letters

Language for leprosy

C Ruth Butlin *has advised the Danish Bangladesh Leprosy Mission. She enjoyed the article* Drugs and Alcohol: Why should we care? *(Easter 2010: 10-11) but makes an important comment about language:*

I regret I am late in sending this comment as I only read the Easter *Triple Helix* recently (having been stranded in Bangladesh for a month by the ash cloud). The author makes a comparison between the situation of leprosy-affected people and that of those who are suffering from substance abuse. He makes some good observations and I sympathise with his point of view. However, I take exception to his use of the word 'leper'.

The word 'leper' has too many unpleasant and unfair associations to be acceptable nowadays in a Christian medical journal. It is considered by leprosy patients' organisations and also by NGOs like The Leprosy Mission which help individuals and communities affected by leprosy – and even by WHO – to be unduly derogatory and stigmatising for referring to individuals who have been affected by leprosy.

I feel that if authors use the word in manuscripts submitted to CMF they could be asked to reword the material, or alternatively the editor could amend it. Of course, if quoting an old book (including older translations of the Bible) the word may occur and be reproduced in that context, but in commenting on a Bible passage the author can surely use other phraseology.

For example, in the AV version of the Leviticus passage, Derrett Watts correctly quotes 'and the leper in whom the plague is…' But afterwards he could say 'In this passage we see the leprosy-affected people have had their dignity removed…', then later 'How did Jesus respond to people affected by leprosy?'

I am very sure that Jesus would never have offended suffering people by using words like 'leper' to speak to them. Nowadays none of us talk about mongols, spastics, cretins… We say 'patients or people with Down's syndrome or cerebral palsy or hypothyroidism'. Similarly we can speak of 'leprosy patients' (when they are under medical care) or 'leprosy-disabled people' in the appropriate context or (especially for those who have been treated and are no longer 'patients') we can use a term like 'person affected by leprosy'.

The author and the editors say 'Thanks. Point taken.'

Christians and medical research

Retired missionary and GP ***Peter Pattisson*** *appreciated the Summer* CMF File *(No 42 Christians and Medical Research):*

Thank you for the latest *CMF File* – one of the best for a while. Sam says in his conclusion: 'It is widely accepted that religion and science are mutually exclusive, but it is part of our task to show this is not true'. Space doubtless prevented Sam expanding on this, but I am reminded of words I heard first from the lips of Francis Schaeffer in the 60s to the effect that both science and biblical religion deal with both facts and faith.

Science requires faith because no one has personally been able to do all the basic research on which scientific advances are built; it has to be taken on trust – trusting the integrity of those who did the research and the reliability of the records of their findings.

Likewise, as biblical Christians, we know that faith is founded on the facts of salvation history and the reliability of the record of those events in the Bible.

Thank you, Sam and Helen, for an excellent *File*.

What is the right model of medicine?

Matthew Jackson*, an ST3 in anaesthetics, comments on the critique of QOF (Summer 2010: 6-8):*

David Misselbrook's discussion of the Quality and Outcomes Framework (QOF) is a welcome addition to the wider debate regarding targets, guidelines, care pathways, protocols, checklists, targets and computer records in healthcare. While sharing many of the discussed objections to 'tick-box medicine', I maintain that such practices need not be to the exclusion of broader 'care'.

Healthcare is increasingly characterised as a complex set of interventions. Because as humans we cannot always be relied upon to perform perfectly, technology has increasingly come to aid our practice – both in paper and computer formats. David Misselbrook quotes examples where the QOF has mechanised the patient-doctor relationship at the expense of 'softer' aspects of care.

An important consideration is whether protocols and such should aid or define practice. Perhaps Jesus' words in Mark 2:27 offer some insight: 'The Sabbath was made for man, not man for the Sabbath'. The error of the Second Temple establishment was to idolise the Sabbath, as opposed to recognising that it was made for holy rest (Genesis 2:3). Its observance became a distraction. Analogously, current medical practice may be said to idolise protocols and check lists. Tools designed to enhance care have paradoxically become a barrier to that goal.

The solution then is not to dismiss protocol, but to reflect on the way it is used. If true care is to be offered, the patient, not the protocol, must become the centre of the encounter. There is no choice offered between care or protocol, but rather a realisation that care may occur through protocol.