeneration) showed light reactive pupils and optic nerve activity.[3] Unfortunately, unlike newborn mice, the equivalent type of human retinal precursor cell is found only in second trimester fetuses; but thankfully, in attempting to transfer their success to human eyes, the team is now looking at the potential of certain cells on the periphery of adult retinas.

Heart attack patients arriving at the London Chest Hospital and the Heart Hospital may soon be offered more than streptokinase and an angiogram.[4] Doctors are launching a trial to see whether injecting a patient's own bone marrow stem cells into recanalised coronary arteries during angioplasty reduces the risk of developing post-infarction cardiac failure.

So, with all these encouraging results from adult stem cell research, it is somewhat disappointing that Australia's parliament recently felt the need to lift its ban on the cloning of human embryos for the purpose of stem cell research.[5] Now that they have the legal go-ahead, Australian researchers are free to indulge in therapeutic cloning. It is sad that, in their pursuit of the admirable aim to cure serious adult diseases, many scientists prefer to create and sacrifice other human lives rather than use patients' own resources.

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Psychological consequences of abortion

Time for the RCOG and RCPsych to review their guidance

Review by **Peter Saunders**
CMF General Secretary

Since 1967, more than six million abortions have been performed in Britain, over 95 percent on the grounds that abortion safeguards the mental health of women with unplanned pregnancies.

In a letter to the *Times*,[1] coinciding with the 39th anniversary of the Abortion Act on 27 October 2006, fifteen specialists in Psychiatry and Obstetrics and Gynaecology, including some CMF members, called upon both the Royal College of Psychiatrists (RCPsych) and the Royal College of Obstetricians and Gynaecologists (RCOG) to revise their guidance on the link between abortion and mental health. They quoted the strong evidence, recently reviewed in *Triple Helix*,[2] that women who choose abortion subsequently suffer from higher rates of depression, self-harm and psychiatric hospitalisation than those who carry their babies to term.

This evidence has recently been strengthened by the findings of a large longitudinal, methodologically robust study from New Zealand[3] which demonstrated that women who had abortions had twice the level of mental health problems and three times the risk of major depressive illness as those who had either given birth or never been pregnant. This research has set a new landmark, showing that even those without any past mental health problems are also at risk. As a consequence the American Psychological Association has withdrawn an official statement that denied a link between abortion and psychological harm.[4]

The Royal College of Obstetricians and Gynaecologists September 2004 guidance on abortion however, which predates this latest research, plays down a link between abortion and psychological harm:

Some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to nonpregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions.[5]

Similarly, the Royal College of Psychiatrists, in a 1993 statement, which does not appear to have been subsequently revised, has stated:

The Royal College of Psychiatrists finds that the risks to psychological health from the termination of pregnancy in the first trimester are much less than the risks associated with proceeding with a pregnancy which is clearly harming the mother's mental health. There is no evidence in such cases of an increased risk of major psychiatric disorder or of long-lasting psychological distress.[6]

Women considering an abortion have a right to know that that there may be long-term adverse psychological effects. Both these sets of guidance from Royal Colleges appear to be out of step with the latest evidence and now require revision. Christian doctors have a key role to play in encouraging this.

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A nasty challenge from NICE

Guidance on prescribing for Alzheimer's to be challenged

Review by **Dr Adrian Treloar**
Consultant in Old Age Psychiatry in London

'I do want to' said our blessed Lord when asked by a leper if he wanted to cure him.[1] As doctors, it is our huge privilege to participate in healing. The challenge of medicine has been to do well what works and to avoid ineffective treatments.

The National Institute for Clinical Excellence (NICE) was set up to appraise treatments and to promote effective care. Recently published NICE guidance states that anti-dementia drugs should not be provided to people with mild or severe dementia.[2] The appraisal *did* demonstrate that these drugs do help in all stages of dementia; however, it then used economic analysis to conclude that they were too expensive. The prescribing of acetylcholinesterase inhibitors donepezil, rivastigmine and galantamine was approved for moderate Alzheimer's, that is those achieving a Mini Mental State Examination (MMSE) of between ten and 20. However, despite evidence that it benefits patients who are distressed or behaviourally disturbed, the use of the NMDA-receptor antagonist memantine has been disallowed, except in research studies.

A person's MMSE is highly affected by language skills, deafness and blindness as well as intellectual ability. The guidance is therefore fundamentally discriminatory. Furthermore, following it may lead to increased nursing home costs and perhaps the use of more expensive, less effective drugs. The view that NICE has got this decision wrong is now widespread, and its guidance is now subject to judicial review. Should clinicians follow controversial guidance or treat the sick?

What should Christian doctors do with patients who may benefit from anti-dementia drugs? Obviously a good assessment is required. We should be honest and compassionate both to patients and their carers. We must tell them what treatments might help. We cannot avoid this problem by denying the existence of an effective treatment option. Inevitably, this will identify patients who may benefit from an affordable treatment, despite NICE not supporting this. In such circumstances we *must* remember our vocation – the *patient* is our first concern. As a result, we must be willing to risk criticism and even disciplinary action. Effective treatment should be prescribed, even if a guideline – and it's reassuring to note that NICE issues *guidance* not policy – has told us not to. The alternative will leave sick patients without effective treatment. We need to stand by our vocation. Our Lord wanted to heal and so must we.

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Peter Saunders examines a controversial report

Resuscitating neonates

The Nuffield Council Report

The Nuffield Council on Bioethics[1] published its long awaited report *Critical care decisions in fetal and neonatal medicine: ethical issues* on 16 November 2006.[2,3,4] In the weeks leading up to its release there was considerable media speculation about its contents with major newspapers highlighting what individual bodies had said in their submissions to the Working Party some 18 months earlier. In particular the RCOG's apparent ambiguity about the role of euthanasia for neonates with congenital abnormalities received special attention[5] with commentator Melanie Phillips dubbing it 'The Royal College of Infanticide'.[6] Some journalists also, quite unjustifiably, attempted to portray the Church of England as supporting euthanasia in some circumstances.[7]

The Nuffield Working Party, chaired by Margaret Brazier, Professor of Law at Manchester University, held a consultation in 2005, and received about 100 responses: 53% from individuals and 47% from organisations. In addition they had held ten fact-finding meetings between February 2005 and May 2006. CMF contributed a submission[8] to the consultation and was also represented at a fact-finding meeting to consider faith-based perspectives. When the report finally emerged there was much to commend in it but also some things about which Christian doctors will have significant reservations.

What was good? First the report came out strongly against euthanasia; active steps to end the life of newborn babies should not be allowed, no matter how serious their condition. The professional obligation of doctors is to preserve life where they can. The Council also recognised the reality of the slippery slope. If euthanasia for seriously ill newborns were allowed it would be very difficult to identify an upper age limit beyond which the practice would not be permitted.

Second, the report wisely endorsed current medical practice and law which allows decisions to be made either to withhold or to withdraw treatment in cases where treatment would be futile or cause intolerable suffering for no benefit. Third, the Council called for palliative care to be given to newborns who are not to be treated, so that they can die peacefully and in comfort instead of simply being left to die suffering the symptoms of their illness. In addition it said that the NHS had a duty to train all professionals working in neonatal medicine in palliative care.

Fourth, the Council urged the Government to accept further responsibility for ensuring that disabled children and their families receive equal access to high quality services as advocated in the National Service Framework for Children, Young People and Maternity Services. And, fifth, stressed that individual doctors should not be driven by the resource implications of their decisions, but rather base them on the best interests of the babies concerned. Finally there was a welcome endorsement of second opinions, facilitators and professional mediation to avoid if at all possible the emotional and financial costs of the courts.

What was not so good? First, the report attempted to give firm guidelines about which babies should be resucitated based on gestational age alone: premature babies born before 22 weeks should not receive intensive care, those born between 22 and 23 weeks should not normally receive it, those born between 23 and 24 weeks should be given intensive care if the parents insist, and that babies born between 24 and 25 weeks should normally receive intensive care. It curiously based these recommendations on the EPICure study,[9] a multi-centre UK-based study carried out in 1995 (twelve years ago), whilst at the same time affirming that advances in neonatal care actually meant that the age at which premature babies can survive has been falling by approximately one week every decade over the last 40 years. CMF had pointed out in its own submission that whilst the EPICure study showed survival rates of 11% for babies born at 23 weeks and 26% at 24 weeks, by contrast data from 1996-2000 in a major recent Minnesota study[10] showed rates of 66% and 81% at 23 and 24 weeks respectively. The Council's approach seemed to be both inflexible and not properly evidence-based. We would have preferred the Council to recommend that every premature baby be treated on its own merits after an assessment by a senior paediatrician of condition, weight and estimated gestational age at birth rather than the guidelines becoming hard-and-fast rules to be applied irrespective of the circumstances of each case. Second, there was a hint that decisions not to give intensive care might be based on a subjective assessment of a baby's quality of life, as opposed to its chance of survival. We must be careful to make the distinction between treatments not worth giving (part of good medical practice), and patients not worth treating (opening the door to eugenics). Third, for a report on the decisions about treatment of premature babies there was surprisingly little space given to a consideration of the causes of prematurity. In particular the considerable evidence-base linking increased risk of prematurity with past abortion was simply ignored and dismissed. It was therefore not surprising that the report also ducked the obvious questions raised by the recent high profile debates about upper limits for abortion. If we are to strive to preserve premature babies in the neonatal unit, then why do we tolerate their destruction in the womb at the same gestational age?

These debates will intensify as neonatal care continues to improve and Christian doctors will have a major continuing role to play, both in advocating the best care for these most vulnerable of human beings, and in insisting that all recommendations are properly evidence-based.

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

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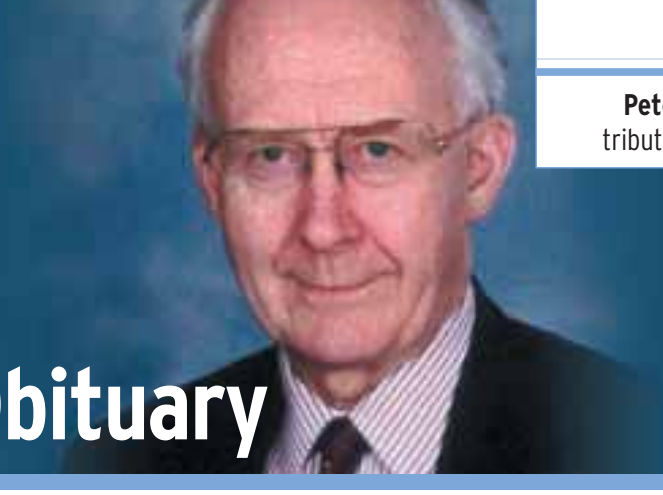
Peter Saunders pays tribute to our President



Alan Johnson - Obituary

Most of our teachers were respected, and many were admired, but only a few were loved. I came to love Alan, because he gave me the greatest gift; integrating my medical practice into a framework of Christian morality. He taught me the expected surgical skills, but he was inspiring in a different way. He combined excellence in science, and the craft of surgery, with actually practising the moral life. After studying under him, I wanted to be like him. I wanted to be a good doctor, not only in a technical sense, but to be clean, decent, saintly, loving, Christ-like.

This tribute from one of Alan Johnson's former trainees sums up beautifully an academic surgeon, who managed to integrate excellence in clinical work, teaching and research with a gift for getting alongside individuals from all walks of life and making them feel valued and important.

Alan Godfrey Johnson was born at home in Epsom Downs in 1938. His father Douglas (affectionately known as 'DJ') was founder secretary of the Inter-Varsity Fellowship (IVF) and later became the first General Secretary of CMF. At the time of his death Alan was himself CMF President and also a past CMF chairman, and was from 1992 to 2004 chairman of ICMDA, the International Christian Medical and Dental Association, and later the ICMDA Trust, during which time that worldwide movement grew from 26 to over 50 national Christian doctors' organisations. Alan was a frequent speaker at ICMDA conferences and member country national conferences, particularly on medical ethical subjects. Students the world over will remember his legendary addresses on managing time and money which began with the words, 'Hitler and mother Theresa each had 24 hours in every day – they just used them differently'.

Alan was educated at Epsom College and studied medicine at Trinity College, Cambridge and University College Hospital (UCH), London. After training in general surgery at UCH and Charing Cross, under surgical giants such as Harding Raines and Norman Tanner, he was appointed Senior Lecturer and later Reader at Charing Cross before moving to Sheffield in 1979 to take up the post of Professor of Surgery which he held until his retirement in 2003.

He became a world authority on gastric motility and aspects of biliary and upper gastrointestinal surgery, pioneered sclerotherapy for oesophageal varices and highly selective vagotomy for peptic ulcer, and was an authority on bile duct reconstruction. He discovered new aspects of gastric motility, including the roles of the hormone cholecystokinin and the stomach pacemaker, and aspects of bile reflux.

His randomised clinical trial comparing the removal of the gall bladder by either laparoscopy or open surgery was heralded by the *Lancet* as 'a new gold standard for surgical trials'. He was widely respected for other work on evidence-based surgery including a trial on lithotripsy for gallstones on behalf of the Department of Health. More recently he championed the introduction of surgical services for obesity in the UK and was Past President of the British Obesity Surgery Society.

Alan Johnson was a prolific academic author writing or editing ten books, over 30 book chapters and more than 200 articles and papers in peer-reviewed journals. As an international speaker on areas of gastrointestinal surgery, he was in demand as a lecturer in all five continents and in over 20 countries worldwide.

His many appointments included Chairman of the Specialist Advisory Committee in General Surgery (1991-1994), President of the Association of Surgeons of Great Britain and Ireland (1993-1994), and Chairman of the Specialist Medical Advisory Committee at the Department of Health (SMAC) (1998-2002).

Throughout his career Alan maintained a strong interest in medical ethics, and his third book on the subject, *Making Sense of Medical Ethics*, jointly written with his son Paul, himself a paediatric surgeon, has just been published posthumously. Alan Johnson had actively opposed the legalisation of euthanasia and in 2004 gave expert evidence to the House of Lords' Select Committee on Lord Joffe's *Assisted Dying for the Terminally Ill Bill*, which was defeated in the House of Lords in May 2006. At the same time he had actively promoted good palliative care as an essential alternative to euthanasia, and had recently co-edited a book on surgical palliative care, currently in press.

Alan also made time for a range of interests outside medicine and was talented in many areas. His hobbies included ornithology, painting, music (he played organ and piano), sport (particularly cricket), and more recently woodcarving.

Despite his rigorous clinical, academic and speaking commitments Alan deliberately made lifestyle choices that gave priority to his family and he constantly acknowledged that his wife Esther had been integral to any success he had had.

It was perhaps fitting that Alan should die on St Luke's Day in the churchyard of a small parish church, St John's Wotton in Broadmoor, having just preached on 'Christian compassion in medicine' at a sister church and about to preach again – a man who was equally home on the international stage and the hospital shop floor – going about his master's business, in a very humble setting. Amongst the many quotations that he used and loved (he kept pages and pages of quotations in his diary) was the quote, 'There is no end to what you can achieve if you don't mind who gets the credit'.

During a routine medical check-up two weeks before he died, his doctor jokingly said that Johnson was so fit 'he would live forever'. His reply was typical, 'I am going to live forever, but not in this life!'

Alan is survived by his wife, Esther, and his three children Paul, Andrew and Fyona.

Alan Johnson, Emeritus Professor of Surgery in Sheffield, was born on January 19, 1938. He died on October 15, 2006, aged 68.

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

Sam Leinster considers the relationship between faith and research

Integrity in RESEARCH

key points

Fraudulent research harms patients, ruins careers and wastes resources. Yet the pressure to succeed academically can be immense and one in five new consultants is tempted to carry out research fraud. As Christians we need to recognise that any kind of deception is wrong. Our scientific understanding can improve our theology, and our faith should spur us on to improve our world by serving other people through research. We need to conduct our research with integrity, diligence, honesty and humility. In so doing, we will be salt and light to our academic colleagues.

Research has long been regarded as an aid to advancement in medicine. Indeed, in some disciplines it is almost a necessity. It is therefore not surprising that individuals have been tempted to falsify the reports of their research, given the increasingly competitive nature of medical careers. There have been well-reported cases of fraud: reporting ground-breaking procedures that never actually took place;[1] deliberate falsification of data;[2] falsification of ethical approval;[3] and falsification of consent forms.[4]

A study of the attitudes of 194 newly appointed consultants to research fraud found that 55.7 percent claimed to have witnessed research misconduct while 5.7 percent admitted to personal misconduct in research.[5] When asked whether they would perpetrate misconduct in research in the future, 18.7 percent either agreed that they would or were unsure if they would. Much of the observed misconduct involved claims of authorship on papers by individuals who had had little or no real input to either the research or the writing up. While this may seem a relatively trivial offence, it can lead to problems, especially when a senior figure lends authority to falsified data as happened in two of the cases referred to above. In both cases the senior person appeared before the GMC charged with serious professional misconduct.

Harming patients, wasting money

Fraudulent reporting of research can harm patients and can lead to a waste of resources. High dose chemotherapy supported by stem cell infusion or bone marrow transplantation was suggested as a potential adjuvant treatment for patients with early breast cancer who had a high risk of early recurrence. One trial was reported as showing significant benefit for the high dose regimen compared with standard treatment. On the basis of this trial, there were moves to introduce this regimen into routine practice, exposing women to high levels of morbidity and placing a heavy burden of cost on the health economy. However, the reported trial results were found to have been falsified and, to date, the evidence for the benefit of high-dose chemotherapy remains inconclusive.[6]

A Christian attitude

In this environment, what should our attitude to research be? Are there any specifically Christian considerations over and above the basic requirement of integrity that is expected of all medical practitioners? To put it another way – why should Christians be involved in research and how should they conduct themselves in it?

Our duty to God

The Lord Jesus taught us that the greatest commandment was, 'You will love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength'.[7] The assumption that Christianity is anti-intellectual

is as far from the truth as it possibly could be. We are called upon to use our minds as part of our worship. God has given us the faculty of curiosity and we honour him when we seek to understand the world around us. Scientific research is a channelling and a refining of that natural curiosity to make it more effective and productive.

Improve our theology

The Apostle Paul tells us, '…since the creation of the world God's invisible qualities have been clearly seen, being understood from what has been made'. [8] In other words, we can understand God's wisdom and his power by contemplating the world around us. It follows from this that the more we understand of the way things work, the greater will be our understanding of God. Far from being the arch-enemy of the Christian, science is a tool by which we come to know more about God. We still tend to fall into the error of supposing that once we have found a scientific explanation for something then we have eliminated God from it. We need to regain Kepler's understanding that in research we are thinking God's thoughts after him. Genomics, proteomics and metabolomics do not diminish our understanding of God's role in creation; they enhance it so that we are led to exclaim with the Psalmist, 'I am fearfully and wonderfully made'. [9]

Improve the world

In Genesis, humanity is given the much misunderstood command, '…fill the world and subdue it'. [10] While the accusation has often been levelled that this justifies the exploitation of nature, it is in reality our mandate for caring for the Earth. We Christians cannot turn our backs on ecological issues on the grounds that our concern is for the Kingdom of God and is purely spiritual. We need the insights that come from good research to understand and fulfil our duty in this regard. The development of modern medicine is part of this duty; Christians have been, and must continue to be, heavily involved in this activity.

Called to serve others

If the first command is to love God, the second is 'Love your neighbour as yourself'. [11] Acting in the best interest of our patients means providing them with the best evidence based management. A false dichotomy is commonly drawn between person-centred medicine and scientific medicine. Good medicine is an amalgam of the two. In order to meet our patients' needs in the most effective ways possible we must be familiar with the latest science and technology. Involvement in research is a natural concomitant of this.

How should we conduct ourselves?

Integrity essentially means wholeness. The principles governing our approach to research are the same as the principles that should govern everything that we do. There are three particularly important principles – diligence, honesty and humility.

Diligence

Every Christian's primary duty is to God but this should show itself in the way we approach our everyday lives. No task should be routine or unimportant because we are told, 'What ever you do work at it with all your heart, as working for the Lord'. [12] This applies to our approach to research as well as everything else.

Good research requires hard work and attention to detail. This starts even before the planning of the project with a systematic review of the literature. Unless you know what is already known, you will not know which questions you should be asking. The planning should be meticulous and must meet the best scientific standards for the type of study that is proposed. This includes an assessment of the resources needed to obtain a valid and useful result.

Perhaps the commonest failing in clinical studies is the recruitment of inadequate numbers of patients to evaluate the hypothesis. Analogous considerations apply to other types of study. All of the possible ethical issues must be considered. Data collection should be thorough and as complete as possible. Missing data can distort an analysis and lead to false conclusions; the effective sample that can be analysed may then be much smaller than the one from which the data was collected. The analysis must be appropriate, making use of all of the available data.

Honesty

Jesus himself exhorted us to be both plain and trustworthy in what we say. [13] Quite apart from the pragmatic reasons for honesty already discussed, Christians are called to follow the one who is the truth; that must mean the truthful reporting of our findings, whether or not they support our cherished hypotheses. [14]

Humility

Humility should be a defining characteristic of our lives as Christians and this applies especially to our approach to research. [15] Our value in God's eyes does not depend on our cleverness or our discoveries. If God has called us to research and given us the talents necessary to be successful in this field, then we must follow that calling faithfully but not think that it makes us in any way superior to others whose calling is different. [16]

We are called to be salt and light in the world. [17] One element of this calling must be the application of the highest standards in the planning, conduct and reporting of research, and the promotion of these standards to others.

Professor Sam Leinster *is Dean of the School of Medicine, Health Policy and Practice at the University of East Anglia*

Scientific research is a channelling and a refining of God-given curiosity

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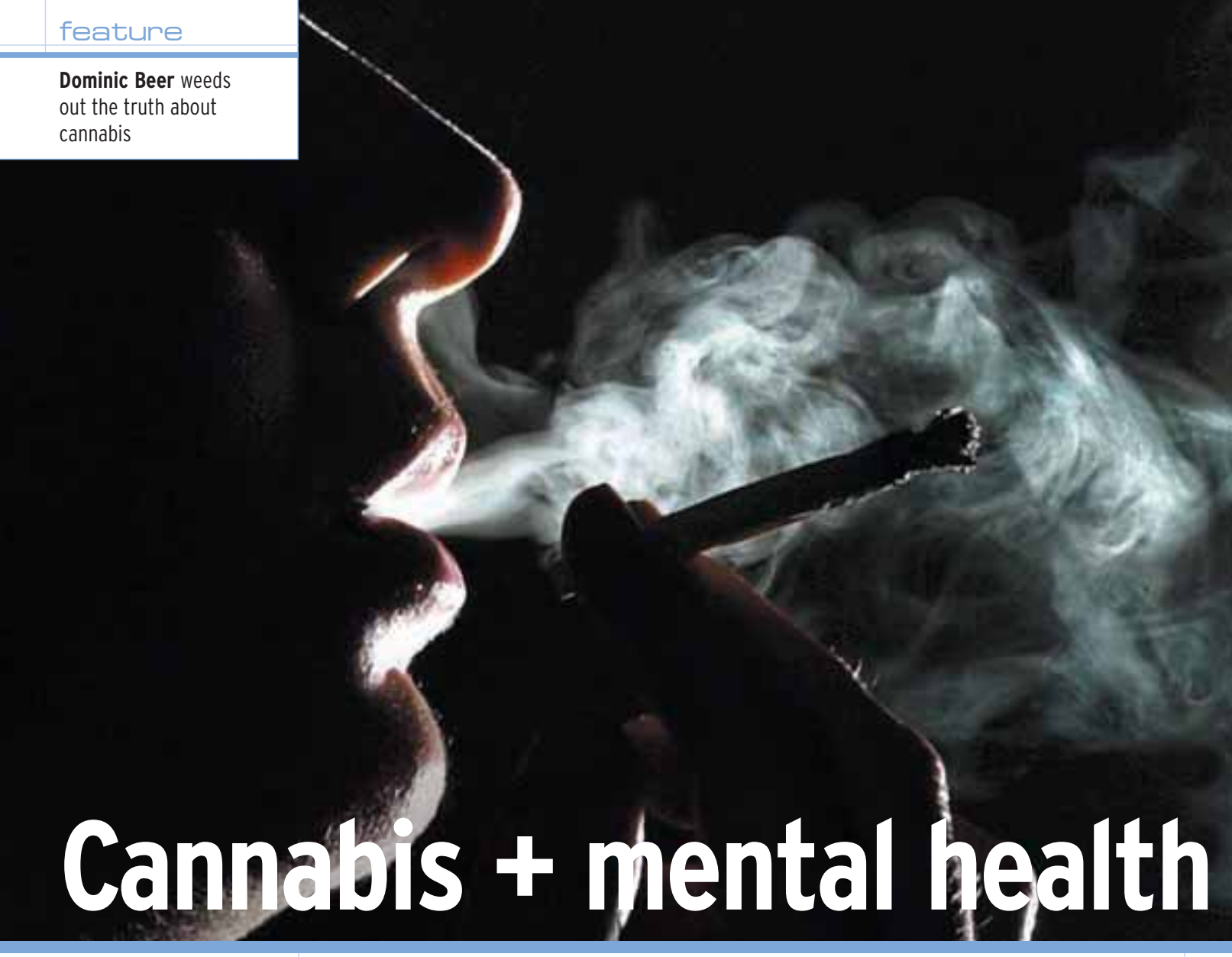
Dominic Beer weeds out the truth about cannabis



Cannabis + mental health

key points

Cannabis is a controversial illegal drug. There is increasing disquiet about its recent reclassification as a Class C drug. An enlarging body of research and expert opinion suggests that it causes a great deal of mental ill health including psychosis. There is increasing evidence that it causes memory and higher functioning problems, and that it is actually chemically (as well as psychologically) addictive. As healthcare professionals, we need to take a public health stance and warn patients, colleagues and other healthcare professionals that cannabis is harmful to the mental health of our vulnerable young people.

Cannabis is a controversial subject. According to a UK Government advisory body, 'cannabis does not pose a serious problem for previously healthy people'.[1] Yet the head of the United Nations Office on Drugs and Crime believes that 'cannabis [is] as bad as heroin'.[2]

Acting on a 2002 recommendation of the Advisory Council on the Misuse of Drugs,[3] cannabis was reclassified (along with amphetamines and barbiturates) in 2004 from Class B to Class C (joining benzodiazepines and anabolic steroids). Despite this reclassification, the maximum penalty for cannabis possession is two years in prison; for supply or intent to supply, the sentence is much stiffer, 14 years plus a fine.[4]

So what is the truth about cannabis?

Action and Effects

The plant *cannabis sativa* contains up to 400 chemicals and 67 compounds, the strongest psychoactive component being 9-delta tetra-hydro-cannabinol (THC). It is thought that cannabis' effects are mediated by THC on cannabinoid receptors (CB1, 2 and 3) in the brain, affecting the amount of dopamine released. This would explain why it is associated with schizophrenic symptoms in some people. It also appears to fit the dopamine hypothesis of schizophrenia, whereby it is postulated that schizophrenic symptoms are produced by an excess of dopamine, especially in the neocortex and limbic system.

Acute cannabis intoxication can lead to acute transient psychotic episodes. Genetic studies may well explain why certain individuals are thus affected: those with the Val/Val variant of the dopamine-regulating catechol-O-methyl transferase (COMT) gene are more susceptible to cannabis-induced psychosis.[5] Cannabis also leads to an exacerbation or recurrence of psychosis in those with pre-existing psychosis.[6,7] In experiments, both positive (for example, delusions) and negative (for example, apathy) symptoms of schizophrenia have been found in healthy human subjects after intravenous administration of cannabis.[8] Cognitive effects also occur: after road traffic accidents, elevated blood levels of cannabis have been detected in injured drivers, even in the absence of alcohol or other drugs.[9]

Longer term effects

These are all short term effects but, in vulnerable people, it seems likely that permanent changes occur after repeated cannabis exposure. There are


Photo Empics

still methodological problems in stating a causal link between cannabis and psychosis. Firstly, there is the problem of the possible presence of confounding factors such as previous psychosis. And secondly, there is the issue of reverse causality – couldn't psychotic patients just be self-medicating, using cannabis to treat their psychoses? However, studies – both longitudinal and cross-sectional – have now controlled for these factors. One review article concluded: 'These studies produce…suggestive evidence that supports the conclusion that the link between the use of cannabis and increased risks of psychosis is likely to be causal'. [10] This is particularly the case in young people where early exposure to cannabis increases the risk of psychosis in later life. It has been calculated that the attributable risk of psychosis from cannabis is eight percent – in other words, if cannabis was eliminated in 15 year olds then the rate of psychosis would fall by eight percent. [11] The same authors later encouraged 'policy and law makers to concentrate their effort on delaying the onset of cannabis use'. [12]

Dependence, both psychological and chemical, occurs in about seven to ten percent of users; early onset of use, especially on a daily or weekly basis, is a strong predictor of future dependence. [13] Furthermore, some studies show a weaker but still significant link between cannabis and depression. [14] There is no conclusive evidence as to whether chronic cannabis use has any long-term cognitive effects in adults; however, there is some evidence that memory, executive functioning and information processing are apparently permanently affected in the offspring of women who used cannabis in pregnancy. [15] Latest research in animals suggests that early exposure to cannabis can lead to greater vulnerability to later heroin addiction. [16]

What should we think?

We should be more cautious than before. In 2000 the Police Foundation said that cannabis was less harmful than alcohol or tobacco. [17] In 2002 the Advisory Committee on the Misuse of Drugs [18] stated that:

- there were no serious problems for previously healthy people;
- there were some risks to health but these were less than for amphetamine;
- even occasional use posed significant dangers for people with mental health problems including schizophrenia, and for those with poor circulation or heart problems.

On the basis of this evidence, the Government reclassified cannabis to a Class C drug but the UK Drugs Czar Keith Hellawell resigned over this move: 'It is giving the wrong messages to parents and children'. [19] The Head of the United Nations Office on Drugs and Crime, Antonio Maria Costa, was also critical of the reclassification, saying that it was a mistake to dismiss cannabis as a soft drug; that it was considerably more potent than a few decades ago and that cannabis dependence was a reality. [20]

Especially for young people, cannabis should *not* be viewed as a soft drug. We should take a personal and public health stance and warn patients, our fellow health professionals, carers, teachers, school students and MPs. The *evidence* shows that, in vulnerable young people, cannabis is associated with later psychotic illness.

Dr Dominic Beer *is consultant psychiatrist at Oxleas NHS Foundation Trust and honorary senior lecturer at the Institute of Psychiatry in London.*

further reading

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Andrew Tomkins looks at how we can all make a difference[1]

Improving international child health

key points

Each year eleven million children die in the developing world from perinatal causes, preventable infections and AIDS. As doctors working within the developed world, it's tempting to think that we can't do anything about this from where we are. However, by lobbying the powers that be, we can tackle the causes of developing world poverty and oppression from afar. We can get involved with short term overseas medical work. In following Christ's example of valuing children highly, we demonstrate the importance of providing passionate paediatrics. And by sharing our time in all these ways and yet not expecting any financial reward, we are 'putting the last first'.

Eleven million children died last year, mostly in the developing world from perinatal causes and infections such as pneumonia, malaria, diarrhoea and HIV. Malnutrition was an underlying factor in more than half these deaths. Many millions more had disability or impaired child development and an unrecognised number of children suffered from child abuse and exploitative labour. These unacceptable facts challenge us all, yet doctors often ask, 'What can I do about it?' These days we all have job plans, holding us accountable to trusts or universities, with clearly identifiable tasks. We can use the same approach to set personal priorities for making a difference to international child health.

Make a social and political diagnosis

Poverty underlies such high mortality rates but it comes in different forms:

- ***Economic poverty*** is multifactorial – corruption, theft and military expenditure; political discord and war; debt, drought and floods; unemployment, and poor salaries for medical staff leading to medical migration.
- ***Social poverty*** is in part due to the globalisation of youth culture, leading to substance abuse along with family stress and dysfunction.
- ***Spiritual poverty*** – children may not feel God's love. Church outreach, with its rallies and long services, often focuses on adults; few churches are child friendly. Furthermore, children find it difficult to experience God's love if they are hungry, sick, exploited, grieving or abused. We can become more informed through organisations such as Tear Fund, Save the Children and World Vision.

Why is health care inadequate?

- ***Inappropriate policies*** – child and parent healthcare may be charged for, as demanded by international funding organisations' economists.
- ***Medical migration*** – developing world nurses and doctors are migrating to the developed world; for example, from Zambia and Malawi to the UK.
- ***Absence of clear treatment protocols*** – examples include lack of effective regimes for treatment of paediatric AIDS, severe malnutrition and perinatal infection. Inadequately trained staff – shortage of lecturers and inadequate learning materials for students.
- ***Out of stock*** – supplies of basic drugs often run out.
- ***Uninvolved communities*** – doctors may not encourage opportunities for community groups to assist them in improving home care.

What can we do?

As doctors in the developed world, we need to stay updated with the current situation. Things change fast and there are many websites bringing new information. Decide whether you're going to be a player rather than a spectator. Make a self-appraisal of the skills you have or could develop. Then aim to use those skills practically and effectively in a variety of ways, both in the UK and overseas. There are several ways that Christian doctors might respond:

Tackle poverty and oppression

'…loose the chains of injustice, and untie the cords of the yoke…set the oppressed free…share your food with the hungry…and your healing will quickly appear.'[2] The impact of individual doctors, other individuals and organisations who supported the Make Poverty History Campaign was striking; the pressure on governments and donors resulted in some remarkable changes.[3] Several African countries have had a large chunk of their international debt cancelled, providing more money for health and education.

Get involved while things are still bad

'If you wait until the wind and weather are just right you will never sow anything.'[4] Too many doctors think or say, 'Poor Africa! Will it ever get better?' But there are many very impressive examples of individuals making a difference through providing clinical care, training and research. Increasing numbers of UK paediatricians now have short or long term involvement with overseas training programmes. It is often best to build a relationship with a teaching, district or church based hospital and to make a commitment over a number of years. However, opportunities for short term work also abound.

The political scenes change fast and governments which nationalised church hospitals are now welcoming expatriate colleagues to work in church based health services. There are also exciting opportunities to develop careers in paediatric research in the fields of infection, nutrition, HIV and health service provision. Strong research collaborations between universities in developing countries and the UK support research training fellowships for bright applicants who work in closely supervised environments. High quality child health research is being funded by, amongst other agencies, the Wellcome Trust and the Medical Research Council (MRC).

Provide passionate paediatrics

Matthew's gospel tells us that Jesus made time for children. When his disciples were rebuking those who brought children to Jesus, our Lord instead gathered these little people to him, put his hands on them and blessed them.[5] We need to develop a passion for paediatric care: Jesus' disciples regarded children as an irritant or a burden, as many people still do today. But Jesus himself was deeply concerned about children and he made himself available to them – this was radically different from the prevalent attitude of his culture.

Organisations such as VIVA work with other Christian organisations, helping them to put 'Children at Risk' higher on their agendas. There are key researchers documenting clinical problems and devising new treatment regimes. Despite appalling lack of resources, child survival and development has been improved in many countries, without just waiting for things to happen. Even the World Bank is changing its attitude.[6] Their policy used to be that primary emphasis should be on economic recovery, and that health would then improve as a result. There hasn't been much evidence to support this policy over the last 20 years, so recently their policy changed to being one of 'Investing in Child Nutrition and Health' as the way to get countries out of poverty. Health programmes will be supported more strongly in the future. The challenge now is one of recruiting doctors to take up these new opportunities in paediatrics and child health.

Share our time

Jesus told the *Parable of the Rich Young Man*, a story about a man who thought he was doing enough.[7] Much of our time in the UK is spent checking that we are fulfilling our job description or ensuring that we achieve the highest possible Research Assessment Exercise (RAE) score. That is fine, as it is what we are paid to do, but we are not contracted to work for our employers 24 hours a day. Jesus lived in an agricultural community where it was possible to spend all of the day (and even some of the night) ploughing, fertilising and weeding. We too live in an environment where it is possible to spend all day and much of the night pursuing employment related activities. But this parable encourages us to make time for things outside our contracted hours.

There are many remarkable examples: after only one year in Africa, a young paediatrician and her husband managed to set up a fund raising charity for the government hospital where she worked; some medics take unpaid leave to teach and supervise research at a new medical school; and others go out of their way to train overseas doctors during their time in the UK. Jesus called this putting the last first.[8]

Expect no financial reward

Jesus also gave us the *Parable of the Workers in the Vineyard*.[9] The hired workers were, expectedly, upset when those who worked longest got the same amount of money as those who had worked for fewer hours. Jesus says that he will reward as he wishes. We live in a competitive professional world where everything we do has to be justified; yet the question remains, 'What do we do with our time after we have fulfilled our contractual obligations?' Jesus asks us to respond radically.

A young paediatrician who recently worked overseas on the RCPCH/VSO scheme[10] described how he took a child with cerebral palsy out of the hospital cot where she had been for 15 years, to show her the sun and the world that it shines upon. He then helped her get to school and, in doing so, received quite a bit of ridicule from other hospital staff. But the hospital's superintendent wrote on this paediatrician's reference that he 'had the courage to assist the weakest'. Is Jesus asking us to find space in our lives for activities which do not focus on our salary, grade or RAE score? Improving international child health, by one means or another, is something that every UK doctor can do.

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Photo: Wellcome

Useful websites

- Tropical Health and Education Trust (THET) *www.thet.org*
- Medical Research Council *www.mrc.ac.uk*
- Save the Children UK *www.savethechildren.org.uk*
- International Information Support Centre *www.asksource.info*
- Tear Fund *www.tearfund.org*
- UNICEF *www.unicef.org*
- VIVA Network *www.viva.org*
- Wellcome Trust *www.wellcome.ac.uk*
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Kevin Vaughan and **Linda Russell** talk about communication at the end of life

Photo: Wellcome

DEATH+DYING

'That injection killed him!' 'He was the kindest man who ever lived.' 'The hospital never told me he was going to die!' 'We did everything together…' These are just some of the things that have been said to me as a GP after a patient's death.

Comfort and compassion

At a deathbed we are confronted with our own mortality and our dependence on God; we doctors are more likely to help our patients and their relatives if our whole lives and the way we practise medicine reflect this dependence. We are not in

Interview with a hospice counsellor

Simply talking their illness journey through can help some patients accept that they are terminally ill

Linda, why did you decide to become a counsellor?
I think that life experiences led me to the decision. As a young woman I lost my mother quite suddenly to breast cancer. I became the family matriarch, supporting the rest of the family in their grief. I felt very alone. Later I worked as an EPAC (Early Pregnancy Assessment Clinic) health care assistant; I watched countless women find out that they'd lost their babies. It was heartbreaking – some of them had no-one to turn to, to talk to.

How did you end up in hospice counselling?
I believe that I was called to this place. Perhaps the experience I went through after my mother's death is another reason. It helps that I'm not frightened of death and dying, although I did feel a bit strange the first time I saw a freshly dead person! The atmosphere here is incredibly peaceful and I know I am in the right place.

What exactly is hospice counselling?
In a nutshell, counselling is skilled listening. We listen to patients, relatives (both before and after their loved ones' deaths) and other staff. By doing so, we facilitate openness and sharing between dying people and their families, between rival family factions, and between patients and their medical and nursing teams. Simply talking their illness journey through can help some patients accept that they are terminally ill; that the time for fighting for a cure is perhaps over; that it's time to switch focus to alleviating their symptoms. Sometimes it is easier to talk to a complete stranger.

Many terminally ill people have unresolved issues that can hinder them in coming to terms with impending death. It can cause unpleasantness at the bedside with tension persisting within a family. Symptoms associated with a patient's illness (for example pain) are often exacerbated too: the concept of total pain – the sum total of pain, composed of true physical pain as well as emotional, social and spiritual pains – is well known in palliative care. Despite high doses of appropriate analgesics, some people with emotional or spiritual distress continue to complain of physical discomfort. Counselling can go a long way to relieving this total pain.

Does your faith affect your work?
Immensely – although by no means everyone working here is Christian, having a belief in life after death really helps in hospice work. It helps me be sensitive

control, but 'we can comfort those in trouble with the comfort we have received from God' [1] when our behaviour (including the way we may touch someone or allow them to cry) demonstrates compassion. We need to listen carefully, speak the truth and, as the Spirit gives opportunity, offer words of hope.

To comfort someone is to give them strength to face their situation as it is; so we need to give relatives unrushed time, acknowledge that our patient has died, and express our sympathy. They may have questions or comments and our first duty is to listen. Asking questions – what actually happened or how the rest of the family are – may help someone to get talking.

Criticism

We ourselves may be distressed at the death. Our reaction may be tinged with regret that our clinical decisions or dealings with the family might have been better. Relatives may also be looking for someone to blame and we need to try not to be defensive, but to give our full attention to comments that have the seeds of complaint within them and answer them carefully. It is important not to say anything that might be taken as critical of another healthcare professional – careless comments by colleagues have sometimes given me extra work to do in explaining a situation to a relative.

Life after death

After expressing sympathy, clarifying the facts and listening to relatives, there may be opportunity for us to give a word of hope or simply to start talking about the next chapter in their lives. It is not our sole responsibility to help relatives in bereavement, a process that takes time. Our role is to make ourselves available and let them choose how much they want to see us. Raising a personal faith flag like 'I do believe there is hope after death' may be appropriate and I have found that relatives may welcome an offer to pray with them. Yet we must act with 'gentleness and respect'. [2] If relatives show signs of not wanting to talk yet, we should withdraw, leaving a clear signal that we are available if required.

We do not want to be a Job's comforter of whom he said, 'miserable comforters are you all! Will your long-winded speeches never end?' [3] The Old Testament tells that, when Jacob heard of Joseph's presumed death at Dothan, 'All his sons and daughters came to comfort him, but he refused to be comforted'. [4] May God help us to know when to keep silent.

I have known relatives come to faith in Christ after the death of some of my patients. I'm sure that, if we are prayerfully sensitive to the Spirit's leading, God will give us opportunities to speak of him in a way that will help some relatives move closer to a relationship with him. In my experience though, others will often be involved in this process: even by simply encouraging relatives to get in touch with a church or another Christian, a doctor may be doing something that makes a difference for eternity. Let us be prayerful and vigilant, always looking for an opportunity to show Christ's love and make him known.

***Kevin Vaughan** is CMF Associate General Secretary and a former GP in Birmingham*

Photo: Empics

Careless comments by colleagues have sometimes given me extra work to do

to people's spiritual needs. We work closely with our chaplains, one of whom is also the hospice's chief executive! Occasionally, people prefer to talk solely to the chaplains, thinking that the word 'counsellor' has psychiatric connotations!

How do you spend your day?

I work as part of a counselling team. Between us we provide support for all the ward patients and their families. Once allocated to a patient and/or their family, we try to keep a personal service going so that they can come to know and trust a specific counsellor.

After a patient dies, we hold a DAD (Day After Death) meeting with relatives and close friends: they are given the opportunity to view their loved one in a comforting environment. The death certificate is handed over and they have the opportunity of asking a doctor about the given cause(s) of death. We also advise them on the business of registering the death and arranging the funeral. Lastly we offer the opportunity of further counselling input.

In addition to our ward work, we care for patients in the Day Hospice and those on our community medical team's books. Group counselling sessions cater for patients' children, spouses and carers. There is also a life limiting illness group that helps younger patients with conditions such as multiple sclerosis come to terms with their lives.

What communication tips could you give?

Unfortunately we witness a lot of emotional fall-out resulting from poor communication between medical/nursing staff and patients or relatives. Many doctors communicate fantastically most of the time. However, all of us can improve the way we deal with terminally ill patients:

- **Make time**. Book them a double GP appointment. See them at the end of your list. Go back to them at the end of the ward round.
- **Rapport is everything**. Don't talk down to patients. Sit at their level.
- **Don't assume**. Check out what is written in clinic letters or notes about a patient's understanding of their illness.
- **Slowly slowly**. Practise asking open-ended questions about how much they know. Take it step by step. Respect a patient's decision not to know or to continue in denial.
- **Watch an expert**. Most hospice doctors and oncologists are experts in the art of gently breaking bad news.

***Linda Russell** is a counsellor at Greenwich and Bexley Cottage Hospice in London.*

What are your experiences of breaking bad news? Tell us online at *www.cmf.org.uk/forum*

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4. Genesis 37:35

obituaries

Betty Cowan OBE
(*q* Glasgow 1951; *d* 10 September 2006)

Family circumstances prevented Betty embarking on a career in medicine until she was in her early thirties. During her first year at Glasgow University she came to personal faith in Christ, and this mapped out her medical missionary career. In 1958 she joined the staff of the Christian Medical College (CMC) in Ludhiana, India.

Betty introduced the concepts of medical research and evidence based medical practice to the College. In 1969 she became professor of medicine. The award of the OBE in 1979 was fitting recognition of her pioneering community work and research, which eventually focused on the plight of the under-three female child in poverty stricken areas; she significantly decreased infant mortality in this vulnerable group. From 1982 to 1984 she was College principal.

In the 1980s the Medical Council of India introduced a new community based medical curriculum; Betty organised training visits for her medical faculty to other parts of the world where this new curriculum was up and running.

In 45 years at CMC, Betty saw many changes. She combined efficient doctoring with care and concern for the person behind the disease. She strengthened faith in Jesus Christ and encouraged in times of difficulty. Scores of tributes from those she influenced around the world give thanks for her life.

Elspeth Campbell

Marie Patricia Gilbert
(*q* St George's 1958; *d* 25 October 2006)

Patricia Gilbert was a former senior clinical medical officer for South Warwickshire. Author of 18 medical books, published in more than 20 languages, she began her writing career with weekly articles for *Nursery World*. Her books included *Common Childhood Illnesses, The A-Z of Syndromes and Disorders*, and *Textbook of Nursery Nursing*, which is still used in the training of nursery nurses.

Born in London, Patricia gained a BSc at Chelsea Polytechnic and qualified at St George's Hospital. After a while in obstetrics and gynaecology, she moved to Warwickshire in the 1960s and started work in child welfare clinics and schools, and then spent time as a locum GP. In the mid-1970s she became senior clinical medical officer and a visiting senior lecturer at Warwick University. Friend and colleague Jean Constantine said, 'Pat loved her work and was totally dedicated to her patients in schools and clinics alike. Her warm personality and caring nature won her enormous respect in the locality'.

Patricia was secretary of her local PCC, organist at Welford parish church for many years and a member of three local choirs. Widowed in 2001, she threw herself into community work for her church and Warwick Hospital League of Friends. Predeceased by her husband Victor, she leaves two daughters, Jenny and Soozy, and two grandchildren.

Peter and Jenny Brookes, Soozy Gilbert

John Michael Rice-Oxley
(*q* Oxford 1943; *d* 19 May 2006)

After spells in military hospitals in Oxford and India during the war, Michael was appointed consultant physician to the Chesterfield Royal in 1953, and sole consultant physician for Worksop and Retford. At Kilton (now Bassetlaw) Hospital in Worksop, he lectured nurses, oversaw medical students, and founded a branch of the British Diabetic Association. An authority on ulcerative colitis, his wide medical experience included hypnosis in the treatment of asthma.

Michael is remembered for his integrity, gentleness of spirit, and concern for others. President of Bassetlaw League of Friends, and chairman of Worksop Civic Society and Music Club (also president of the latter), his dedication to his community was unwavering. His contribution to church life was, likewise, enormous and included being churchwarden and the first lay chairman of the Deanery Synod. He was a keen rambler, reader and music lover, and an enthusiastic photographer. A loving husband, his wife Anne survives him. An inspiration to his three sons and six grandchildren, Michael was the hub of a vast network of family and friends whom he ensured stayed connected.

Tom and Andrew Rice-Oxley

Robert Sibbald Walker
(*q* Glasgow 1944; *d* 29 April 2006)

Robert Walker was born in Glasgow, studied medicine there and completed house jobs in Glasgow Royal Infirmary. Enlisting as a lieutenant with the Royal Army Medical Corps, he spent three years in India, surviving a skull fracture when his army lorry overturned.

Robert obtained his MD in 1948. Until his retirement in 1988, he worked as a physician in Law Hospital in South Lanarkshire. In 1961 he took his family to Boston for a year as a Harvard University research fellow. Subsequently, he developed Law Hospital's cardiology and diabetic services. He taught undergraduates, examined for the RCP and was President of the Scottish Society of Physicians in 1984. A former colleague summed him up as, 'a physician with unrivalled determination, driven by a commitment to the NHS and the very highest of standards'; also, 'a man who engaged with patients from all walks of life with understanding, care and humour'. Throughout his professional life he was involved with CMF, serving as Scottish representative on the executive committee and as UK chairman between 1983 and 1985. He organised annual CMF lectures at the RCP and RCS.

Robert keenly supported medical mission and led Whitecraigs Boys Crusader class and camps. He loved travel and took his family round Europe, delving behind the Iron Curtain. Devoted to his family, Robert is survived by Catherine, his wife of 55 years, five children and ten grandchildren. They gave him much pleasure.

Alison Walker

We try to commission obituaries but are limited by the information we have to hand, which explains the variable length of reports.
We welcome 200 word submissions in the above format and particularly value personal reflections.

The Baby Business

How Money, Science and Politics Drive the Commerce of Conception
Debora Spar

- Harvard Business School Press 2006
- £15.99 Hb 299pp
- ISBN 1 59139 6204

From the position of a Harvard Business School professor, Deborah Spar tackles the thorny issue of infertility and the markets that it has created. Her thesis is much broader than one might expect. She covers the ethical dilemmas thoroughly and describes beginning of life issues in a clear and engaging manner, embracing multiple perspectives as she tours the arena.

In-vitro fertilisation (IVF), pre-implantation genetic diagnosis (PGD), cloning, surrogacy and adoption are described accurately, and their positives and negatives weighed. Her chapter headings include quotes from Genesis 30:1 and Isaiah 54:1-2, and the final chapter is called *Songs of Solomon*. This seemingly tries to hide a utopian ethic in her conclusions.

Put simply, Spar argues that the market for babies exists because of the human longing to procreate. When the natural process fails, no price can be put on the possibility of creating a baby. Couples will pay whatever they can afford, even when a fertility specialist hasn't succeeded for them on previous attempts. The author states plainly: 'the market will function even if the morals are cloudy and the law uncertain'.

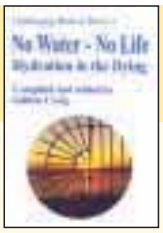
Spar's research shows that the market for babies is large as up to 15% of couples are infertile; in the USA about a third of these seek treatment. The product sold by clinics is not babies but 'hope and medicine to make babies'. Each IVF cycle has a 60-70% failure rate. Buying and selling of gametes occurs in many states and is not well regulated. A top-of-the-league egg from a university student donor can change hands for up to $50,000!

In recent years, couples considering adoption have had to wait longer as the number of available babies has dwindled with the surge in abortions. The combination of low IVF success rates and fewer domestic babies available for adoption has resulted in a market for international adoption. The fees charged in some cases reach up to $25,000. Her main arguments here are for tighter government regulation.

In the middle of the book, Spar discusses the issues surrounding designer babies and unpacks the history of eugenics during the Nazi regime. The USA led the way in this field in the 1930s, and Germany subsequently amplified it. She further discusses the attempt of the anti-abortion lobby to block PGD and embryo research, and the outlawing of cloning in the USA by President Bush. Some of her research reveals disturbing philosophical applications.

Spar concludes by laying out various models by which the baby business could be regulated. She feels that there should be a wider political debate to decide which techniques are acceptable and which are not. But, as she says, the fact remains that as long as the will and the technology exist somewhere in the world, no amount of ethical persuasion will stop somebody from using it, especially if there is a profit to be made. Although this book is not aimed directly at Christians, it would be helpful for any Christian interested in the challenges raised by the fertility business.

***John Wenham** is a GP Principal in Manchester*



No Water – No Life

Hydration in the Dying
Gillian Craig (ed)

- Fairway Folio 2004
- £15 Pb 188pp
- ISBN 0 95454 4536

The debate about hydration in the dying has been intense and very important. Gillian Craig, a retired geriatrician, brings an excellent breath of fresh air to this debate, providing data, published research and a wide range of opinion. The style of the book is interesting, a collage of papers and opinion. In one book she provides access to a lot of papers and opinions, along with just a few bits of her own commentary.

Hydration is essential for life but a view has arisen that those who are dying do not suffer from thirst. Developed in the context of cancer care, this view has been extrapolated to those who have fluid and food removed following strokes and other illnesses. Under English and Welsh Law, artificial nutrition and hydration are viewed as medical treatments. As such, BMA guidance permits their removal with the result that patients who have suffered a stroke or other illness may die from dehydration. Craig's book scrutinizes this practice and the clinical evidence and moral theories that are used to support it.

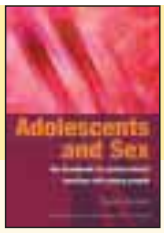
Craig has worked hard to review the broad body of evidence on this subject, to challenge current medical wisdom, and to put it into context. Having read her work, I am drawn to the conclusion that the evidence has often been selected and extrapolated to fit with the desire to believe that removing food and fluid is okay. This is most certainly Craig's view. She has done a huge service in putting the evidence into a single, readable place.

an excellent breath of fresh air to this debate, providing data, published research and a wide range of opinion

The book outlines the way in which medical opinion has changed in recent years. Dame Cicely Saunders supported the use of subcutaneous fluids and I well remember using them when I first qualified. I still find that patients and relatives consider it to help at times. But my overriding impression is that there is now a widespread fear of starting fluids and a perceived wisdom that doing so does not reduce suffering.

I recommend this book as an excellent reference and summary of this crucial debate; it is relevant to all who care for frail dying people.

***Adrian Treloar** is a Consultant in Old Age Psychiatry in London*



Adolescents and Sex

The handbook for professionals working with young people
Sarah Beckaert

- Radcliffe Publishing 2005
- £21.95 Pb 200pp
- ISBN 1 85775 880 3

The rate of increase of sexually transmitted infections (STIs) is alarming. This clear, well-referenced book includes factual information on teenage pregnancy, contraception and STIs, alongside thought-provoking chapters on important issues for debate. It is useful for clinical practice, service commissioners, youth workers and church ministers, and parents.

The opening chapters allow for reflection on the complexity of the interval between childhood and adulthood. The milestones of adolescence in chapter one are an excellent reminder of normality. The importance of listening to young people so as to develop good communication with them is emphasised. Beckaert also looks at the other kinds of risk-taking behaviour that adolescents engage in.

I was encouraged to read: 'for professionals working with young people in the area of sexual health, child protection considerations are paramount'. This chapter's legal issues are important, especially as professionals and lay individuals may interpret laws and guidelines differently. The Frazer guidelines are laid out clearly, but Beckaert has not made clear the amount of time required to assess a young person's competence and understanding. Furthermore, there is insufficient discussion about confidentiality and children under 13 years of age. There is a detailed section on the age of consent debate but I question the accuracy of conclusions drawn from a Channel 4 programme and a teenagers' magazine.

Sex and relationships education and abstinence campaigns are discussed. Unfortunately, the importance of empowering young people by teaching techniques to resist pressure is not highlighted as an area that requires equality with providing information on contraception and STIs.

The cover of marginalised groups is excellent and wide ranging, covering looked-after-children and child prostitutes. The marginalisation of boys (who have not been equal partners with girls in the sexual health debate) is acknowledged. Specific projects are discussed, such as the use of role models in schools for African-Caribbean boys and also using peer educators working alongside disabled people. Sexual health outreach in youth settings is also dealt with well and demonstrates the importance of involving parents in this matter.

Churched young people are subject to the same worldly pressures as all their peers. Although it isn't written from a Christian perspective, this book will help to make parents, professionals and church communities more aware of these issues.

***Hazel Curtis** is a consultant paediatrician with a special interest in community work in Exeter*

Lessons Learned on the Journey

Exploring the realities of faith through word and art
Bob Snyder, illustrated by Andras Simon

- Baxter Press 2004
- Limited Edition $250 contribution
  Standard Edition $30 contribution Hb 107pp
- ISBN 1 88823 7503

Some years ago, when he moved from Philadelphia to Hungary to work with International Health Services, emergency physician Bob Snyder began to write a journal of the spiritual lessons that God was teaching him through everyday experiences. In this book, Bob has brought together 50 of these vignettes and asked his friend, Christian artist Andras Simon, to illustrate them. Each page can be read as a separate 'thought for the day' and contains Bob's reflections on a personal experience or conversation in the light of Scripture, with an original line drawing by Andras to stimulate the reader's own thoughts on the day's theme.

Bob's personal struggles and refreshing humility in his walk with Christ come through on every page, as he looks at topics as varied as learning to live with gratitude, the benefits of repeated practice, harnessing the power of words and taking advantage of our weaknesses. In a gentle way, these pages are packed with biblical truth, but the way in is usually through a personal experience. The line drawings for each page combine startling simplicity with penetrating insight.

Bob and his wife Pamela are especially interested in the power of faith stories to communicate Christ to our generation. Why do millions of people in Britain watch *EastEnders* every week? It is because everyone loves a story. One of the great discoveries for Christians today may be that, even when our friends and colleagues will not come to a meeting or listen to preaching, we can always tell something of our story by sharing our testimony with them as we sit and have a meal or a drink together in a 'safe' environment. We not only have ideas about God to share, but we can also tell of a living God who makes a difference to our every day lives.

Bob's personal struggles and refreshing humility in his walk with Christ come through on every page

I have used this book in a number of ways: to read daily for a month or so; as an aid to meditation for a concentrated period of retreat; and to refer back to a particular theme as an occasion arises. The short chapters make it very accessible and I have been both encouraged and challenged by it. I warmly commend it as an aid to reflecting on your own personal journey with Christ.

***Kevin Vaughan** is Associate General Secretary of CMF and a former GP*

eutychus

War on women

The UN has received a stark warning about the growing global incidence of sex selected abortions and prenatal sex selection. Speaking about the growing popularity of 'son preference', demographics expert Dr Eberstadt from the American Enterprise Institute termed the trend a 'Global War Against Baby Girls'. China's demographics have been permanently skewed by the practice, and India is following suit. Most African countries are becoming increasingly vulnerable to this preference as well. In some areas there is a three to two ratio of boy to girl births. And as all these baby boys grow up into men, the practice of trafficking women will just become worse. Interestingly, this is not just a developing world phenomenon – it is increasingly popular in Latin America and Eastern Europe as well. Bizarrely, rising levels of education have worsened the problem in some countries. Making sex selection abortions illegal across the world may not cure the problem – it made the practice more popular in South Korea. Eberstadt warned that the world is 'moving to the realm of science fiction' with the ratio of boys to girls already at levels 'beyond nature'. (*Friday Fax* 2006; 8 December, *www.thefactis.org/default.aspx?control=ArticleMaster&aid=1636&authid=11*)

Small ecstasy use harmful

Taking even a small amount of ecstasy can cause brain damage to first time users. University of Amsterdam researchers did brain scans and memory tests on people with no history of ecstasy use but who were at risk of doing so in the future. Repeating the tests 18 months later, the 59 people who had used ecstasy showed evidence of decreased blood flow and memory loss. The class A drug is used by about half a million people in the UK. Long term or heavy ecstasy use can also damage neurons and cause anxiety, confusion, depression and insomnia. (*BBC News* 2006; 28 November, *news.bbc.co.uk/1/hi/health/6190538.stm*)

Demand for increased hospice care

Help the Hospices say that urgent government action is required to ensure that every patient with a terminal illness has access to hospice care, if they so desire. The charity found that many marginalised groups (for example homeless people) do not know how to access hospice services. Funding and referral problems are identified as problem areas, as is the issue of regional variation in the number of hospice beds. The Department of Health is now preparing a new palliative care strategy. (*BBC News* 2006; 8 October, *news.bbc.co.uk/1/hi/health/5412290.stm*)

Doctor MP admits liberal abortion aim

Liberal Democrat MP Dr Evan Harris has admitted that his aim in promoting a review of the abortion law is in fact the liberalisation of abortion. Writing in the *Guardian* in response to accusations from the pro-choice lobby that he might be secretly anti-abortion, Dr Harris said, 'Since there is currently a large pro-choice majority in the Commons, pro-choice campaigners should recognise that it is sensible to have a rational review of the medical, scientific and social issues as a precursor to an early parliamentary debate on liberalisation'. He then urged the pro-abortion lobby not attack each other. (*The Guardian* 2006; 10 November, *society.guardian.co.uk/health/story/0,,1944262,00.html*)

Conscientious objection in the pharmacy

A Muslim pharmacist working for Lloyds Pharmacy refused to supply a woman in her thirties with the morning after pill. After she complained, a spokesperson for the chain of chemists did apologise to the woman. However, he went on to support the pharmacist, and referred to the conscience objection clause in the Royal Pharmaceutical Society of Great Britain's ethics code: '...if supplying the morning-after pill is contrary to a pharmacist's personal, religious or moral beliefs they are entirely within their rights not to supply it'. (*Telegraph* 2006; 14 October, *www.telegraph.co.uk/news/main.jhtml?xml=/news/ 2006/10/14/npill14.xml*)

Cystic fibrosis screening

Following on from the announcement that Chancellor Gordon Brown's youngest child has cystic fibrosis, *The Daily Mail* has publicised pre-implantation genetic haplotyping, a screening technique that checks embryos for up to 6,000 inherited illnesses. Born in October, twins Thomas and Freddie Greenstreet are the first British babies to be born after undergoing this screening test, arranged after their older sister Lizzie was diagnosed with cystic fibrosis. There is now pressure to introduce the test for routine NHS IVF treatments. (*Daily Mail* 2006; 30 November, *www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=419761&in_page_id=1770*)

Adult stem cells for chronic back pain

Patients' own mesenchymal bone marrow stem cells are being used in a Manchester trial to regenerate the nucleus pulposus of degenerated intervertebral discs. Researchers are aiming to start pre-clinical trials in 2007, and hope that this innovative treatment might be available within three years. So maybe soon NHS GPs will have a bit more to offer the UK's twelve million chronic low back pain patients than codeine and another sick note. (*BBC News* 2006, 30 November, *news.bbc.co.uk/1/hi/health/6196644.stm*)

Poor family planning and emergency contraception

When it comes to birth control, Scottish couples are not planning ahead. A study published in the *Lancet* looked at 4,000 women attending antenatal clinics and another 900 seeking abortions; its findings suggest that up to one in three Scottish births are not planned. Ten percent of births were totally unintended, and a further quarter of mothers were uncertain about their intention to conceive. Emergency contraception use was low, even amongst those women with no intention of conceiving. Lead researcher Professor Glasier said, 'Emergency contraception is unlikely to make a substantial difference to pregnancy rates'. (*BBC News* 2006; 17 November, *news.bbc.co.uk/1/hi/scotland/edinburgh_and_east/6153736.stm*)

Money isn't everything

It's official – money does not make you happy. A survey by MTV confirmed that young people in developing nations are at least twice as likely to feel happy than their peers in the developed world. Indians top the happiness chart whilst only eight percent of Japanese youngsters said that they were happy! Less than one in three British 16-34 year olds reported happiness. Even more interesting: 'The happier young people of the developing world are also the most religious'. (*biz.yahoo.com/prnews/061120/nym178.html?.v=57*)

HPV vaccine

***Chris Richards**, Newcastle paediatrician and Director of Lovewise, argues that immunising against cervical cancer is aiding and abetting sin.*

I disagree with Trevor Stammers (*Triple Helix* 2006; Winter:7) that Christians should welcome the development and use of the HPV vaccine.

There are two biblical reasons against mass HPV immunisation of our young people. Both are based on the fact that Christians sin when they 'aid and abet' others to break God's commands.[1] Both Old and New Testament passages affirm fornication to be sinful.[2] 98% of cervical cancer is caused by genital HPV infection. Almost all such infections result from consensual fornication or adultery (with the exceptions of rape, incest and a faithful wife being infected by an adulterous husband). For this reason, providing such a vaccine to teenage girls will (except in these rare situations) anticipate fornication and therefore condone it. Christian doctors should have no part in this.

Those seeking to protect the faithful wife might propose immunising her or her husband after marriage. In so doing, however, they may be promoting promiscuity in the husband by immunising him, or in both by immunising her. In any case how many newly weds would knowingly consider immunisation where its only purpose anticipates their infidelity, so soon after making vows of absolute mutual trust?

Secondly, young people will perceive that the consequences of fornication have been lessened and therefore fornicate more. Stammers is correct in outlining the vaccine's limitations. But vaccines are never promoted on their weaknesses for obvious commercial and political reasons. The public health message employed to encourage uptake may be 'another triumph over cancer'. But the fact that prevention of this cancer is being attempted by preventing genital HPV will not be missed amongst our increasingly streetwise and promiscuous children – not least because HPV is the name of the vaccine. They will take home (and to bed) the message that safer sex is safer still. Epidemiological studies have shown that condom promotion increases rather than decreases STI acquisition, probably by increasing sexual activity through the false hope of consequenceless sex.[3] This vaccine will do the same.

It is another form of harm reduction strategy that may seem enticing but actually leads to many more problems in the long term. Like condom promotion to the unmarried and clean needles for drug addicts, it is both unethical and damaging.[4]

London GP Trevor Stammers replies.

I have considerable sympathy with Chris Richards' concerns. However caution over the possible problems and inevitable media spin with mass vaccination should not necessarily lead Christians to fail to welcome the vaccine itself.

A few questions to put Richards' comments within a wider biblical perspective on living godly lives in a far-from-perfect world:

First, doesn't Jesus teach us that God 'causes his sun to rise on the evil and the good'[5] and even more outrageously, 'he is kind to the ungrateful and wicked'? Does this mean that the Lord is aiding and abetting sin?

Secondly, are the 'rare' exceptions that Chris also allows in order to protect the 'innocent' so very rare? There were 11,766 allegations of rape in 2002[6] and probably many more that were never reported. Adultery, secret as it is, is difficult to quantify but recent reports in the press suggest it is far from rare.[7]

I wish I could say that adultery is uncommon among Christians, but sadly there can hardly be a church in the UK of more than 100 members whose congregation is unaffected. Both as a local GP, and in conversations with leaders throughout the UK, I know of many cases, including those of Christian doctors. Wouldn't a good stoning have been a much better deterrent to casual sex than Jesus' gentle, 'Go now and leave your life of sin', spoken to the woman caught in adultery?[8] Who are we to begrudge, let alone deny, young girls throughout the world being protected against a killer disease that many will otherwise die of as victims of predatory men?

references

1. Mark 9:42
2. Deuteronomy 22:20-21; 1 Corinthians 6:18
3. Paton D. *Random Behaviour Or Rational Choice? Family Planning, Teenage Pregnancy And STIs. www.loveforlife.org.uk/research/main.htm*
4. *Triple Helix* 2003; Autumn:11-13
5. Matthew 5:45
6. *news.independent.co.uk/uk/politics/article349758.ece*
7. *www.timesonline.co.uk/article/0,,7-1267449,00.html*
8. John 8:11

Tell us what you think!

Letters

Many of our members have noticed, and some have commented on the fact that *Triple Helix* doesn't have a regular letters page. Rest assured, this is not for lack of wanting one. Quite simply, we don't have a regular letters column because it would be a blank feature for most issues. Some may argue that this is *because* it isn't a regular feature! Nonetheless, we want to address this issue.

Our editorial team receives very little written feedback, debate or comment. Our members' views and opinions do matter to us and we take all constructive comments seriously. The Christian Medical Fellowship is just that, a *fellowship* within which there is a range of opinion. We are keen to acknowledge diversity of views as none of us has the monopoly on truth. We can receive letters by email, fax or post (contact details are on the inside front cover of each issue). If possible, letters should be succinct, factual and under 250 words. We try to edit them as little as possible but do retain the right to do so for clarity and length.

CMF Forum

Did you know that CMF has had an online discussion forum? Specialist forums cover ethics, juniors, psychiatry and students, and there is also a general chat section. Go to *www.cmf.org.uk/forum* and register using your CMF membership number; you can obtain that by emailing your full name and postcode to *forum@cmf.org.uk*.

***Rachael Pickering** is Triple Helix Associate Editor*

news from abroad

It's a real privilege to be on the receiving end of the many newsletters our members working abroad send to us. Some leave you in tears, others fill you with laughter. I've extracted details from one of them, changing some of the details slightly for security reasons. It gives a brilliant word picture of medical work in a very different culture:

The patient

Once everyone has been greeted and the excess family removed (I've still not cultivated the ability to shout loudly and angrily enough), the fun, sorry, the work begins. Personal greetings are exchanged while I crouch next to the patient's bed and stroke a hand. The next challenge is the examination. As well as being buried beneath numerous blankets, most women, for example, wear at least one thick cardigan, two dresses, a beautifully hand embroidered vest-like garment which allows quick access for breast feeding (virtually a life time occupation here), an old piece of cloth tied several times around the painful area, and finally a piece of paper (glued with some formidable combination of egg and I'm not quite sure what) stuck directly over the skin. Try removing it at your peril!

The examination

There are aids in the battle though. For instance, if you want to listen to someone's chest, you just climb right behind them on the bed. Squatting on their pillow with stethoscope in your ears, you can get a good grip on all their layers of clothing, yank them upwards and finally place your stethoscope on the patient's back and whisper 'breathe' in their ear. It all seems so natural that I chuckle with God: at some point in the future, I might forget myself and leap up behind some prim middle class English lady on her pristine NHS bed and cry 'Breathe!'

The outpatient clinic

Stumbling out from the ward round, my heart does a little leap when I see the clinic surrounded by the colourful crowd of women and children. I know it means work and 'difficult' patients, but it is still an undeniably beautiful picture. An amazing array of people old and young, draped in beautiful bright turquoises, royal blues, purples, reds, greens, pinks. Even the blacks and browns have swirls of silvery glitter woven through them.

The crowd previously waiting outside has now been sifted and those who clearly don't have anything wrong with them have been sent away. The rest, after paying a cursory fee, are furnished with a number and ushered in. The women, however, are mostly illiterate and innumerate and the concept of queuing is totally alien. Unsurprisingly, the number system falls apart and all 40 women lurch forward in unison. The trick to survival seems to be to remain standing inside the clinic room, grab the nearest lady with your right hand and simultaneously pull the door shut behind her with your left. The door thankfully, is solid wood and about three inches thick. Anyone who tries sneaking in is usually shot down within seconds by cries of 'Get out, get out, get out!'

The consultation

Inside the room, which is no more than three metres square, there are usually two nurses and myself examining at least one patient, each of whom generally has at least one baby secreted some where on her person! It doesn't really make for a calm medical consultation. On the other hand, if I or my patient can't understand each other, there is always help available. There is no place for confidentiality here!

Is there a French speaking doctor out there?

In the last *News from Abroad* I asked, 'Where are the men?' and 'Where are the surgeons?' This time it's a different cry. One of our members (a retired GP) writes from Cameroon:

Meskine is a small hospital of 100 beds with a very busy OPD which has seen a 50% increase in numbers from 32,000 in 2005 to 45,000 patients in 2006. We carry out some 1,500 operations a year. Although the hospital is only twelve years old, it has gained a good reputation by word of mouth, and attracts patients from Chad, Nigeria and Ethiopia as well as a large area of Cameroon. The medical consultations are all carried out in French.

The hospital has paediatric, maternity, TB, leprosy and isolation wards together with X-Ray, ECHO, laboratory and physiotherapy services. We have a great team of nurses, many often doing the work of junior doctors. All doctors and medical students who come here are amazed by the vast spectrum of pathology.

Our aim is to share Jesus Christ with the patients and their families through a good standard of medical care and low key evangelism. We have devotions every morning and a ward prayer round every Thursday when we pray with all the patients individually, if they wish, and they usually do!

Contact John Baigent at *jonbaigent@aol.com* if you want to know more.

Known current needs

- General duties doctor at Rumingae Hospital, Papua New Guinea
- Help is needed in setting up a 'hospice in the home' service in Kyrgyzstan
- The United Christian Hospital, Lahore, Pakistan needs doctors
- The Leprosy Mission need a physician in NW Bangladesh
- Mercy Ships are looking for a physician to help in Sierra Leone
- An ophthalmologist is needed in Trinidad & Tobago
- Crosslinks need a medical officer to take over a clinic in Tanzania

You can find full details of these and other overseas vacancies on our overseas website *www.healthserve.org/overseas_opportunites/*

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

Janet Goodall allows us a sneak preview of her forthcoming book *The Shepherd is My Lord*

A Valley EXPERIENCE

However I reached this place, there is no possible evil, without or within, that our Good Shepherd is powerless to keep at bay or to slay. He is a match for them all.

I can either react to the difficulties in ways that only add to the pain, or I can respond to the nail-pierced hand that has allowed them. It can take time to make the change, for the spirit might be willing but my emotions have left me too weak for much more than SOS prayers. Some comfort comes from Paul's testimony of the solace found in his valley: 'But he said to me, "My grace is sufficient for you, for my power is made perfect in weakness"'.[1] Even a heavy heart can respond to that.

At times like this, it is also some comfort to know that, in his own darkest valley, the crucified Lord cried 'Why?'[2] I can see now the answer to his question in the light of his resurrection and my salvation; he sees already the answer to mine. Whatever the feelings, the fact is that as then, so now, he loves me with unfailing love. His presence will never fail. His power will open up the way and bring me out into the clear again. I cannot fly out of this valley on the wings of a dove, nor run away from it, but *I will walk through it*, step by step, with his help. Perhaps only then will I realise how, in this dark, strange, confined and fearful place, I have slowly come to know the Shepherd more personally than I have ever known him before. I can no longer be objective as I describe his role.

One Sunday morning I was invited to a Jewish synagogue to join a group who were discussing this particular psalm of David. It was a privileged and interesting experience in other ways to be in the company of students whose primary focus was on the Old Testament, and I was invited to join in the discussion if I wished. There came a moment when I felt impelled to speak, as one of the company said, 'I have never understood why in the fourth verse the psalmist changes from using the third person singular to the second'. 'Why!' I found myself exclaiming, 'It's in life's valleys that we get to know him so much better. *He* leads and guides, but in the valley, *you* are with me'.

Yes, he is *my* Shepherd, and I have so far been happy to accept the many benefits he provides for all of us in his flock. Now he has proved himself faithful on a more intimate and personal level, when I have been in big trouble and utterly dependent on him. I'm getting to know him better because I've not just been one amongst many. We have walked this lonely way together. Whether I come out the other side to find myself face to face with my Lord and Shepherd, death behind and eternal life still stretching ahead, or whether the end of the valley finds me still walking beside him here on earth, the outcome is up to him. The certainty is that he is with me, all the way, and banishes fear. I will therefore fear no evil.

***Janet Goodall** is a retired paediatric consultant in Stoke on Trent*

references

1. 2 Corinthians 12:9
2. Matthew 27:46

uniting and equipping christian doctors

To find out more... telephone or visit our website

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