Katy Barker introduces **Emma Lowe** on life and death in A&E

Junior doctors on the FRONTLINE

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Have you ever wondered where Jesus would be found working if he were a junior doctor today, or how he would respond to the challenges of practising modern medicine? Over the next few articles we are going to look at some of the difficulties and rewards of being a Christian working in some particularly problematic areas for junior doctors.

We start with those working on the front line in hospital, in the Accident and Emergency department. Most foundation doctors will spend time here, and those in specialty training are often called back there to advise or assist. In short, it is a department we are all likely to be involved with.

Emma Lowe is a junior doctor working in a busy A&E department in the centre of Leeds. Here she shares some of her experiences: both the challenges and the rewards A&E offers.

A&E: I love it there

It was with a sense of trepidation that I started working in A&E this August and donned my shell-suit style green scrubs for the first time. Yet it is with real sadness that I will say goodbye to working there. It has been one of the most challenging, stressful and rewarding few months of my life and although sometimes the challenges seemed too much, it is probably through these that I have learnt so much and come to love it there.

It is impossible to talk about the challenges of emergency medicine without mentioning time management. The four-hour breach rule is a constant pressure and often dictates what we can do for our patients while they are in the department. This is not such a problem when the department is quiet, but when a patient has waited 3 hours 45 minutes to see a doctor there is limited scope for the Christian challenge of going the extra mile.[1] However, if by doing more than is required we let a patient breach, the hospital gets fined and this may prevent someone else from doing his or her best for a patient.

Looking for God's hand

For me the challenge has been looking for God's hand in the department. We look after the 'hungry or thirsty…and sick'[2] and God has clearly pointed out to me the patients I did have to go the extra mile for. People often come to A&E when their lives are in crisis, so we should not underestimate how potent a single intervention can be. It is important to remember we do not work for bed managers and targets but for our patients. We are reminded that 'whatever you did for one of the least of these brothers of mine, you did for me'.[3] Every day we are working for God's glory, whether we have lots of time or only a little, and should be 'working at it with all your heart, as working for the Lord, not for men'.[4]

Another time related challenge is the constantly changing rota with very few conventional shift times. The lack of a regular shift pattern, and often being at work when friends and family are free can make it a lonely job. Working alternate weekends and countless evenings makes regular attendance at church and small groups impossible and finding 'quiet time' a struggle. I have found no easy solution to this other than making a concerted effort to make God a priority in my life. Indeed, we are reminded that it is by spending time with God that we get true rest.[5]

Facing suffering daily

Facing suffering on a daily basis has been one of the hardest spiritual challenges. Although we hear daily about suffering in the news, and I was used to dealing with patients who are very unwell, suffering is often more acute in A&E. On one occasion I watched a child die in 'resus' and then heard their parents' grief as they absorbed the news. Other times I heard how some of the regular attendees came to be homeless and alcohol-dependent through massive personal tragedy. It has been a personal challenge to understand and reconcile this with my faith. The answer to the age old question of suffering is beyond the scope of this article, but it has been through the help of CMF and other Christian literature, prayer, and the support of Christian friends and family that I have come to a greater understanding of this.

Challenges and rewards

I could write almost endlessly about the challenges and rewards of the emergency department. It is often at the most difficult times in our lives that we feel God's presence and guidance most keenly and this has certainly been true over the past four months. I am frequently faced with situations I know I cannot deal with on my own, which leaves me with no option but to turn to God for help.

The Lord said to him, 'Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind? Is it not I, the Lord? Now go; I will help you speak and I will teach you what to say.'[6]

Whatever challenges A&E may throw at us, God is bigger than all of them, and he promises never to leave us, nor forsake us.

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2. Matthew 25:37-46
3. Matthew 25:40
4. Colossians 3:23
5. Matthew 11: 28-30
6. Exodus 4:11-12

Ian Spillman reviews progress with child mortality

MDG 4
– a world of difference for child health

key points

Most deaths of children under five years are attributable to acute respiratory infections (mostly pneumonia), diarrhoea, malaria, measles, HIV/AIDS and neonatal conditions – which are all avoidable through existing interventions which are available and technologically appropriate. [2]

Child mortality would fall 14-31% a year if interventions to clean up water, provide clean fuel for cooking, and improve children's nutrition reached everyone who needed them. [3]

Christian hospitals and non-governmental organisations play a key part in providing health care in many developing countries.

Millennium Development Goal 4: [1]
Reduce child mortality
Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

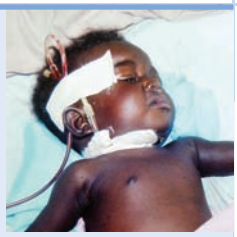
We certainly live in a world of difference. The death of a child is a tragic loss, yet every year there is a 'silent tsunami' with 8.8 million children under five dying in 2008 [4] – that is, 24,000 children a day, an annual loss roughly equivalent to the entire population of Bolivia. Some 40% of these deaths occur within the first month of life; [5] nearly three quarters of these neonatal deaths could be prevented if women were adequately nourished and received an appropriate continuum of care during pregnancy, childbirth and the postnatal period. [2]

In poignant contrast to the growing western problems of childhood obesity and diabetes, malnutrition plays a part in half of these deaths, [2] in turn directly related to poverty. Most mothers breastfeed their babies, but then are unable to afford nutritious food when it is time to wean. Tackling child mortality is not just about feeding starving children. To stay healthy, all children need clean water, food, healthcare and a home. Around 400 million children have no access to safe water.

Shockingly in an era when we can unravel the human genome, perform amazing surgical procedures and produce ultra-sophisticated designer drugs, some 1.4 million children die every year because they simply lack access to safe drinking water and adequate sanitation. [2] Others succumb to gastroenteritis or pneumonia [6] for a lack of oral rehydration solution or basic antibiotics.

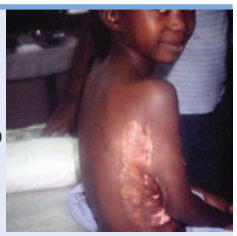
HIV/AIDS is a huge and growing problem for children. In 2006, the estimated number of children

Case: Asiimwe



Presentation: age 3, pulse 168, resp rate 55, cap refill 3-4 sec, pale, semi-conscious, febrile, gallop rhythm, liver 4 cm below right costal margin...
Clinical assessment: heart failure due to anaemia due to malaria
Rx: 10-20ml/kg 0.9% saline via external jugular line, glucose, urgent transfusion, anti-malarials...
Outcome: improved
Prognosis: initially good but as family very poor, in mud and stick house with no nets, Asiimwe will very soon be re-infected with malaria. The parasites are becoming increasingly resistant to anti-malarials and the newer drugs are orders of magnitude more expensive than the older treatments such as chloroquine, making it more and more difficult for the family to afford treatment...
Overview: internationally the median coverage of insecticide-treated nets is just 3% in the subset of the 60 countries that are endemic for malaria and for which data are available. [5,10] Such rates should greatly challenge us since the evidence for nets producing a dramatic reduction in both mortality and morbidity from malaria in children under five was published back in 1991 from studies in the Gambia, [11,12] yet still today many children like Asiimwe are unprotected...

Case: Lois



Presentation: age 10. Lois had sustained severe burns from a paraffin stove. Taken by her family to a government hospital, but no treatment received as her family too poor to pay. Consequently Lois developed adhesions of her right upper arm to her chest wall so she was unable to abduct the arm. Her family had accepted this so she was not only physically handicapped but also socially impaired as would not be able to marry with this impediment. Months later she developed infection under the scar tissue but this time was seen in a church hospital. She underwent surgery to release the adhesions and then had staged skin grafts. Her treatment was subsidised by the Good Samaritan fund supported by Christian donors.

Outcome: good range of arm movements, dignity restored.

Overview: Many children suffer burns due to cooking on open fires or stoves and lack of supervision. Poverty limits access to healthcare with potential huge impact on a child's future...

under 15 years old living with HIV was 2.3 million – 87% of whom are in sub-Saharan Africa.[2] Furthermore, around 15.2 million children have lost one or both parents to AIDS.

Kingdom goals

As Christians we share greater goals than MDG 4 – not only for justice and physical health for the world's children but also the 'life in all its fullness' that Jesus came to bring.[7] He called his followers to walk in his shoes, to be both the 'light' and 'salt' the world needs so much – that perfect mixture of grace, love, compassion and mercy with holiness, justice and righteousness that lies at the heart of the Gospel and mission. How amazing that the God of eternity, who formed the vastness of the cosmos and the intricate mechanism of each ion channel also identifies with the poor:

Whatever you did for one of the least of these brothers of mine, you did for me.[8]

He who oppresses the poor shows contempt for their Maker, but whoever is kind to the needy honours God.[9]

We therefore have a special responsibility to care for the vulnerable, the widows and orphans, the forgotten refugees, and especially the children.

Progress

Substantial progress has been made, with global under-five mortality falling 28% from 1990-2008. Countries such as Bangladesh and Malawi have shown proof of concept that MDG 4 is achievable even in poor environments.[4] However, there are large disparities between different groups and countries,[2] exacerbated in conflict zones. If current trends continue, the MDG will not be achieved until 2045 – thirty years later than planned.[2,13]

Except for Afghanistan, all of the 34 countries with mortality rates higher than 100 per 1,000 live births are in sub-Saharan Africa. Hopefully, improvement will be seen with interventions such as insecticide-treated bed nets; prevention of vertical transmission of HIV; vitamin A supplementation; and immunisation for Haemophilus influenzae type B, measles and tetanus. However pneumonia, the single leading cause of death in children,[6] has been neglected, and diarrhoeal diseases continue to devastate many lives.

In 2007 the International Health Partnership (IHP) was launched by the UK;[14] and Women and Children First: the Global Business Plan for Maternal, Newborn and Child Health by Norway.[15] These along with the Canadian Catalytic Initiative to Save a Million Lives,[16] have been packaged as part of a broader Global Campaign for the Health Millennium Goals (MDGs).[17] This offers enormous potential to speed progress, though we need to pray for wisdom in the best use of resources to reach those in greatest need.

Making a world of difference

New technological advances have been made in developing vaccines for pneumococcus and rotavirus; low osmolarity oral rehydration therapy; zinc treatment for diarrhoea; long-lasting insecticide-treated bed nets; and artemisinin combination treatments for malaria. All these interventions have the potential to contribute to major gains in child survival if implemented at scale and in an equitable manner.[5] The challenge remains to actually make it happen on the ground.

So what should be our response as Christians? Jesus told his disciples, daunted by a vast hungry crowd: 'you give them something to eat'[18] and he calls us to do the same today. We can all pray and share; supporting CMF's overseas work[19] and that of different missions and agencies such as Tearfund.[20] Sign up to Micah Challenge[21] and mobilise churches to participate actively. Some of us are called to go overseas to serve and encourage and partner in this noble work either with missions or as tentmakers in various secular roles.[22] In preparation, consider attending the annual CMF Developing Health course[19] and a course in working cross-culturally, eg those run at All Nations Christian College;[23] or arrange to visit a church hospital such as Kisiizi Hospital in Uganda[24] to experience modern medical mission.

Go in God's strength for 'unless the Lord builds the house, its builders labour in vain'.[25] As a missionary doctor on his own in a remote area, faced with performing a surgical procedure, wrote: 'it's a tiny needle – but in the mighty hand of God'.[26]

Hudson Taylor once said 'God is looking for wicks to burn…the oil and the fire come free'. Let us all press on, not only that MDG 4 is accomplished but also to see the world's children finding for themselves 'life in all its fullness'.

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