Christmas 2008

for today's Christian doctor

triple helix

climate change

God's plans for us, men's sexual health, asylum seekers, Christ in the workplace, the dangers of doing nothing, reviews, the wider horizon

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Assisted suicide

The law is both clear and right

Photos: PA Photos

Debbie Purdy

Two recent high profile cases have understandably reignited public debate on assisted suicide. Debbie Purdy, a 45-year-old woman with primary progressive multiple sclerosis, had sought 'clarification' of the law to ensure that her husband would not be prosecuted should he accompany her to the *Dignitas* suicide facility in Zurich, Switzerland. The High Court in October turned down her application, but in the light of public interest allowed her to proceed to the Court of Appeal, while making it very clear that her arguments were extremely unlikely to succeed.[1] The parents of Daniel James, a 23-year-old rendered tetraplegic following a rugby accident in March 2007, are under police investigation for accompanying him to the same clinic to commit suicide this September.[2]

Under the Suicide Act 1961, it is neither illegal to commit suicide nor to attempt it, but assisting suicide remains a crime carrying a discretionary prison sentence of up to 14 years. However, although over 100 British people have made one way trips to *Dignitas* in the last five years, no one has been prosecuted so far.

Lord Carlile, speaking on Radio Four *Today*, in defending this apparent anomaly explained that British law has 'a stern face but a not unkind heart'. The Director of Public Prosecutions, in deciding whether or not to bring a case, must decide both whether there is enough evidence to secure a conviction, and also whether doing so would be in the public interest. Judges are similarly given flexibility to 'temper justice with mercy' in what are often deeply harrowing circumstances. Only 3% of all crime leads to a conviction and these cases can be amongst the most difficult of all.

The law is both clear and right. Changing it to allow assisted suicide, even in limited circumstances, would place vulnerable people – the sick, elderly, depressed and disabled – under pressure, whether real or imagined, to request early death for fear of being a financial or emotional burden on their family, on carers or on the state. The so-called 'right to die' can so easily become the duty to die. Accepting assisted suicide as a 'treatment option' would also pose a dangerous temptation to burdened relatives and health providers when weighing up the cost of a glassful of barbiturate against ongoing care. It is noteworthy that even *Dignity in Dying* (formerly the Voluntary Euthanasia Society)[3] are being careful now to distance themselves from more radical euthanasia advocates like Philip Nitschke[4] and Baroness Warnock.[5]

The law is a blunt instrument but hard cases make bad law. We have laws precisely because we recognise there are limits to personal choice and that we are not entitled to make choices which endanger the reasonable freedoms of others.

Requests for assisted suicide are thankfully extremely rare, and virtually never persist if patients' physical, emotional and spiritual needs are properly addressed. There are over 70,000 people in Britain with multiple sclerosis and 20,000 with tetraplegia but only a very small number ever request death and for most it is in reality a cry for help. The 100 people travelling to Switzerland to end their lives have to be seen against a background of over 3,000,000 deaths from all causes in Britain over the same period. One in 30,000 is not a high demand.

Our key priority must always be to make the very best care more widely accessible. We also need better public education as the call to change the law is often driven by distressed relatives whose loved ones have died badly or by the 'worried well' who have been frightened by media stories. Ms Purdy's expressed fears of choking to death or experiencing excruciating pain are quite groundless with good palliative care, and the public is being misled. Many with MS now live an almost normal lifespan and it is not at all clear, even given the type of MS Debbie Purdy has, that she would ever need assistance to end her life, should she be determined to do so. The case needs to be seen in the wider context of a well funded and carefully orchestrated campaign to press the boundaries of the present law.

Good role models, like Alison Davies[6] and Matt Hampson,[7] who have come through understandable initial despair to adapt to chronic illness or have found meaning and purpose in the presence of suffering and disability, need much more media exposure.

The House of Lords in 2006 quite rightly rejected Lord Joffe's Assisted Dying Bill and although as Christians we will wish to emphasise that actively ending lives is wrong *per se*, we can also unite with people of all faiths and none in promoting palliative care and opposing euthanasia,[8] on grounds of compassion and public safety.[9]

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

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news reviews

Mental Health Act amended

Guiding principles welcomed but could the law be abused in future?

Review by **Dominic Beer**
Consultant psychiatrist, Oxleas NHS Foundation Trust

Finally, the 1983 Mental Health Act has been amended.[1] Much stays the same. What is new? The two most noteworthy changes are that the definition of mental disorder has been significantly broadened to 'any disorder or disability of mind' and that Community Treatment Orders have been introduced.

Parliament's 'guiding principles' behind the Amendment are:[2]

- To treat and minimise the undesirable effects of mental disorder
- To provide the least restrictive treatment setting which is consistent with protection of the patient and the public
- To respect the rights of patients
- To involve patients and carers in care
- To provide effective, efficient and equitable care

Why has it taken so long to change apparently so little? The government was besieged by a coalition of professionals, civil liberty and patients' groups who saw the widening of the definition of mental disorder and the introduction of Community Treatment Orders as gross infringements of liberty. However, after the murders committed by Michael Stone on the Russell family, the government wanted to ensure that those with personality disorder would not be ineligible for treatment, as long as 'treatment is available'. Community Treatment Orders will have greater power than the current 'supervised discharge', but it will still not be possible to enforce an injection while the patient is in the community – the patient must be brought back to hospital.

There are a number of other changes – no persons under 18 will be allowed admission to adult mental health wards after 2010; independent mental health advocates will be brought in; others, besides doctors, can be 'Responsible Clinicians' and those, besides social workers, can act as 'Approved Mental Health Professionals'; the 'Nearest Relative' can be a civil partner; and other than in an emergency ECT cannot be given to an unwilling patient who retains capacity.

Christians welcome the following principles:

- Compassion – the basic purpose of the Act is to provide care for suffering people
- Justice – care should be provided for all, regardless of income, employment, race
- Truth – each case will be subject to independent review by a tribunal

The big unknown factor is whether any future government might abuse the wide definition of mental disorder. At this stage all one can say is that the stated principles of respecting and involving patients and the necessity to provide 'appropriate treatment' might act as a defence against any future abuse.

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Healing miracles at Lakeland?

'Gamaliel principle' effective again

Review by **Andrew Fergusson**
CMF Head of Communications

Earlier this year supernatural phenomena were being reported in Lakeland, Florida at 'revival' events organised by Fresh Fire Ministries, and led by Todd Bentley.[1] Respected evangelical R T Kendall, now retired in Florida, was concerned but did not want to ignore a true work of God:[2]

'What complicated things most of all was that people were apparently being healed. At last count there were 37 resurrections from the dead. If only one of them had a coroner's death certificate it would be a very serious matter to say that what was going on there was not of God. The fact that ABC news could find no documentary evidence of a miracle was not enough to sway me one way or the other. I was even prepared – for a while – to overlook the claim that the angel Emma is the secret explanation for the special revelations and miracles. I believe in angels. What if Emma were a part of the 'yuk' factor?' He continued with a critique of what was not happening at the meetings, as well as one of what was, and concluded 'I can only call this "another gospel" as in Galatians 1'.

CMF is a member of the Evangelical Alliance and was consulted informally about an appropriate response. In an open letter on 10 June[3] General Director Joel Edwards referred back to a 1994 EA statement about the 'Toronto Blessing' which ended with Jonathan Edwards' classic tests about a phenomenon:

- Does it raise people's estimation of Jesus Christ?
- Does it operate against the interests of Satan?
- Does it lead to a greater regard for Scripture and truth?
- Does it result in a greater awareness of and seriousness about the things of God?
- Does it lead to a greater love for God, for other Christians and for the wider world?

In the event, Todd Bentley stepped down from public ministry and things seem to have gone quiet. CMF, EA and others had been advocating the 'Gamaliel principle'. In Acts 5 we read that because of healing miracles being performed daily through Peter and the apostles, they were brought before the Sanhedrin where Gamaliel recommended a principle which values evidence and accepts a God who does miracles: '…I advise you: Leave these men alone! Let them go! For if their purpose or activity is of human origin, it will fail. But if it is from God, you will not be able to stop these men; you will only find yourselves fighting against God.'[4]

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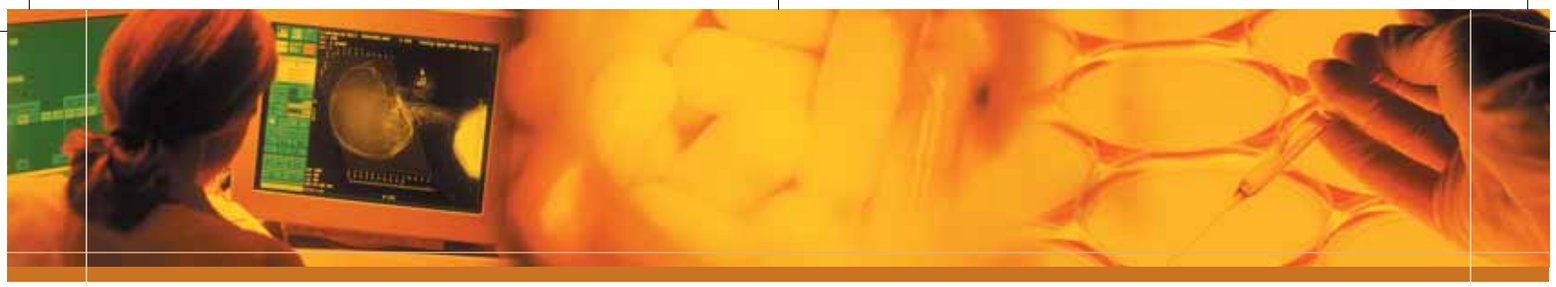

Top-up payments

How do we deploy finite resources wisely?

Review by **Helen Barratt**
Academic Clinical Fellow in public health

This autumn, debate about patients paying to 'top-up' NHS care has dominated the media. In West Sussex, Carole Simmons' family paid privately for the drug *Avastin*, not available on the NHS. They believed it would prolong her life. However, their NHS treatment was withdrawn as a consequence, leaving them with a £20,000 bill for her routine care.[1]

This story is not unique. Although the issue is not confined to cancer treatments, the government asked the National Clinical Director for Cancer to review this policy. He concluded[2] patients could continue with 'top-up' treatments administered in non-NHS settings, but this is unlikely to signal the end of the debate. Deeper issues still need to be explored:

- The 'fiction of the wonder drug': the media frequently describe drugs as 'lifesaving' when they may only prolong survival for a few weeks. Some argue this detracts from open and constructive discussion about end of life care.[3]
- The increasing tension between the autonomy and demands of patient-consumers, and the role of the doctor as a service provider.
- The relationship between senior clinicians – focused on their patient – and the local PCT, making individual funding decisions, but responsible for the population's health.[4]
- The place of evidence in clinical judgment, and particularly the role of the National Institute of Health and Clinical Excellence, considered by some to be 'denying care to those who need it most'.[5]
- Whether we should be striving to provide NHS care free at the point of need to everyone, regardless of the cost or evidence, or looking at other ways to deploy finite resources wisely.

The debate raises questions about ethical principles such as fairness and equity.[6] We should be cautious about measures that would further marginalise those already disadvantaged, and must think about how Christians should make use of the resources God has entrusted to us,[7] as well as about our relationship to authority structures such as NICE. There may be no clear answers, but it is time we engaged in this debate logically, carefully and sensitively, avoiding the knee-jerk reactions that dog the media.

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HFE Bill

Things could have been even worse

Review by **Peter Saunders**
CMF General Secretary

The 1967 Abortion Act caused 6.8 million abortions. The 1990 Human Fertilisation and Embryology Act provided for various forms of assisted conception, but through allowing embryo freezing, research and disposal up to 14 days has also destroyed 2.2 million human embryos – a total of nine million early human lives in 40 years.

The 2008 Human Fertilisation and Embryology Bill[1] takes us several steps further by bringing in more liberal embryo research, saviour siblings, animal-human hybrids, fatherless IVF children, and by making legal without explicit consent the use of tissue from children, mentally incapacitated adults and people who have died in order to make cloned and hybrid embryos. CMF throughout has opposed the bill as an attack on human dignity, the family and life itself.[2]

All attempts to remove these provisions from the bill, or to legalise them only when alternative research routes do not exist, were defeated in both Lords and Commons as government Peers and MPs faced a three line whip. Most would have voted this way regardless, due to a successful propaganda campaign by *The Times* backed by various scientific institutions, patient interest groups and MPs.

Key was the Prime Minister who wrote in May that 'embryonic stem cell therapy' gave us 'a profound opportunity to save and transform millions of lives' and that animal-human hybrid research is 'an inherently moral endeavour that can save and improve the lives of thousands and over time millions of people'.[3] The facts suggest otherwise. The PM, in thrall to research scientists and the biotechnology industry, has embraced this emperor's new clothes technology at the very time when scientists worldwide are turning to the ethical alternatives of adult and cord blood stem cells and iPS (induced pluripotent stem cells). In October the National Institute of Health website listed 2,170 clinical trials involving adult stem cells, 125 involving cord blood stem cells, but *not one clinical trial in humans* involving embryonic stem cells.[4]

The bill completed its eleven month journey through Parliament on 29 October with a debate in the Lords and now needs only royal assent, a mere formality, to make it law. The only saving grace has been that the abortion law has not been further liberalised. It was a huge answer to prayer when liberalising amendments calling for abortion on request up to 24 weeks, nurse and GP surgery abortion, and extension to Northern Ireland fell. At the eleventh hour the government acted to prevent debate on these, apparently in response to pressure from the media, Northern Ireland MPs and cross-party back-benchers.[5] The new HFE Act is certainly bad, but could have been even worse.

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Jason and **Rachel Roach** outline the health impact of climate change

CLIMATE CHANGE

key points

Acknowledging that some Christians feel that climate change is being over-emphasised, the authors argue that we should establish the facts, review our response, and see concern for the environment as service to its creator and as an opportunity for the gospel.

Global temperature is rising significantly and it is more than 90% certain that most of the warming is due to the observed increase in man-made greenhouse gas emissions.

Practical suggestions in a health care context are made for tackling the causes. Public health must be seen as a priority, and must become more proactive, as globally we tackle the effects.

'This is a moral issue... if we allow it to happen, that is deeply unethical'

Al Gore, *An Inconvenient Truth*

Climate change has undoubtedly become the new gospel issue of our age. It claims that our chief problem is neglect of the earth, and that salvation for us and the planet hinges on our repentance. David Walker is absolutely right when he says that 'inasmuch as the "climate change gospel" stands independent of the gospel of Jesus Christ ... it is a false gospel'.[1] Salvation does not lie in nursing our dying planet back to health, but in the Lord Jesus Christ.

However, John 14:15 tells us disciples of Jesus Christ must obey his commands, and if concern for the environment is a neglected area of our service of the creator, it is indeed right that we recover it. We need to ask then, what are the facts, and what is our role (if any) in alleviating the consequences?

The facts

Since the industrial revolution began more than 150 years ago, the average global surface temperature has risen by 0.76°C. This warming is leading to disrupted seasonal weather patterns and an increased frequency and severity of extreme events. In different parts of the world this means more heatwaves, more floods and droughts, and more intense storms and hurricanes. According to the Intergovernmental Panel on Climate Change[2] there is more than 90% certainty that most of the warming is due to the observed increase in man-made greenhouse gas emissions.[3] Many of the national science academies of the world (including those in the USA) have publicly pledged their agreement.[4]

Should we care?

First, the Bible affirms that our Lord Jesus eternally rules the physical and spiritual realms.[5] It is mistaken to think that our 'dominion'[6] gives us *carte blanche* to use the earth's resources however we like – they still belong to God.[7] The dominion God intends is a responsible dominion that 'cares',[8] remembers where our resources come from, and uses them with the wider interests of humanity in mind.[9]

This need not be seen as a distraction from other priorities such as evangelism. We routinely balance many responsibilities as Christians, such as taking time to love our spouses or doing our work diligently. We rightly recognise that this earth is in some senses temporary, but so are our marriages and our jobs! In other words, that in itself is not a reason to disobey God's instructions for discipleship.

Secondly, God commands us to love our neighbours as ourselves. He specifically rebukes those who try and define 'neighbour' too narrowly;[10] after all, he provides practical resources for billions

each day.[11] Climate change impacts our poorest and most vulnerable 'neighbours' most severely. These are the very people we are instructed to show particular care for.[12]

Health implications

While in some regions climate change may lead to fewer deaths in winter, scientists consider that most of the health implications are negative.[13] Emerging evidence shows that climate change has:[14]

- altered the distribution of some infectious disease vectors
- altered the seasonal distribution of some allergenic pollen species
- increased heatwave-related deaths (eg 35,000 excess deaths in Europe in 2003)[15]

In addition, it is predicted that in time there will be additional health consequences such as:[16]

- increasing burden from malnutrition and diarrhoeal, cardio-respiratory, and infectious diseases
- increased morbidity and mortality from heatwaves, floods, and droughts
- changed distribution and transmission season of some disease vectors
- substantial burden on health services

All these will be greatest in low-income countries. In all countries, those at greater risk include the urban poor, the elderly and children, traditional societies, subsistence farmers, and coastal populations.

What we can do

Tackling climate change requires effective action in all areas of society, from international bodies down to individuals. As Christians we must of course recognise that there are many important issues that need addressing in our world. However, if we are to be a distinctive community then we must consider how to respond to the ethical issues that face us today. Practically, responding to the climate change problem mainly requires us to do what we already do but to do it *differently*.

Whenever we seek to respond to climate change, in any area of life, we need to view what we are doing from a different perspective, by asking two questions:

- How can we reduce the greenhouse gas emissions produced by this action/department/church etc? (Thereby tackling the *cause* of climate change)
- How can we reduce the negative consequences that are going to arise as a result of climate change for people we are working with in this sector/geographical area? (Thereby tackling the *effects* of climate change)

Tackling the causes

Whether we are thinking about a hospital, a surgery, our church, or home, the answers to the first question are often similar. There is a wide range of practical (often simple) steps we can take to reduce our greenhouse gas emissions, or 'carbon footprint', and lots of information is available on how to do this. Three key areas to think through are:

Responding to the climate change problem mainly requires us to do what we already do but to do it differently

1. **Energy use**: 70% of energy use in primary health care is attributed to heating, so optimising thermostat and air conditioning settings, combined with checking natural ventilation and insulation, is essential. In addition, turning off lights and stand-by functions and using energy saving light-bulbs will provide substantial savings.

2. **Transport**: 5% of UK road transport emissions can be traced to NHS-related journeys. Therefore, where feasible, driving less or when necessary driving in a way that reduces fuel consumption will help. Promoting and developing car-share and public transport initiatives, perhaps by providing bicycle storage and changing facilities, may encourage this.

If concern for the environment is a neglected area... it is indeed right that we recover it

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3. **Waste disposal**: reducing (using email and telephone communication and electronic storage rather than paper), reusing (eg using reusable coffee/water cups in surgeries rather than paper or styrofoam ones), and recycling (eg collection bins for patients and staff, using refill printer cartridges).

These actions may sound familiar, and run the risk for some of being over-familiar, but we must not become numb to them. They *will* make a difference. For example, with around a quarter of the UK's emissions coming from the energy used to run our homes, these simple steps would have a significant impact if we all did them. Health care institutions also have enormous power to reduce emissions, particularly the NHS as one of the largest employers in the world.[17]

In our workplaces and churches we need people who are asking questions and pushing for change – could you encourage your team to recycle, or your church to change their light-bulbs? Could you raise a few key points in a professional meeting or with your church leader? Even just asking the relevant staff what policies are already in place can help to raise the profile of the issue. It often works well if there is a group of like-minded people from across an organisation who work together to identify areas for change. Coming up with innovative ideas to motivate and inspire people is really important.

Tackling the effects

Minimising the negative effects of climate change is perhaps more complicated, and certainly very context-specific. In this case, strengthening public health services will need to be a central component of our response.[18] Doing so is the only way to ensure our public health interventions will be robust anyway. But what could this mean specifically?

First, public health services will increasingly need to anticipate risks, becoming more proactive rather than reactive. For example more heatwaves will necessitate improvements to housing, management of chronic diseases, and care of the elderly and vulnerable.[19] Therefore participation in public health will need to broaden, for example, to climate scientists, urban planners and housing specialists. A few countries have already developed warning systems for imminent heatwaves and floods.[20]

Secondly, current public health projects need to be screened for future risks to climate change, to ensure they improve the wellbeing of communities in the long-term.[21] This is a complex task, and there will be some uncertainties.[13] Nevertheless disease protection strategies must be reviewed and strengthened, and communication to the public must be enhanced, to raise awareness of the increased risks of food-borne diseases and allergic disorders.[22]

> As we take stewardship seriously we may well gain opportunities to explain the gospel

Thirdly, with increasing frequency and severity of natural disasters particularly affecting developing countries, there will no doubt also be an increased need for expertise and practical assistance on the ground. Health professionals could consider devoting a block of time to an area of the world recovering from disaster, or be on standby for new ones.

Conclusion

Even if we take a pessimistic view of our ability to tackle climate change, our response amounts to basic discipleship. This means we cannot excuse ourselves from doing it any more than we can excuse ourselves from fighting lust, envy and greed. In addition, as we take stewardship seriously we may well gain opportunities to explain the gospel.[23]

Jason Roach *is a former Editor of* BMJ Clinical Evidence *and his wife* ***Rachel*** *is the former Climate Change Policy Officer at Tearfund*

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Rachael Pickering
on changing plans

God has got plans for us

The best thing about my new job is its remoteness – 60-mile round trips for house calls through the beautiful Yorkshire countryside. A whole hour per patient to admire the scenery and relax, think and pray, brood or just-be-alone! Last week I decided to use the drive to plan this issue of *Juniors' Forum*. I always think better with music on but the only CD in the car was my little girl's favourite anthem collection, *Party Time* by good old Ishmael[1]...and I don't mean Hagar's son![2] Worryingly, I was soon hooked on track five, *God has got plans for us*, but it got me thinking...

Think right back, to your school days. When did you decide to become a doctor? What did you do to make sure that you got into medical school? And now as a houseman, Foundation or ST doctor, you've read *So you want to be a brain surgeon!*[3] from cover to cover and are planning your future.

What's your plan?

For some of us, life's management plan was always marked out in large block capitals. I think back to my very first week at medical school and a fellow fresher telling me earnestly that the only kind of doctor he was interested in becoming was a vascular surgeon – he's recently been awarded his CST in vascular surgery. Then I recall sitting in the Swanwick conference centre's conservatory at the 1996 CMF student conference, listening to my friend Sarah saying that she thought God wanted her to become a missionary gynaecologist. And just this last February, we sat in the same conservatory discussing her impending appointment as the gynaecologist for an African hospital. For some of us though, life's plan has never been darkly inked. My closest Christian friend at medical school felt that God wanted her to train as a doctor but not necessarily practise medicine – she's now a school teacher.

Last minute revisions get scrawled over the clearest of life plans. Has this happened to you? The MMC fiasco, tiredness and jadedness, medical errors and complaints, family illness and troubles, true love and babies, unrequited love, physical and mental illness, personality clashes and run-ins with the boss – these are just a few of the joys and trials that have obstructed my friends' career paths. And speaking personally, this year has seen my carefully-crafted London-based life fall apart.

Whose plan?

The Bible is very clear that God has a plan for each of our lives and that he's prepared in advance good things for us to do.[4] Having said that, he doesn't promise us an easy road, nor does he promise to tell us way in advance the path he has marked out for us. The psalmist tells us that God's word is a lamp to our feet,[5] not to our horizon! Even if we have correctly discerned the particular mountaintop he's leading us to, often we may get over one ridge only to find a great big valley in between, full of rocks and a river to cross before we get to our final destination!

James even goes so far as to tell us that we are to 'consider it pure joy' when we face trials, because these are the things that produce perseverance – an essential quality for true maturity.[6] Paul reminds us that 'in all things', presumably the good and the bad, 'God works for the good of those who love him'.[7]

Good things can certainly come from difficult situations when our carefully laid plans are turned upside down. Matt Kehoe has written before in *Triple Helix* of the job crisis that led him to work in New Zealand.[8] And through this completely unexpected turn of events he has been able to contribute significantly to the recent growth in the New Zealand CMF – not something he would have foreseen!

> God's word is a lamp to our feet, not to our horizon

Scripture gives plenty of examples. Paul and Barnabas fell out over whether to take John Mark with them on a missionary journey.[9] No doubt observers thought this was tragic – the breaking of a great partnership! But in God's providence it simply meant that more people got involved and the gospel was spread further afield than it might otherwise have been. Likewise, Paul getting shipwrecked[10] seemed like a complete disaster, but it ended up as a demonstration of God's protection with the added benefit of giving Paul three months to evangelise Malta![11]

Trust and obey

So whether it's exam failure, missing out on your ST rotation of choice, having to relocate suddenly or any other seeming disaster, God really is bigger than all of that – even if our own decisions or failings played a part in the situation. It isn't easy to see what he's doing in the midst of the turmoil. When life isn't going our way, it's tempting to dream up a quick-fix, Baldrick-style 'cunning plan!'[12] But it's better to hang on in there and trust him. One day you'll sit back, deploy the retrospectoscope and see God's definitive management plan for your life.

***Rachael Pickering** is a portfolio GP moving from London to Yorkshire and is handing over the editing of the Forum for 2009*

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Roxana Whelan on dilemmas of men's sexual health

Photo: PA Photos

Ten years of VIAGRA

key points

Since effective oral treatments for erectile dysfunction came in ten years ago, more men are consulting about sexual difficulties. These are common but discussion is often taboo.

Christian doctors will want to consider sexual problems holistically. Erectile dysfunction may not only be the cause but the manifestation of emotional problems, relationship difficulties, or spiritual issues such as guilt.

After reviewing biblical teaching both on sexual behaviour and on judging, the author concludes there are often no easy answers about prescribing but reminds us of our duty to protect both our patients and others.

A man has a quick consultation. You deal with the problem and hand over a prescription but he hovers. 'Actually there's something else, doctor… err, I'm seeing this lady and, well, I'm having problems. I was wondering, err, you know those tablets…?'

This scenario has become more familiar over the last ten years because of new therapies for erectile dysfunction, greater media attention, and hence greater public awareness of the problem.

The issue of men's sexual health is not often covered in Christian medical publications. *Triple Helix* ran an article[1] on *Viagra* when it was first licensed in 1998, but since then the issue has hardly been considered. We frequently read about abortion, contraception and teenage sex, but rarely about male sexual dysfunction.

A US study showed that 52% of men aged 40-70 experienced some degree of erectile dysfunction (ED), while 10% experienced complete erectile dysfunction.[2] Premature ejaculation is also common, affecting up to 40% of men[3] while hypoactive sexual desire affects 15%.[4]

We know men consult doctors less frequently than women do.[5] Reasons include busyness and lifestyle stress, but also embarrassment, reluctance to admit to problems, and fear. Sexual problems carry a particular taboo. Visiting a doctor about a sexual problem not only introduces an embarrassing topic but acknowledges that all is not well in the bedroom. This can feel like an admission of guilt, failure or weakness, or even a threat to one's masculinity. There is also a common belief that nothing can be done anyway.

Changing times

The advent of the contraceptive pill and the legalisation of abortion in the 1960s have led to a radical change in attitudes towards sex and relationships. In 1960 the marriage rate for men was 62 per 1,000 (62 out of every 1,000 single men married each year). This had dropped to 28 per 1,000 by 2000. By contrast the divorce rate in 1960 was 1.7 per 1,000 married men, rising to 12.7 per 1,000 by 2000.[6] The age at first marriage has also risen. People are more likely to have sexual relationships before marriage and to start new relationships at various stages of life.

The advent of Viagra

Viagra (sildenafil) celebrates the tenth anniversary of its British licence this year. Previous therapies were unappealing, ineffective, or little known. Some unlicensed therapies were helpful, while recreational drugs were often used to enhance performance. *Viagra*'s arrival made a big splash; seductive advertising in the medical press was paralleled by provocative headlines nationally. People became aware not only that erectile dysfunction was common, but something could be done about it. That something could be as simple as taking a tablet obtained on prescription.

On the one hand was a sense that 'everybody's doing it', yet on the other the taboo remained. To obtain *Viagra* a man had to admit to his doctor there was a problem. Fuelled by demand, many private clinics and providers sprang up, and the internet became a common source of supply. The blue diamond-shaped tablet became recognised across the globe, a symbol of sexual freedom and rejuvenation for men, as the contraceptive pill had been for women. A problem which had been hidden under the bed-clothes for years suddenly came into the limelight and competitors brought other oral treatments onto the market.

So what's the problem?

Christian doctors will meet a range of men requesting *Viagra* or similar treatments, or asking for help with sexual problems. Each man will have his


Photo: PA Photos

own situation. Some will be married, some cohabiting, some in a new relationship, some having an affair. Some will be in homosexual partnerships. Some will be engaging in casual sex. Some may even be perpetrators of abuse.

So what is the dilemma? Is there a dilemma at all? Is erectile dysfunction purely a medical problem which needs to be managed with the best available treatment, whatever the context? Or is there an ethical and moral dimension too?

A holistic approach

By its very nature, a sexual problem has several dimensions. Erectile dysfunction is not merely the inability to achieve an erection. Emotionally, it often causes anxiety and loss of self-esteem, and socially, it affects the man's relationship, often leading to awkwardness and insecurity. The partner's response may be loving and accepting, or there may be tension and arguments. The security of the relationship may become conditional on the man's performance. Erectile dysfunction may not only be the cause but the manifestation of emotional problems, relationship difficulties, or spiritual issues such as guilt.

As doctors we need to explore not only what is happening physically but what is happening emotionally, socially and spiritually. Is the relationship compatible with the patient's value system, or is it a source of guilt? Is it a healthy relationship? Is there pressure to have sexual intercourse? We may be able to tease out other issues which need addressing. There may be a mental health problem which requires treatment. There may be issues which would be helped by counselling. There may be problems within the relationship which need to be tackled, possibly with the help of a third party such as *Relate*.[7] The man may need to think carefully about whether he is in the right relationship.

Biblical considerations

Having explored these issues, the problem may persist and we have to decide: are we going to prescribe or not? What would God have us do in these situations? In the Bible we read that sexual intercourse is given by God to unite a man and a woman within marriage: 'For this reason a man will leave his father and mother and be united to his wife, and they will become one flesh'.[8] The Ten Commandments forbid adultery,[9] and both Jesus[10] and Paul[11] endorse this. Does this mean we should decline to prescribe *Viagra* and the like to men who are not married?

We know many of our patients have different beliefs, and hence different lifestyles, from our own. Jesus taught we should not judge others.[12] He demonstrated this with the woman caught in adultery, but then told her to 'go now and leave your life of sin'.[13] Paul specifically taught that we should not judge those outside the church.[14] The GMC guidelines on *Personal Beliefs and Medical Practice*[15] state that we should not impose our personal beliefs on patients, nor should we allow our beliefs to prejudice their care. But we are required to obey God rather than men.[16]

The dilemma is this: is a prescription in certain circumstances tantamount to condoning sin? Or does failure to prescribe constitute passing judgment?

No easy answers

There are no easy answers, and the decision will ultimately be a matter for each doctor's conscience.[17] It will also depend on the individual situation. For a man in a consenting adult heterosexual relationship, it could be argued we should respect his lifestyle choice and provide treatment for his medical problem. We could argue that those in long-term relationships are living 'as if married' and should be treated as such. While most Christians would view homosexual partnerships as wrong,[18] we must be careful not to judge the couple. And we must be aware of GMC guidelines and recent legal changes on discrimination. Where we feel unable to prescribe, patients are entitled to a second opinion if they are unhappy with our decision.

We also have a duty to protect both our patients and others. Somebody requesting *Viagra* for a series of casual relationships is putting his physical and emotional health at risk, and may spread sexually transmitted infections to others. Somebody having an extramarital affair is harming his wife. One would have strong grounds for saying 'No' in these situations. A man having intercourse with a minor of either sex is acting illegally, and we should take appropriate action.

Whether or not we eventually prescribe in these situations, we may be able to introduce some of God's values within the consultation. One useful question is 'How important is sex within your relationship?' This gently challenges the assumption that it is all-important. Encouraging couples to shift the focus away from sex and to spend more time talking or enjoying each other's company in other ways can be helpful. It may be necessary to challenge the attitude of a partner whose love has become conditional on sexual performance.

Affirming sex within marriage

Finally we turn to the case of married men with erectile dysfunction. Often they are more reluctant to come forward and discuss their problems. Yet here we need to affirm God's gift of sex within marriage,[8] encourage them to talk, and at least to consider therapeutic options. We need to communicate that this is an important issue worth exploring.

Conclusion

Men's sexual problems are common, and present in various scenarios. While we should uphold the Bible's teaching about sex within marriage, we need to respect our patients and not to judge. Individual doctors will draw the line in different places about prescribing medication for erectile dysfunction. In all situations, we should bear in mind our patients' emotional and spiritual needs as well as their medical ones, and also the wellbeing of other parties.

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Photos: PA Photos

A symbol of sexual freedom and rejuvenation for men, as the contraceptive pill had been for women

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Steve Fouch on restoring primary care for failed asylum seekers

Photo: PA Photos

Winning a care fight

key points

Seeking to stamp out 'health tourism', the government in 2004 consulted about denying access to primary health care for failed asylum seekers.

CMF made a formal Submission, arguing this would produce an unacceptable professional dilemma between responsibilities to the GMC and to law, had ethical and legal flaws, raised serious public health concerns, and conflicted with clear biblical principles.

Nothing was heard until 2008 when campaigning group *Medsin* published the previously concealed responses to the government consultation. The Department of Health finally withdrew all plans to exclude failed asylum seekers from primary care.

In August 2004 CMF was approached by a member about a government consultation on denying access to primary care for failed asylum seekers.[1] This followed the Department of Health ruling in April 2004 that those classed as 'not lawfully resident' in the UK, including vulnerable migrant groups such as those whose claims for asylum had been rejected, were no longer eligible for free NHS hospital care.[2] Although this decision was overturned by a judicial review in April 2008,[3] the government was evidently working towards excluding from all but emergency healthcare all those who had failed asylum claims (or had appeals pending).

The reasons for this are not clear, but it seems in part to have been about stopping so-called 'health tourism', ie non-UK nationals seeking residence in the UK in order to access free healthcare. However, in the process, this proposal would also have left no recourse to even basic primary healthcare to a vulnerable group of people, already without access to housing, work or benefits. Along with a number of organisations and several individual CMF members, CMF responded corporately, strongly expressing concern about these proposals. We raised objections in several areas:[4]

Professional objections

The first line of the General Medical Council's *Duties of a Doctor* is 'make the care of your patient your first concern'.[5] By requiring doctors to determine who is eligible to be treated, these proposals would require GPs intentionally to withhold treatment in order to check a patient's eligibility, thus putting them in breach of *Duties of a Doctor* and therefore liable to a charge of serious professional misconduct by the GMC. Conversely, if they observed the GMC's requirements they would be in breach of the law. This created an unacceptable professional dilemma.

Ethical and legal objections

Asylum seekers' primary reason for coming to the UK is to seek refuge from difficult situations in their home countries – persecution, war, threat of death or unjust imprisonment, etc. Exact figures are uncertain, but there are probably more than 40,000 failed asylum seekers, scattered throughout the UK.[6] This is a significant community, and includes the elderly, pregnant women, children, and people with a variety of chronic or infectious health problems. The current regulations mean that these people are not entitled to housing, benefits, or work, thus making them very likely to be living in poverty,

Photo: PA Photos

in poor and overcrowded housing, or on the streets.

Furthermore, it is questionable whether failed asylum seekers are not 'ordinarily resident' in the UK – the legal foundation upon which the denial of access was to be based. The case for the existence of 'health tourism' has not been proved,[7] so we questioned firstly why these proposals were being considered at all, and secondly what was the legal basis on which failed asylum seekers were being included within the proposals? This point was upheld in the judicial review by Mr Justice Mitting in April 2008, which found failed asylum seekers to be 'ordinarily resident' and thus eligible for free NHS hospital care.[8]

In terms of international law the proposals were also highly questionable, as the government would be violating the right of failed asylum seekers to the highest attainable standard of health, as guaranteed by the International Covenant on Economic, Social and Cultural Rights.[9]

Public health objections

Children were not explicitly mentioned in the proposals. Denying access to primary care would mean a growing population of potentially unimmunised children – with all the implications this would have for levels of 'herd immunity' for common childhood diseases in the general population.

Furthermore, there were serious concerns raised about infectious diseases, particularly tuberculosis and HIV/AIDS. If failed asylum seekers were denied access to primary care, the chance to detect such conditions early would be lost. This could increase public exposure to individuals with infectious TB, and mean that it would only be detected in the later stages when it required emergency treatment. Full access to primary care serves a far more effective public health function than specialist treatment facilities, is better for the patient, and is likely to be more cost-effective.

Biblical objections

The Bible acknowledges the detrimental impact of being forced to leave one's country.[10] Large parts of the Old Testament deal with the reality of exile and being a refugee. The Pentateuch in particular consistently affirms that God's people have a duty towards the foreigners in their midst.[11]

As Christians we believe we have a particular responsibility, duty and privilege to care for the vulnerable and those who are in need, as if they were Jesus himself.[12] He himself was a refugee.[13] Surely our duty must include those in our country who have fled their homeland, and whose status as asylum seekers ('failed' or otherwise) renders them particularly vulnerable?

Therefore any steps that force us as Christians and as doctors not to treat or care for vulnerable people, such as failed asylum seekers, cannot be seen as righteous or just. We thus have a duty to stand up and speak out on their behalf.[14]

What happened to these protests?

After making these arguments, we heard nothing further for almost four years. However, early in 2008, we were contacted by Medsin,[15] a campaigning group of medical students who had been trying to find out what had happened to the proposals. Applying under the Freedom of Information Act, they had been denied access to the results of the consultation, so were now approaching those organisations who had been involved with the consultation for permission to publish their responses.

When they published their findings[16] it was apparent that almost everyone consulted had raised the same sets of objections and deep concerns about the proposals as had CMF.[17] Consequently the Department of Health finally and publicly withdrew all plans to exclude failed asylum seekers from primary care this October,[18] although they are still appealing the judicial review on secondary care.

The encouragement for all of us is that if we raise our voices together, we can successfully challenge unjust legislation and policies.

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A keynote lecture by **John Wyatt** on opportunities and threats in healthcare

Serving Christ in the workplace

key points

Addressing 600 doctors, dentists and students from 60 countries, the speaker reviewed the history of mission but emphasised that we are Christian physicians at this particular time in world history. He saw four aspects to the workplace: two bad news, but two good.

The bad news aspects are that the workplace is a place of pressure – from covenantal care becoming contractual, from unlimited demands, and from the state; and it can be a place of various dangers.

The good news is that the workplace is also a place for witness at a time of unprecedented global communication, and a place for showing *agape* love, which never fails.

The pioneer missionaries of the Christian church were motivated by a vision: a dream of a worldwide church in which people from every nation and tongue would gather together in unity. They sacrificed their lives in the hope that this vision would become a reality, yet their eyes never saw it.

Henry Martyn laboured to learn more than 15 languages so that he could translate the scriptures. He then spent months on dangerous voyages to Asia and beyond, before dying at the age of 31, exhausted and broken. William Carey gave everything he had to travel to India, and devoted his life to the establishment of an indigenous Christian church, while thousands and thousands of unknown missionary martyrs have sacrificed their lives taking the good news of Jesus Christ to lands that have never heard it.

Now, perhaps for the first time in history, our eyes are privileged to see what they never saw. Because of their labours, their sacrifice, and their vision, the worldwide church has become a living reality, a tangible demonstration of God's power and reality in a cynical age. God has called us to serve him as doctors in this particular time of world history, in a particular national and global context.

Faithful to Christ in the workplace

God could have called you to be a physician in the early church, trained in the Hippocratic medicine of the time, using your skills to support the disciples. He could have called you to be a Christian physician in the Middle Ages, when great plagues where sweeping through Europe and conscientious physicians carried a terrible risk of death in the course of carrying out their duties. He could have called you to work at the time of the great missionary movement in the 19th and 20th centuries, when thousands died from malaria and other tropical diseases, and the average life expectancy of medical missionaries in Africa was six months. But, instead, God has called you to be a Christian physician now, at this particular time in world history. We thus have a duty to try and understand what is happening in our world, and to be faithful to Christ in the place he has chosen to put us.

In the UK alone doctors will find themselves working with different resources in a variety of settings, from the technologically advanced environment of critical care departments, to small general practice clinics. Yet four themes are common to many workplaces; two are bad news, but the other two are good news.

1. A place of pressure

Covenant becomes contract

Across the world, medicine is progressively being transformed from a profession dedicated to patient care to a modern service industry, with consequent economic pressures. In the past a doctor had a personal covenant with the patient – a relationship

of trust, confidentiality, and commitment. Of course this ideal often fell short, but it was a context in which many Christians found it easy to follow their vocation to serve Christ.

However, in a service industry the personal covenant is superseded by a legally binding contract and patients are replaced by 'healthcare consumers'. In place of open-ended commitment, we have targets to meet – case throughput, minimum waiting times, and financial targets. In place of a relationship of trust, we have annual appraisal, disciplinary hearings and complaint procedures.

Not all of this is bad, but the trend is transforming the nature of the workplace into a place of pressure, where conformity is demanded. In a highly regulated setting such as the modern hospital the person who stands out, for example the physician with a conscientious objection to a particular procedure, is a problem. In some workplaces the Christian may be seen as divisive, intolerant, judgmental and anti-social.

Unlimited demands

These also cause pressure. The needs are endless and the expectations of patients and managers are often unrealistic. There is a bottomless pit of demand for care and professionals may find themselves trapped like rats.

The 18th century Enlightenment promoted the idea that human rationality and science without religion could lead to world peace and harmony. Such thinking lies behind this demand trend in healthcare. The future is viewed as a product of human ingenuity, which we create by our actions. This leads to relentless pressure – we can never stop because otherwise the future will fail, the building will go wrong.

But this is a delusional way of thinking. The truth is that we cannot create the future; it is held in the providential purposes of the God of history. We are called to make wise choices, and these will have certain consequences downstream, but the future is not ours to create, nor does it depend on us.

We see this in the sign of the Sabbath, the seventh day of creation when God rested or – more literally – 'stopped' from the work of creation, to celebrate and enjoy what had been achieved. He gives us the Sabbath as a reminder that we too can cease, stop from our work, and celebrate, confident in the knowledge that God is in control of the future.

Pressure from the state

In the UK the government is increasingly seeking to take control of medical regulation, instead of allowing the profession to set the standards and ensure they are met. This is an ominous trend, but nothing new. On many occasions in the past the state has tried to pervert medical practice in ways which are unhealthy. Consider for example Stalin or the Nazis. The methods may be different today – it is more subtle and more humane – but it may ultimately be just as damaging.

In biblical thinking the state can be an ally: God's servant to execute judgement on evildoers. However, by the time we come to the book of Revelation, the state has become the enemy, the focus of satanic opposition to God's people.

So we should not be surprised to find ourselves under pressure, but at the same time we must remember in whose hands the future is held. In the words of the psalmist: 'The kings of the earth take their stand and the rulers gather together against the Lord and against his Anointed One…The one enthroned in heaven laughs, the Lord scoffs at them. Then he rebukes them in his anger and terrifies them in his wrath, saying "I have installed my King on Zion, my holy hill."' [1]

2. A place of danger

The dangers in the workplace vary. For some there is direct opposition: even in the UK, Christian doctors have been criticised and even suspended from work for speaking about Christ to their patients, whilst others have been referred to the General Medical Council for expressing their beliefs about abortion.

I think this trend is likely to continue, but we must remember Jesus' words: 'Blessed are those who are persecuted because of righteousness, for theirs is the kingdom of heaven. Blessed are you when people insult you, persecute you and falsely say all kinds of evil against you because of me. Rejoice and be glad because great is your reward in heaven…' [2]

But there are also other, more subtle, risks in the workplace. The risks of materialism, of too much money or power, are corrosive and dangerous. Like the weeds that strangle the good seed, materialism can strangle our Christian commitment and witness, squeezing us into the world's mould.

There is also the risk of excessive work, fatigue, and burn-out. I think that very often it is Christian doctors, filled with a sense of vocation and duty, who are most at risk of burn-out. We are limited and frail, and so we have to learn to live within the boundaries of our humanity – the way that God has made us. This means taking adequate opportunities for rest, as well as bearing one another's burdens.

Our frailty is part of God's design. He could have chosen to make us like angels – strong, resilient, and powerful – but, instead, he had a different plan: he chose to put the reflection of his character in a being made from dust. Because we are made out of dust, we are frail, vulnerable and dependent. We are *designed* to be a burden to others.

You came into the world totally dependent on the love and care of others, and most of us will end our lives totally dependent on the love and care of others. This is not a terrible evil reality, but part of the design. The apostle Paul tells us that we should 'bear one another's burdens and so fulfil the law of Christ'. [3] Many of us need to learn this lesson again in the world of healthcare.

Four themes are common to many workplaces; two are bad news, but the other two are good news

3. A place for witness

The workplace is where we are called to be witnesses. We are not just witnesses to ethical principles or godly ways of practice; we are called to witness to a person, the Lord Jesus Christ.

We are called to be salt and light, preventing corruption and decay, and shining truth into dark corners, making evil apparent. However, as physicians we have a further special privilege – the privilege of being a carer. Because we are physical beings, we need physical hands to care for us, and this is our role as Christian carers – effectively to show God's love 'with skin on'.

Christian health professionals have had a special place in the spread of the good news about Christ in the 21st century. Church historians point out how the Gospel came at a very unusual and particular time in world history. The long period of relative peace military force established during the time of the Roman Empire is often called the *Pax Romana*. Unusually, it was a time when it was possible to travel freely within Europe, with common trading standards, a common currency, and common languages.

The good news about Jesus was dropped into this era and spread like wildfire. However, according to historians, Christianity primarily spread via the trade routes; not by specialised evangelists, but by ordinary Christians going about their jobs.

Since the collapse of the Roman Empire, there has been no similar global empire until now. Over the last 20 years we have seen the rise of a new global reality, the power of globalisation. We see similar features to the *Pax Romana*: global peace maintained by military alliance, free travel and communication, common trading and legal standards, currencies, languages, etc. This time it is even more powerful than before: the Roman Empire had an amazingly good postal system, but it had no internet.

4. A place for love

Christians invented the word *agape* to describe the special kind of love that was distinctively Christian. One of the roots of the word is the concept of respect, so *agape* is 'respect love', or love that gives itself in service to another.

Importantly, *agape* love respects the other as equal in dignity. *Agape* love says 'we are both human beings. You are special, and I am here to respect you because you are unique.' It is by showing this love to our patients that we demonstrate the reality of the unseen Gospel and Christ's presence in our midst.

Agape love also points towards the future hope of a new creation. When we love someone in the present, showing practical, empathic, respectful, sacrificial caring, we are also pointing to the future, to the hope of the resurrection. We are treating someone now in the light of what, by God's grace, they are going to be.

Christianity primarily spread via the trade routes; not by specialised evangelists, but by ordinary Christians going about their jobs

From the apostle Paul we learn that although tongues will fail, prophecies will become unnecessary, and partial knowledge will become complete, the acts of genuine *agape*-love, those acts that demonstrate Christ-like caring here and now, will in some mysterious way become part of the new heaven and the new earth. Love 'always protects, always trusts, always hopes, always perseveres. Love never fails…'[4]

This is the time in world history that God has called us to serve him. We are seeing a new phase in the growth of the Christian faith, and we are called to play our role in this big picture. It is by being the hands of Jesus, the presence of Jesus in our hospitals and clinics, that we can be part of this wonderful worldwide ministry.

John Wyatt *is Professor of Ethics and Perinatology at University College London*

This article has been edited from his keynote address given at the recent ICMDA Europe-Eurasia conference at Schladming, Austria – Resources [Un]limited

references

1. Psalm 2:2, 4-6
2. Matthew 5:10-12a
3. Galatians 6:2
4. 1 Corinthians 13:7,8

eutychus

NHS our religion?

Diamond celebrations are past, but 'The National Health Service is the closest thing the English have to a religion' (Nigel Lawson 1992) remains relevant. In 1976 Barbara Castle said the NHS was 'the nearest thing to the embodiment of the Good Samaritan that we have' while by 1999 Julia Neuberger was more reflective: 'Like theological belief, belief in the NHS rests on assertions, apparently revealed truths – and woe betide those who try to say otherwise'. Eutychus most enjoyed J B S Haldane's 1964 'Thanks to the nurses and Nye Bevan, The NHS is quite like heaven'. (*BMJ* 2008; 337:26)

Stem cells and humour

While work on induced pluripotent stem cells advances apace around the world, another possible source of embryonic-like stem cells caused Professor Robin Lovell-Badge of the National Institute for Medical Research to joke. A project at King's College London had used 22 samples from testicular biopsies or medical castrations and had derived pluripotent cells. The professor commented 'An answer to how these...cells can be used will have to be left dangling a little longer'. (*http://news.bbc.co.uk/1/hi/health/7659120.stm*)

Sperm and consent

A woman is battling to use sperm taken from her dead husband. He died unexpectedly during routine surgery in 2007, and sperm obtained *post mortem* is now stored. Because the law only allows sperm to be used with written donor consent, she went to court to seek permission for use. The judge ruled 'I am not satisfied that it is possible to lawfully remove, or authorise the removal of gametes (sperm or eggs) from a dead person, who has not given an effective advanced consent to this'. The HFEA welcomed the ruling, which confirmed their decision. (*http://news.bbc.co.uk/1/hi/england/7659430.stm*)

IVF births up

The world's first IVF baby, Louise Brown, turned 30 this year, and latest IVF statistics show more successes than ever. In 2006 there were 10,242 births resulting in 12,596 babies, a 13% rise on the number of births the year before. Success rates per treatment started rose to 23%, while in 1992 when the regulator started collecting data the live birth rate was 13%. These statistics were announced as the HFEA launched its 'Find a Clinic' website. (*http://guide.hfea.gov.uk/guide*)

Cyclebeads – natural family planning

UNFPA, the United Nations Population Fund, has perhaps belatedly supported a form of natural family planning with the launch of 'Cyclebeads'. These consist of a string of plastic beads, each colour-coded to represent a different day in a woman's menstrual cycle. The day she starts her period, she puts a rubber ring on a red bead and then moves it forward following an arrow, one day at a time. She can thus confine intercourse to days of low pregnancy likelihood. (*www.unfpa.org/news/news.cfm?ID=1111*)

Assisted suicide in Spain?

The Spanish health minister announced that end of life care is due for an overhaul, and that legalising assisted suicide might be proposed. His comments appeared in an article headlined 'Your body is yours – that is socialist' and included 'Spain may end up with legislation similar to that in Switzerland or the Netherlands'. A spokesman for the opposition Popular Party said 'The Socialists have renounced palliative care. They don't talk any more about a dignified death: they talk about assisted suicide.' (*BMJ* 2008; 337:a1697)

The Grim Reaper's road map

Staying with death, but natural death this time – ghoulishly titled to attract attention, an atlas of mortality in Great Britain has been published. Sheffield and Bristol University researchers analysed almost 15 million death records from 1981-2004 to depict geographical variations. Eutychus notes that death, like Time, is often shown with a scythe... (*BMA News* 2008; 25 October:6)

Homoeopaths on the warpath

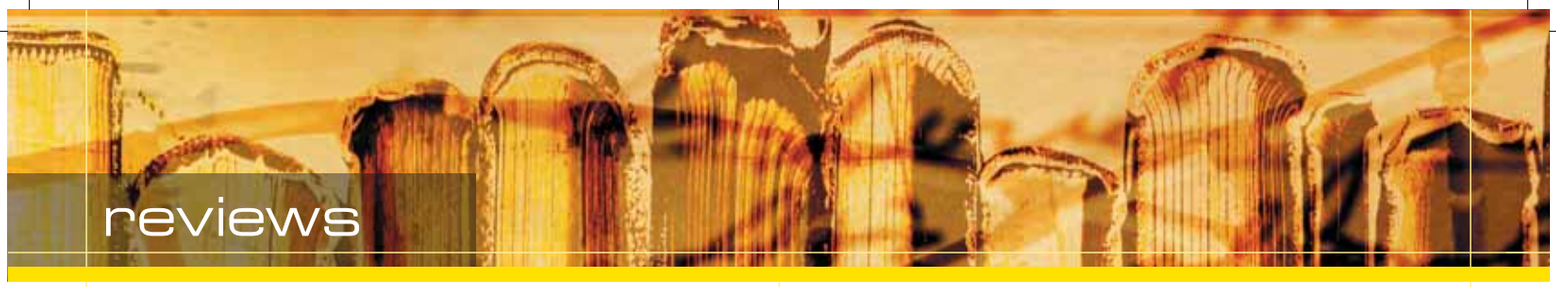
The *BMJ* published a letter from Edzard Ernst, professor of complementary medicine at Peninsula Medical School, complaining that since his book critically evaluating the evidence for homoeopathy and other alternative treatments had come out, 'UK homoeopaths have been engaging in an elaborate campaign of multiple letter writing, repeatedly invoking the Freedom of Information Act to harass and silence me. This letter shows that they have failed.' Ernst continued 'What is at stake here is our right, I would argue our duty, to speak out against misleading claims and dangerous concepts. We should find ways of protecting ourselves against such enemies of reason.' (*BMJ* 2008; 337:a2063)

Can faith in God relieve pain?

The *Daily Telegraph* reported Oxford University research that gave electric shocks to 12 Roman Catholics and 12 atheists as they were having their brains MRI-scanned and as they viewed Sassoferrato's 17th century religious painting *Virgin Mary* and da Vinci's 15th century secular painting *Lady with an Ermine*. The Catholics reported 12% less pain with the former, and the scanner indicated engagement of neural mechanisms of pain modulation. Neither painting had any such effect on the atheists. Eutychus remains sceptical about any grand conclusions and wonders how Protestant volunteers might have fared. (*www.telegraph.co.uk/news/newstopics/religion/3096743/Belief-in-God-really-can-relieve-pain.html*)

Getting it out of the system

In an article exploring why so many doctors became famous writers (Conan Doyle, Chekhov, Keats, Somerset Maugham) Erin Sullivan, who helps teach the MA in history of medicine at UCL, is reported as suggesting writing may be an outlet for the emotions doctors confront professionally. 'Medicine is now part of the sciences, but it still has a lot to do with people, and how they make sense of events in their lives.' What a privilege medicine is. (*BMA News* 2008; 4 October:15)



reviews

Good to Great and the Social Sectors

Jim Collins

- Random House 2006
- £6.99 Pb 37pp
- ISBN 1 9052 11 32 5

Being Strategic about Leadership: *the principles that work in God's world*

Jill Garrett

- Christian Research Leadership Lecture 2006
- £2.50 Pb 16pp
- ISBN 978 1 85321172 0

These two papers are worth reading together. Jim Collins, a non-Christian and author of a larger volume on business management entitled *Good to Great*, has written this monograph specifically for managers and leaders in non-profit organisations. Jill Garrett, in a Christian Research Leadership Lecture delivered in 2006, refers to Collins' work and her own recent research which demonstrates that biblical principles are best practice for leaders and managers in both business and non-profit organisations such as charities and churches.

Thriving organisations have selfless leaders, who are primarily ambitious for the cause they work for rather than for themselves. They have a clear focus on 'what we do best and are passionate about' and do not allow themselves to get distracted by other worthwhile things; just as Jesus, who could have fed or healed many more people, fixed his eyes on Jerusalem and Calvary. Selfless leaders enable each team member to contribute their best to the organisation for the sake of those it serves, akin to 'enabling the saints for works of service', and they rise above circumstances by creating pockets of greatness in the context of systemic constraints (such as the NHS!) through conscious choice (commitment) and discipline.

Other practical points are considered, such as the need to develop 'brand' reputation (demonstrating the fruits of the Spirit), and the importance of getting the right person (vocation) in the right place (functioning as a body). It is worth being rigorous when appointing personnel as once the wrong person is in place it is usually much harder to get them out!

The leader's behaviour has a powerful effect for good or ill. In one project 5,000 people were asked 'What would inspire you to follow someone?' and disturbingly one third of them said they had never worked for an inspirational leader. In a poll of 1,000 people who had left their jobs, 70% said they had not left their company but they had left their manager. Organisations thrive when the leader is humble, willing to acknowledge a mistake, quick to praise others, and works to develop a succession team who will take the organisation on further.

If you're keen to apply Christian principles in any Christian enterprise, wanting to avoid pitfalls and ready to learn practical tips, these short booklets are well worth the hour they take to read.

***Kevin Vaughan** is CMF Head of Graduate Ministries*

Bound with Love

Letters Home from China 1935-1945

Edited by Audrey Salters

- Agequod Publications 2007
- £12.50 Pb 360pp
- ISBN 978 0 9557536 0 2

The story of a mission doctor and his family living in inland China during a very disturbed period is told in a series of letters sent home by both husband and wife. Edited by their daughter, who was born in Japanese-occupied China, there are passages interposed to explain the historical and political background of the time.

In a homely fashion one learns of the challenges of living in a very different culture: learning the language, obtaining supplies, and bringing up children in poor hygienic and dietary conditions, especially when latterly interned by the Japanese. Extended separation from family and home church, in their case for ten years, emphasises the blessings and difficulties of communication and the joy of receiving practical gifts even when sometimes they were inappropriate. There are details of medical and surgical problems, many of which were war-related. We are told of the long tradition of Chinese medicine but that hospital care only arrived with the Christian missions. As a historical down to earth document of practical living for Christ in difficult circumstances it is fascinating, and should be of great interest to anyone with a concern for, or preparing to work in, outback Asia or similar situations.

***Arthur Wyatt** is a retired surgeon who frequently visits China*

Carry the Spices

Chua Choon Lan and Tan Lei Yong (eds)

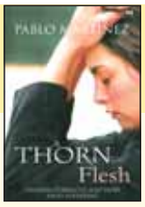
- Medical Missions Foundation, Singapore
- No price quoted. Pb 259pp
- ISBN 978 981 05 9220 2

Anyone interested in medical missions and every would-be medical missionary should read this splendid book. Its 28 short chapters (each with evocative colour photographs) carry the first-hand accounts of some two dozen Singaporean medical missionaries and their families over the last 40 years. It is a reminder to any European or North American missionary of how the cutting edge of cross-cultural missions has shifted to Asia, Africa and South America and that some (often the majority) of their colleagues will be from these regions.

The setting is fresh and contemporary; the principles familiar: personal conversion is essential before service can be contemplated; prayerful parents and wise pastors prepare the way for sacrificial choices; pride is an ever-present snare for the would-be servant of the Lord; the pathway of preparation is often long and tortuous, but God is faithful; issues of culture shock – and reverse culture shock – affect us all; and finding the right path for children's education is never easy.

There are accounts from Asia and Africa; from surgeons, public health teachers, dentists and doctors who were led into full time pastoral ministry. Highly recommended.

***Peter Pattisson** was formerly a medical missionary in East Asia*



A thorn in the flesh: *finding strength and hope amid suffering*

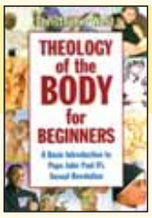
Pablo Martinez

- InterVarsity Press 2007
- £7.99 Pb 192pp
- ISBN 978 1 84474 188 5

Some people claim to have lost faith in God because he did not answer their fervent prayers for healing. Pablo Martinez, Christian psychiatrist and Bible teacher, reveals how prolonged suffering can instead enhance a relationship with God as the sufferer learns to stop futile (though not purposeful) fighting and discovers 'the supernatural antidote of grace'. Godly grace gradually enables those undergoing the sorest trials to display patient acceptance – 'the best "sermon" that we can ever preach'.

Pablo openly tells of his own protracted, distressing eye disease and intermittent surgery. The 'thorn' of his title refers to anything similarly painful, limiting, humiliating and prolonged. He illustrates how God can provide a way out by helping the sufferer to look for and then accept *his* perspective on the problem. With prayerful support, reflecting on biblical examples, especially that of the Lord Jesus Christ himself, will in time take us beyond the suffering to find what it can achieve. Pablo's own painful journey has through God's grace produced a pearl. This book will enrich sufferers and carers alike.

***Janet Goodall** is a retired paediatrician in Stoke-on-Trent*



Theology of the Body for Beginners

Christopher West

- Ascension Press 2004
- $11.99 Pb 151pp
- ISBN: 1 932645 34 9

Broken families, abortion, AIDS, internet pornography, clergy abuse, homosexual 'marriage': church and world are in a profound sexual crisis. Is there a way out? For such a time as this have we been given Pope John Paul II and his 'theology of the body'. Based on the words of Jesus, his reflections on the body and sex take us to the root of the modern crisis and chart the path to authentic sexual liberation. Yet the Pope's profound scholarship often intimidates the average person.

Christopher West therefore provides a short summary of this revolutionary teaching. I love his book because he speaks the truth in love, proclaiming clearly and fearlessly, yet with gentle tone and effortless humour. Moreover, it's for our healing and redemption, rather than condemnation.

God created us male and female because in essence our sexuality is an icon: the physical represents divine truth. The ultimate purpose of marriage is to point to the infinitely deeper union within the Godhead, and between Jesus and the Church. Sex should therefore be revered and held in high esteem, not grasped at grubbily. If sexual sin is a problem for you, read this book. If not, read it anyway, better to minister to those who struggle in this area.

***Charlie Vivian** is an occupational medicine consultant in Cheltenham*

Complementary and Alternative Medicine *Should Christians be involved?*

Robina Coker

- CMF 2008
- £8.00 Pb 137pp
- ISBN 978 0906747384

In a climate where alternative medicine has become increasingly popular, Dr Coker's substantially revised version of her 1995 book seeks to explain the range of therapies that now exist and to suggest ways to handle patients and relatives who may request advice on such issues.

A good overview analyses the different practices critically, both from medical and Christian perspectives, and the level makes it extremely accessible to non-medics. There are discussion points at the end of each chapter that could be used in small groups (work- or church-based) and an invaluable A-Z chapter which outlines the basic principles of a number of available therapies – very useful when a patient asks your opinion on a therapy you have never even heard of!

A variety of case studies is included, which help us as doctors to consider how we would respond to different scenarios. The book is a very flexible and useful resource, especially for those in general practice, providing practical information and also helping us to think through some of the issues before being confronted with them in surgery. It could easily be shared with interested patients and church members.

***Abi Crutchlow** is a psychiatry trainee in Surrey*

Foundations for Medical Ethics

Sean Doherty

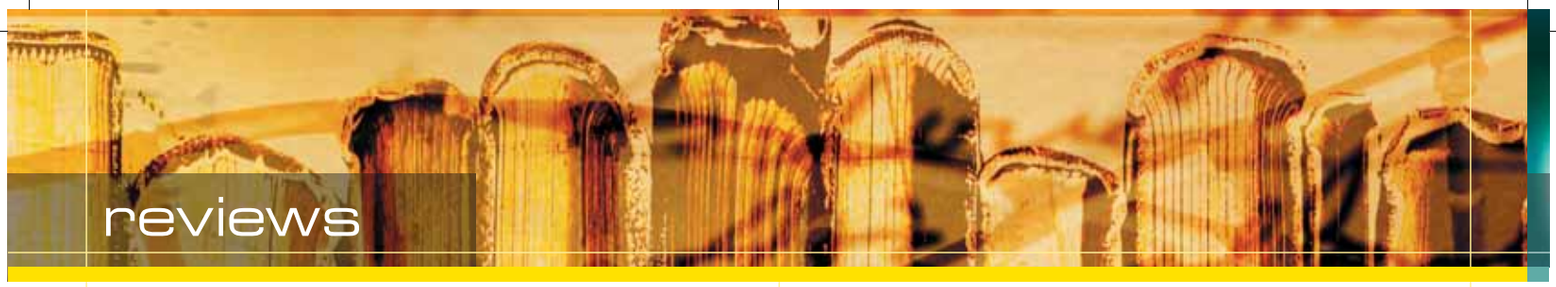
- Grove Books 2007
- £2.95 Pb 28pp
- ISSN 1470-854X

Most Christian medical ethics books on the market are written by clinicians, aiming to provide biblical answers to tricky issues. Sean Doherty's thought-provoking booklet starts from a different premise. Doherty is an Anglican curate and has led a medical ethics course for undergraduates, which formed the basis of the book. Rather than tackling particular issues, he aims to set out relevant theological issues and apply these to the medical world.

In five short chapters, he begins by setting out the fundamental assumptions that shape the background of contemporary medicine. Although the booklet is not extensively referenced, the first chapter addresses humanity's quest to overcome our limitations, as well as the rise of consumer-driven practice, where the role of the doctor is largely to fulfil the patient's desires. He goes on to describe the goodness of creation, and how suffering originated, before exploring how creation will be redeemed. The final chapter examines how we should think about health and healing today.

This pamphlet is unlikely to provide answers about specific ethical issues, but Doherty's approach is refreshing, and he raises many questions about the medical project which are worth reflection.

***Helen Barratt** is an academic clinical fellow in public health in London*



reviews

Using the Bible in Christian Ministry
A workbook
Stephen Pattison, Margaret Cooling, Trevor Cooling

- Darton, Longman and Todd 2007
- £14.95 Pb 160pp
- ISBN 0 23252 6818

This book arose out of research between the Bible Society and Cardiff University. It aims to enable those in pastoral ministry to use the Bible more effectively. Workbook style, it gives opportunity for reflection and group work. Two strong features emerge. It helpfully acknowledges that our tendency to respond to our circumstances sinfully is fundamental in every pastoral issue. Our preconceptions, about when and where biblical input is appropriate, are also challenged. There are novel suggestions as to how this might be done sensitively in various contexts.

There are weaknesses though. It tries to be non-prescriptive, leaving readers to reflect on their own views. This approach, in a book that aims to encourage people to *use the Bible* in Christian ministry, is somewhat surprising! Secondly, it merely hints at how the gospel provides an overarching approach to pastoral care. However, pastoral carers desperately need detailed guidance on this subject.

If you are looking to review and challenge your practice, then this book is a good place to start. Look elsewhere though for practical help on interpreting and applying the Bible to pastoral situations.

***Jason Roach** is medically qualified and training to be an Anglican minister*

Healing for the Wounded Life
How to Understand Your Illness and Find Biblical Solutions
John Gordon

- Thankful Books 2007
- £9.95 Pb 256pp
- ISBN 978 1 90508 410 4

Dr Gordon is a devout Christian clinician who lets God into every aspect of his professional practice, and then offers the fruit of his deep reflections. His scholarly book will repay careful study on many different levels: as a guide for Christians struggling with health issues, as a guide and reference for practitioners such as hospital chaplains, and as a basis for Bible study groups.

He reiterates the link between truth and health; that there is no way to the Father except through Christ; and that the essence of recovering health is accepting Jesus as personal Saviour, repenting, and being guided by the Holy Spirit. These are familiar phrases, but this book gives exemplars and biblical references to help us appreciate when they may be operating in our lives.

I did not find it an easy read, mainly because the author's reach is so wide and his grasp so thorough. This meant engaging in several different ways, which I found I could not do all at one reading. This level of engagement needed may put off many who would benefit. Alternatively, the work could be presented as several books to make it more palatable to a popular audience.

***Margaret Whitelaw** is a psychologist and member of BACIP*

Gay Children, Straight Parents
A plan for family healing
Richard Cohen

- Intervarsity Press USA 2007
- $12.00 Pb 233pp
- ISBN 978 0 8308 347 2

This book offers psychotherapist Richard Cohen's advice from his personal experiences to families who have a homosexual son or daughter.

My husband and I are parents of a gay son who is a Christian, and we found what was written in the first part of the book to be very helpful. Parents are encouraged to love their homosexual sons and daughters unconditionally, and are also offered further helpful advice explaining various coping strategies when dealing with very difficult issues. These will particularly apply to Christian parents.

We found the second part of the book more difficult reading, as it involves certain aspects of the author's psychotherapeutic plan of action to enable parents to assist their children through the process of 'healing' from their homosexuality. My husband and I both felt very uncomfortable with some of his methods, which include many references to what he calls 'same-sex parent display of physical affection'.

My feelings are that this book may be better suited for the American culture, rather than for Britain.

*'**Ruth**' lives in Wales*

Who am I?
Experiences of Donor Conception
Alexina McWhinnie

- Idreos Education Trust 2006
- £6.95 Pb 66pp
- ISBN 0 9554031 0 3

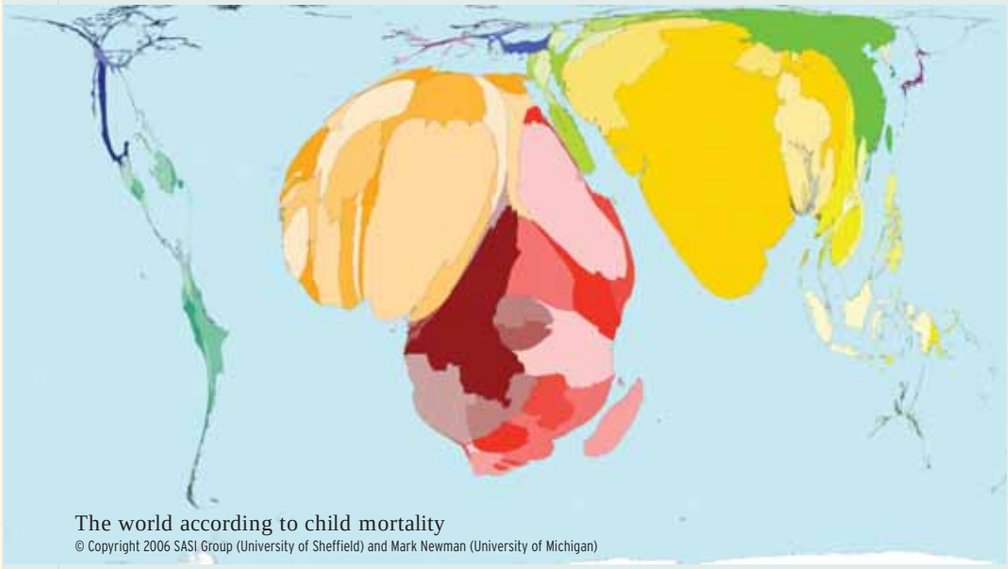
Joanne, Christine and Louise were all conceived following donor insemination (DI). Having been aware early in life of this, Joanne experiences increasing 'genetic bewilderment'. Christine's domineering mother used this secret knowledge as a weapon against her. The eighteen months after Louise learned the truth were the darkest of her life.

Social scientist Dr McWhinnie considers research into the lives of families in which children have been conceived by gamete donation. Around 90 published analyses confirm these three stories as being typical. When the pain of fractured identity and family strain becomes intense, a DI-conceived person may even feel angry they were ever born.

The issue of donor anonymity is another issue. Louise speaks for her co-contributors: 'the least harmful scenario...is one where the child is told the truth from an early age, and where identifying information is available about the donor'. McWhinnie concludes: 'It is more than time that the voices and experiences of DI offspring should be recognised and listened to...they carry for a lifetime the consequences of assisted reproductive technological intervention: intervention which they do not choose or consent to'. I couldn't agree more!

***Gordon Stirrat** is Emeritus Professor of Obstetrics and Gynaecology in Bristol*

Is this how God sees the world?



The world according to child mortality

More than 2,000 verses in the Bible speak about God's special concern for the poor. This map shows where the poor of the world's children are: territories have been resized according to the proportion of all deaths of children aged over 1 year and under 5 years old.[1] In parts of sub-Saharan Africa, 20% of children do not live to see their fifth birthday. The world turns a blind eye, but God does not:

But you see, O Lord; you take notice of trouble and suffering…the helpless commit themselves to you; you have always helped the needy…

You will listen, O Lord, to the prayers of the lowly; you will give them courage.

You will hear the cries of the oppressed and the orphans; you will judge in their favour. (Psalm 10:14,17,18 GNB)

The map effectively shows the enormous gap between rich and poor. As I write, the BBC News website reports:[2]

This year's harvest in Zimbabwe has been the worst in the country's modern history. Some Zimbabweans get by on one meal a day if they are lucky, but there is a growing sense of desperation. Farmers are without seeds, fertiliser and fuel. Next year's harvest is already being written off as a disaster as well.

Reported on the same page is news of the $700 billion which the US government is finding to rescue its financial system. Rich and poor seem to inhabit different worlds – but those who are starving in Zimbabwe are our brothers and sisters. Wendenda, a woman from a village in Burkina Faso, is featured in a Tear Fund film.[3] She says

To British people I say – on this earth we are far away, but in heaven we won't be far apart

As the new Head of International Ministries, I want to see CMF reflect God's heart for the poor. Christian doctors have enormous potential to serve in many and various ways – there are opportunities for juniors and seniors, specialists and generalists, researchers and teachers…and all others in between.

What could you do?

- Give a week to go and teach with PRIME
- Give a week to go on a summer team to Eastern Europe, to encourage students and juniors in less well established fellowships
- Give two weeks to use your skills as part of a specialist team
- Give two weeks to go on a 'mission exposure trip' to see and understand the needs
- Give six months, or a year, or more, to serve in a poor country
- If you can't go, could you fund someone else who can?
- Be a 'buddy' for a CMF member overseas, keeping them up to date on professional issues
- Encourage your hospital/practice/trust to form a partnership with a hospital in a needy place
- Sponsor a medical student in a developing country through the Medic-to-Medic programme *www.imet2000.org/medictomedic/index.html*
- Encourage your church to sign up to Micah Challenge

The HealthServe website *www.healthserve.org* is the place to go to look at opportunities and find details of organisations working in needy places. We have recently had requests for help from Bangladesh, Zimbabwe, Peru and Mongolia – there are needs in all directions!

And from somebody who did it:

Retired GP John Baigent, now working in West Africa, writes in *Re-tyred not Retired*:

So many times in Meskine I have felt like I have been walking on the water of God's faithfulness. I have so often been out of my depth, but leaning on him have been able to make a difference in the lives of many people.

***Vicky Lavy** is CMF Head of International Ministries*

references

1. *www.worldmapper.org/display.php?selected=263*
2. BBC News, World, Africa. *Zimbabwe starves as despair grows*. 23 October 2008 *news.bbc.co.uk/1/hi/world/africa/7685819.stm*
3. Tearfund. Step up to the plate film. *www.tearfund.org/Churches/Harvest+-+Step+up+to+the+plate/Step+up+to+the+plate+film.htm*

letters

Forsaken your first love?

__Andy Mott__, Hon Tutor and GP Sub-Dean at Brighton and Sussex Medical School, was very challenged by the Final Thoughts in the last edition:

'Iron sharpens iron, and one person sharpens another' [1]

I was much affected by Bernie Palmer's meditation entitled 'Forsaken your first love?' [2] I was particularly struck by his speaking of our need for regular spiritual appraisal. But whoever heard of appraisal without an appraiser? So, who is to be our spiritual appraiser?

Ultimately, of course, the Holy Spirit himself, speaking through scripture, but as so often with his gracious dealings with us, also speaking through our brethren. This is given particular emphasis in Bernie's meditation, because the warning of spiritual apathy quoted [3] is given to a church, inferring the solution is to be found within the fellowship and not to be left to individuals struggling alone with their consciences.

whoever heard of appraisal without an appraiser?

Tony was not just my best friend and soul mate of 30 years, but also my spiritual director. We met regularly and I was accountable to him in an agreed way for my walk with Jesus. He would not only ask the questions Bernie poses in his article, but expect answers. Without such a firm and loving sounding board, my answers are either too soft or too hard. In this way Tony helped me stay close to Jesus – such godly accountability was a necessary part of my walk with the Lord.

Tragically, Tony was killed in a car accident 18 months ago, an incomprehensible loss to his family and to his many friends. As I thank God for my firm but gracious 'appraiser' and search for another, I pray you too may be granted a 'Tony' to help you rekindle your first love for Jesus and keep you walking closely to the one who 'sticks closer than a brother'. [4]

references

1. Proverbs 27:17
2. *Triple Helix* 2008; Summer:23
3. Revelation 2:1-7
4. Proverbs 18:24

Advance decisions to refuse treatment

__Peter Gibson__ is a consultant physician doing general medicine in Manchester. He was unhappy with a News Review piece in the last edition:

I enjoyed reading many of the well balanced articles in the Summer 2008 *Triple Helix*. However, I was very disappointed by the article [1] about 'Advance decisions to refuse treatment' which was (in my view) very unbalanced.

Sometimes, we have patients with multiple co-morbidities and limited life expectancy who lack mental capacity to make decisions about treatment at the time of their admission to hospital. It would be very helpful for us to know to what extent they want medical interventions to prolong their life. At present, I suspect that we give some of these patients a lot of invasive, unpleasant, painful medical treatment, when what they would really like is good quality palliative care.

The legislation is not perfect. However, it has been carefully drafted and deals with most of the concerns raised in the article.

***Andrew Fergusson** replies:*

Peter and I have had a constructive correspondence about this. For the record, although he practises in the Manchester area, he had no personal involvement in the Salford scheme which promotes ADRTs.

I totally agree that 'we give some of these patients a lot of invasive, unpleasant, painful medical treatment, when what they would really like is good quality palliative care', and I agree that prior knowledge of patients' general wishes can be very helpful should they become incapacitated and unable to express them.

The *News Review* piece was stimulated by the aggressive promotion of ADRTs (and an activist in the euthanasia campaign group *Dignity in Dying* was centrally involved in the Salford initiative), but 'we stand by our story'. While I agree with Peter Gibson that we must recognise the inevitability and often the rightness of natural death, we must also be vigilant about the possibility of unnatural deaths.

reference

1. Fergusson A. *Triple Helix* 2008; Summer:5

Peter Pattisson on the dangers of doing nothing

Opportunity (un)limited

If you falter in times of trouble, how small is your strength! Rescue those being led away to death; hold back those staggering towards slaughter. If you say, "But we knew nothing about this," does not he who weighs the heart perceive it? Does not he who guards your life know it? Will he not repay each person according to what he has done?[1]

This scripture contains one command, two excuses and three questions. All focus on the dangers of doing nothing. *The first excuse* comes before the command, as there will always be 'times of trouble':

- It's not a good time at the moment
- My strength is so small
- I have such limited resources
- I have exams coming up
- I have a young family
- I have financial problems
- The pressure of secularism or of Islam is too strong

It will never be convenient to respond to the call of God. Paul told Timothy: 'Preach the Word…in season and out of season'.[2] What is the antidote to this poisonous sense of inadequacy? 'Those who hope in the Lord will renew their strength.'[3] In him are resources unlimited, but access requires the daily discipline of Bible reading and prayer. Of course we don't have resources in ourselves. We need to come to him.

The command is in two parts. 'Rescue' (save) those being carried off by forces beyond their control. Death faces us all, and before then what forces sweep us away – corruption, political oppression, religious persecution, HIV/AIDS, TB, malnutrition, war, child soldiers, refugees, trafficking, prostitution, slavery, abortion, euthanasia. As Christians we are called to rescue young and old, women and men, from these and many other situations.

'Hold back' those who through their own ignorance or wilfulness are heading for disaster. The original is a double negative – 'Do *not* not restrain'. This part speaks of rebellious forces within: what the Bible calls 'sin'. Symptoms of this inner disease – sexual lifestyles, abuse of alcohol/drugs, obesity – lead to morbidity and an early death, but it is the underlying condition that requires radical surgery. 'The wages of sin is death.'[4]

The second excuse says 'It's not my job, I never realised'. But you cannot use this excuse. You cannot say 'I'll just do my medical job. Let others speak for Jesus, fight for justice, lobby for righteousness, go to the ends of the earth.' When I was a student, God arrested me with these words: 'there are some who are ignorant of God – I say this to your shame'.[5]

None of us can avoid *the three questions*. Turn them into statements from the Lord:

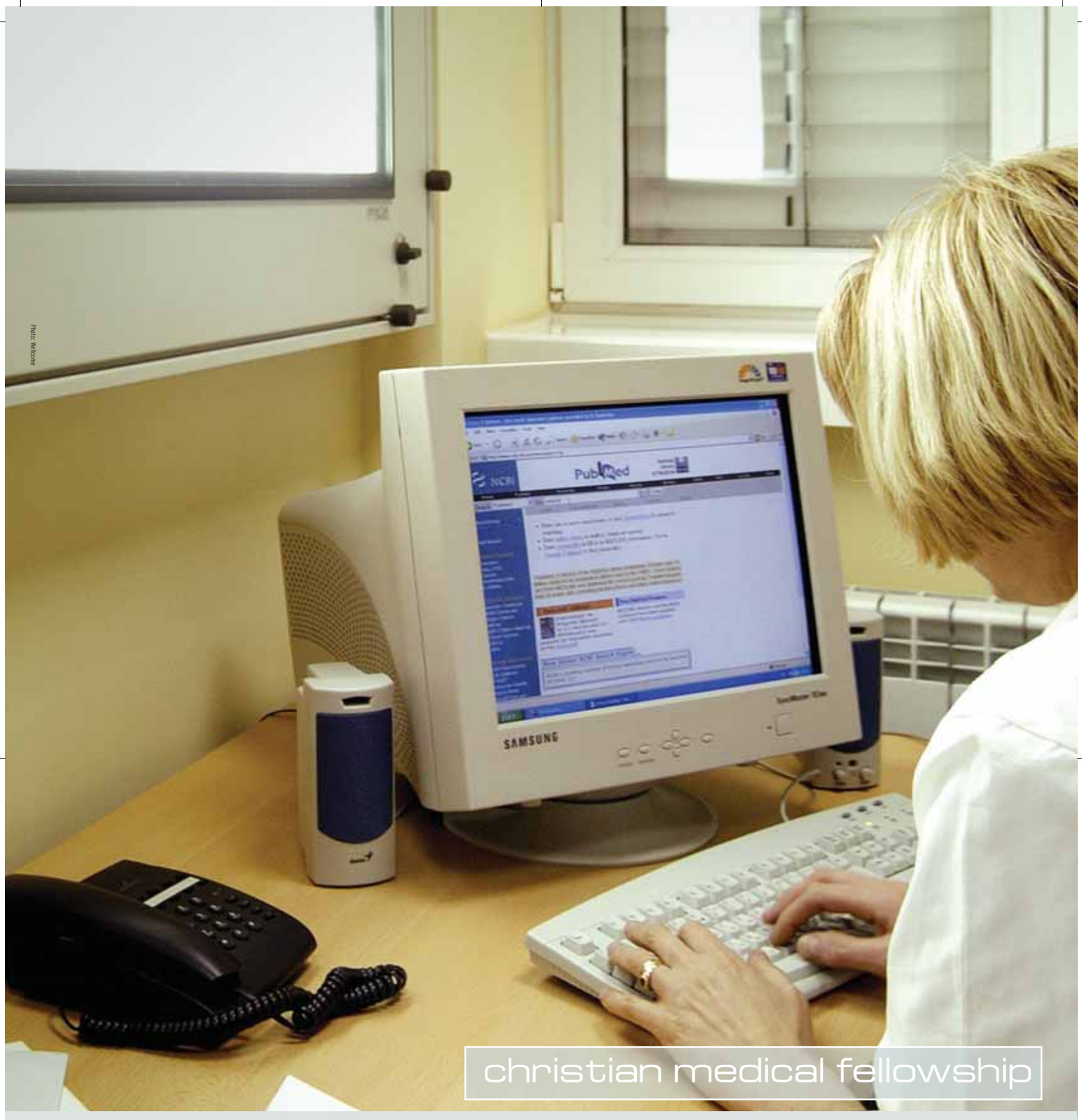
- 'I weigh your heart.' I know your hidden motives. One may be challenged to move into cross-cultural ministry in another country; another to the sometimes harder task of staying and living for Christ among family and friends.
- 'I guard your life.' The safest place you can be is in the centre of God's will for you.
- 'I repay each person according to what he has done.' At the end of the road, what will you have to give to the Lord?

'Only one life; 'twill soon be past.
Only what's done for Jesus will last.'[6]

***Peter Pattisson** has just retired as Regional Secretary for ICMDA Europe-Eurasia and this has been edited from his closing address at the Schladming conference*

reference

1. Proverbs 24:10-12
2. 2 Timothy 4:2
3. See Isaiah 40:28-31
4. Romans 6:23
5. 1 Corinthians 15:34
6. Anon



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