Triple Helix

Christian dimensions in healthcare

Drugs in prisons
Healing in the killing fields
Professionals under pressure

Photo: courtesy of Prison Service Press

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No. 2

Photo: courtesy of Prison Service Press

editorial:

what's your intention?

Several recent high profile euthanasia-related cases have again highlighted the ethical concept of intention. Drs Irwin and Moor announced last July that they had assisted in the deaths of 50 and 150 patients respectively, and gave as reason for these admissions desire to draw attention to what they see as the hypocrisy of doctors giving doses of narcotics which may shorten life, allegedly hiding behind the (unhelpfully named) 'doctrine of double effect'.

Motor neuron disease patient Annie Lindsell went to the High Court, ostensibly to seek clarification of the law, asking that high doses of diamorphine could be used for symptoms of 'distress', as well as for the traditionally accepted symptom of pain. The case was withdrawn after the diamorphine regime her doctor wanted to employ was negotiated downwards very considerably to a level standard in palliative care, and which could not have the intention to kill.

It was obvious from the media that many, some professionals included, did not understand the concepts involved. The concept of intention is quite simple. Intention is about purpose - 'What did the health professional mean to do when she performed the act? What did she mean to do when she omitted to act?' Intention speaks to the head; motive speaks more to the heart - 'Why was that her intention? What thoughts were going through her mind?'

Intention is a long-accepted concept in British law and ethics, and it comes from the Bible. In the Old Testament, 'cities of refuge' were arranged for those who had committed manslaughter rather than murder: 'he killed his neighbour unintentionally and without malice aforethought'[1]. This distinction, which centres on the importance of intention, remains foundational in British law on homicide.

Lay people intuitively accept that what you meant to do matters. Why do those moral philosophers who have such influence in healthcare ethics today have so much trouble with the concept? They claim that intention is of no moral relevance, only the outcome matters. Thus for them, the ethics of the death of a cancer patient are the same, whether the patient was despatched by lethal injection from a euthanasiast doctor or whether pneumonia ('the old man's friend') was (perhaps rightly) left untreated so that the patient's life came to a natural end. The outcome was the same, so there was no significant moral difference in the behaviour of the doctor in the two situations.

Intention squares with the intuitions of most of us, particularly those who believe in a God who judges our hearts, so why do the philosophers have such a problem? Could it be that they believe 'there are no absolutes'?

Incidentally, is that an absolute statement? If it is an absolute statement, then there is one thing in the whole of the universe which is an absolute - that statement - and it is therefore shown to be untrue. Or is the statement not an absolute one? In which case, there are some absolutes. Either way, the statement is absurd, but that hasn't stopped it being recited by expert ethicists in the media.

It is time both in ethics and in everyday life we nailed this particular lie. Intention does matter. God judges partly on the basis of it. So may the law of the land. No patient requires to be killed intentionally by act or omission as part of their healthcare.

So, in deliberately trying to engineer confusion about this very clear concept, euthanasiasts and others, what's your intention?

Andrew Fergusson

Reference

1. Joshua 20:5

enter a shoplifter exit an addict

Peter Walker of Prison Fellowship examines the growing scandal of illicit drug use in Britain's prisons

Mickie stood facing the inside of the huge wooden prison gates. Behind him were the bars of the inner gates. Behind them, the cells that had been his home for the past two years.

For Mickie this was the moment he had dreamed of. The gates would open and he would be free. He felt in his pocket and clutched the small brown envelope which contained his release money. Anticipation mixed with fear of the unknown. For although Mickie, now aged 23, had passed this way before, he had this time acquired some extra baggage in the form of a drug habit which he had not had when he came into prison.

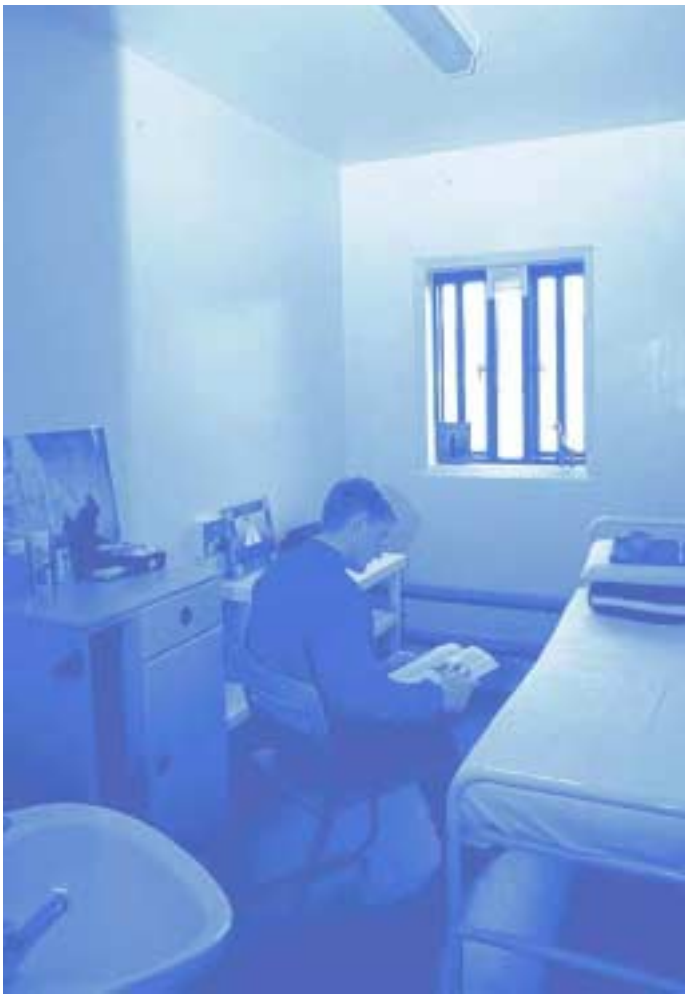

Photo: courtesy of Prison Service Press

Unlike Mickie, many of his fellow inmates have been involved with drugs prior to prison. In a survey of 1,751 sentenced male prisoners, 43% had misused drugs in the six month period before entering prison[1]. Maybe this is not too surprising. It is estimated that as much as 70% of crime, mainly burglary and theft, is perpetrated to fund a drink or drugs habit.

There is increasing concern for the likes of Mickie who are gaining a drug habit whilst inside prison. A National Association for the Care and Resettlement of Offenders report confirms the situation[2], as does an Inspector's report on HMP Styal. Here, inmates and staff reported that drugs were freely available, and that 'a number of inmates were introduced to drugs for the first time and became addicted in Styal. "Enter a shoplifter, exit an addict." '[3] HMP Styal is a women's prison, but is not untypical.

Drug misuse in prison is causing increasing concern. This has resulted in the introduction of a mandatory drug testing (MDT) programme for prisoners. The types of drugs available inside are as varied as on the outside. For example, in the year to February 1996, 11,749 prisoners were tested under the MDT programme. 2,922 proved positive for cannabis, 616 for opiates, 278 for benzodiazepines, 22 for cocaine, 12 for methadone, seven for amphetamines and two for barbiturates - a total of 3,859. Overall around 30% of prisoners tested positive[4], some for more than one drug.

HM Chief Inspector of Prisons states 'Increasingly we are finding evidence of hard drugs in establishments'[5]. There is anecdotal evidence that as traces of opiate, amphetamine and barbiturate stay in the body for less time than cannabis, prisoners are moving to these drugs to avoid testing positive under MDT[6]. A positive MDT would mean loss of privileges in prison, and adversely affect options for home leave, early release and parole.

The Prison Service hierarchy is concerned about the impact of the drug culture inside. The Inspector has stated that drugs 'pose a threat to good order and compromise the safety of other prisoners and staff. Control is put in jeopardy and there are serious health risks, not only to users but to others as well'[7]. The Director General of the Prison Service has said 'We have a duty of care for the prisoner and, I believe, a moral obligation to offer treatment. We also have a strong practical incentive to do so if we are ever

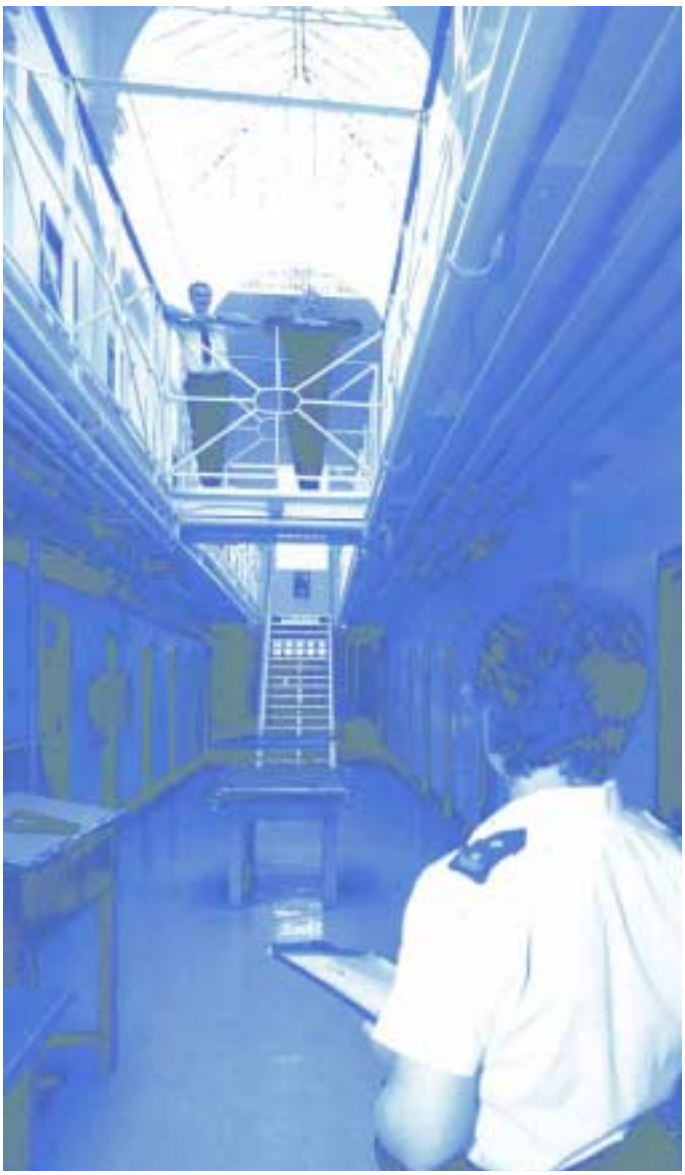

Photo: courtesy of Prison Service Press

to get prisoners to break out of the circle of drug misuse which causes such problems both inside and outside of prison and all too often turns the prison gate into a revolving door.'[8]

Yet in Styal, as in other establishments, drugs are readily available, and known to be so by local staff. James, an ex-prisoner, says 'Drugs are an omnipresent force in prison, actually cheaper and more easily available than on the outside'[9].

The prison population is now over 62,000 and growing at the rate of 250 per week. Local staff are concerned about the effects of overcrowding, especially rising tensions amongst inmates. On some wings there is tacit understanding that limited drug use is tolerated as it 'keeps the prisoners quiet'. As James says[9] 'It is a sorely tempting route to escape'.

As on the outside there is much debate about harm minimisation and risk reduction. There is a growing lobby promoting a pragmatic approach to the problem, especially with calls for needle exchange schemes. This, despite the recommendations of both the Prison Service's AIDS Advisory Committee in 1995 and more recently the Advisory Council on the Misuse of Drugs (in prison) in 1996. Both bodies considered the feasibility of setting up needle exchanges in prisons, but rejected the idea due to concern that provision of needles 'would more likely lead to an increase in injecting than to a reduction in sharing'[10].

On the fringe of this debate is the growing call for decriminalisation of certain categories of drugs. With prison space at a premium and costing over £400 per week per inmate, maybe this will influence government to reduce the criminality of some drug use.

We, the Christian community, have many issues to face and arguments to be involved with in the whole arena of drug misuse. We need an open and positive debate, and we need it now.

As for Mickie? Like so many others we were able to link Mickie with Prison Fellowship volunteers who helped him find accommodation and stood by him as he overcame his drug habit. Mickie is now settled in a local church, but is finding it hard to get employment. But that's another story . .

Peter Walker is Executive Director of Prison Fellowship (England and Wales) and can be contacted at PO Box 945, Maldon, Essex CM9 4EW

References

1 Research study for the Home Office by Professor John Gunn, Institute of Psychiatry, quoted in 'Drugs on the Inside', NACRO, 1996

2 Drugs on the Inside, NACRO, 1996

3 HM Inspector of Prisons Report on Styal, 1995

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5 HM Inspector of Prisons Annual Report, 1994-95

6 'Drug Misusers and the Prison System.' The Advisory Council on the Misuse of Drugs. HMSO, 1996

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8 Address by Richard Tilt, Director General of the Prison Service, to the Prison Service Drugs Conference, 12th March 1996

9 Polly Toynbee, *The Independent*, 7th August 1997

10 Reported in 'Drugs on the Inside', NACRO, 1996

Prayer can be bad for your knees.

1,500 year-old skeletons stored beneath the crypt of St Stephen's Monastery in Jerusalem have revealed that almost all the monks had arthritis of the knees. It is concluded they spent much time kneeling in daily worship. Any evidence of this association nowadays? (Source: *The Sciences*, 1997; 37(4):11)

But faith helps healthy immunity?

Researchers in North Carolina tested a randomly selected group of 1,727 elderly adults for immune system activity. The 60% who went to church at least once a week were healthier on five out of nine tests. Comments the trial leader: 'People who have a strong faith, go to church, and have the support of others involved in the church, are less depressed and less stressed. They are not as anxious as other people . . there may be a lot of benefits to (religion) in terms of mental and physical health.' (Source: *The Times*, 24 October 1997)

NPs alongside GPs?

In an editorial entitled 'Nurse practitioners in general practice - an inevitable progression?', NPs are reported doing more and more in primary care, and in well-referenced statements are described as 'popular with patients and good at listening, explaining and understanding'. 'They are not however a cheap alternative to doctors' and it doesn't surprise Eutychus that 'the development of the NP role is being hampered by finance'. (Source: *British Journal of General Practice*, November 1997; p696-697)

Council of Europe bans human cloning.

A protocol banning human cloning has been adopted by the Council of Europe. It would prohibit 'any intervention seeking to create a human being genetically identical to another human being, whether living or dead'. The protocol must now be ratified by all 40 members. (Source: *British Medical Journal*, 15 November 1997; 315: 1252)

After Dolly, Polly.

Polly is not a parrot but a sheep, born in July 1997, genetically engineered to carry human genes and then cloned. She and her four sisters open up commercial possibilities for producing flocks of identical sheep or other farmyard animals able to produce human proteins in their milk for the treatment of disease. (Source: Nick Nuttall, *The Times*, 25 July 1997)

Children haunted by violent videos.

A British Psychological Society conference was told in September that graphic scenes of screen violence stick in children's minds and have a far more profound effect on them than nudity, sex scenes or bad language. 1,500 children aged between 10-11 were interviewed in South Australia and asked to describe scenes from commercially available videos. Said researcher Glenn Cupit: 'Children most often report particularly persistent and unwelcome memories about violent scenes like people being cut up with chainsaws, being put through meat mincers and that sort of thing'. (Source: Roger Dobson, *The Independent*, 15 September 1997)

Divorce damages children long term.

A British longitudinal study carried out for the Joseph Rowntree Foundation followed more than 11,400 children born in 1958 and found that children who grew up with both parents were on average better qualified and obtained better jobs. However, it was financial hardship and factors before the divorce which were thought to explain the poorer outcome. (Source: *British Medical Journal*, 4 October 1997; 315: 832)

Sterilisation without consent in Sweden and France.

In two separate BMJ articles, up to 60,000 Swedish women were reported to have been forcibly sterilised from the 1930s to the 1970s for 'undesirable' racial characteristics or otherwise 'inferior' qualities such as very poor eyesight, mental retardation or an 'unhealthy sexual appetite'; while in France it was claimed that tubal ligation - which even when voluntary is illegal - has been performed in recent years on about 15,000 mentally handicapped women, sometimes without their permission and even without their knowledge. Is eugenics ever far away? (Sources: *British Medical Journal*, 6 September 1997; 315: 563 and 20 September 1997; 315: 697)

Scientists with faith.

The percentage of scientists with religious faith has remained almost steady for 80 years. In 1916, 42% of scientists believed in a God who hears and answers prayer, while in 1996 the figure was 39%. (Source: *Nature*, 3 April 1997 reported in *Religion Watch*, May 1997, Vol.12 No.7 p4)

Spring Harvest young people and drugs.

In a paper titled 'Knowledge and experience of drug use amongst church affiliated young people', Cook et al describe a self report questionnaire survey among 7,666 young people at Spring Harvest in 1995. The statistics for those offered drugs and those trying drugs were only slightly lower overall than in secular surveys, though those giving more positive responses to questions on Christian commitment were significantly less likely to have been offered the drugs listed or to have used them. Churches take note. (Source: *Drug and Alcohol Dependence*, 1997; 46: 9-17)

Enabling the disabled.

Healing and Wholeness has a superb two-page spread of cartoons giving brilliant insights into attitudes to disability. The themes behind the cartoons give some hint: 'the compulsive labeller, the fixated stare/horrified flinch, the ignore-it ostrich, the over-willing helper, the intrusive friend, the admiring sanctifier, and the obsessive healer'. (Source: *Healing and Wholeness*, November/December 1997; p32-33)

Patients have responsibilities too - official.

Health Secretary Frank Dobson announced in October that the British government will replace the patient's charter with a new NHS Charter which will emphasise patients' responsibilities to the health service, for example, in keeping appointments and in treating NHS staff with respect. It will be published in July to coincide with the 50th anniversary of the NHS. Eutychus remembers stern instructions on early NHS medical cards and welcomes any reminder of reciprocal responsibility. (Source: *British Medical Journal*, 18 October 1997; 315: 971)

readers' letters:

Revising the Hippocratic Oath

Several took up the invitation in the first edition to comment on the comparison between the Hippocratic Oath and the BMA's draft revision of it.

***Dr Nicholas Vincent** from Chelmsford was critical of the revision and opposed to swearing any oaths:*

I have just read the article 'Off with the old - on with the new'. I found the 'new' version lacking any commitment or reference points. 'Core values' means different things to different people.
I have never sworn an oath and as a Christian I think I should not. Reference Matthew 5:33-37 and James 5:12. I have yet to end up in a court of law but I think I would quote them the above and then continue with my evidence.

***Dr Peter Snell** of Abergavenny took the opposite view:*

What an attractive and well-balanced magazine! On the question of the Oath, I could not possibly swear the Edelstein translation - 'by . . . all the gods and goddesses' etc. But I approve of the 'Draft Revision of the Hippocratic Oath' and gladly support it.

***Ruth Bennett** of Godalming, who trained in nursing and midwifery, makes a more detailed critique of the draft revision:*

My overall feeling about the draft 'Oath' is that it is a feeble, watered-down version of the original. It offers little protection to patients and clients and fails to uphold some of the high ideals of the Greek oath.

* Being religion-free it fails to uphold the standards which a practising Christian would expect to follow
* Contemporary it may be but, sadly, this reveals the current erosion of previously accepted norms
* It is not really a statement of ethics; the Geneva Convention Code of Medical Ethics is a clearer, simpler statement
* The first two sentences are nothing like an oath
* Many of the 'promises' are qualified: 'I will do my best', 'I will make every effort', 'as independently as possible', 'as truthfully as I can' are all phrases which imply that at times the person will not have to do these things
* The clear renunciation of abortion and euthanasia have vanished
* Confidentiality is watered down
* The undertaking to abstain from sexual relations with clients is missing
* The addition of respect for patients with limited mental awareness is welcome and should be regarded as including children

Whether doctors should swear an oath on qualification is open to question. Personally I am not sure that it should be an expectation. It may be valuable for the international community to have an agreed Code of Ethics such as the Geneva Convention but if this is the best the BMA can come up with, I would prefer that no modern 'oath' were imposed on entrants to the profession, or on those qualified longer.

*Two doctors have produced their own versions. **Dr Bryan Thompson** of Kilmarnock seems to have edited the 'old' and the 'new' into one:*

I promise in utmost truth/I swear by Almighty God that I will fulfil according to my ability and judgment the policies and details of this document:

1. I will wholeheartedly and unreservedly use my knowledge and acquired skills in the art of healing for the benefit of any person who may request them of me, or who may be presented to me for such. At the time of presentation and treatment, any person shall have my full attention and concern, with the compassion and respect due to them as my fellow human being.
2. I will always endeavour to keep the sick in my care from harmful measures or treatment, and from any form of injustice from third parties. I will take special care of vulnerable persons, who lack means of expressing themselves and their needs. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy or abortifacient except within the ethical and legal framework provided by the Medical Council or governmental health authority of my country (and that only if she has developed a life-endangering condition, and the tenets of Paragraph 3 are being observed).
3. I will not seek to keep a patient under my sole care when it is apparent that he/she is in need of specialist care beyond my capacity. Rather will I withdraw in favour of colleagues with the appropriate knowledge and expertise. In case of failure or mistake on my part, I am ready to acknowledge such a fault.
4. I will hold those who have taught me my art as equal to my parents, and each colleague who has gained knowledge and expertise in my own, or any other branch of medicine or health, with certification thereof, shall be as my brother or sister.
5. I accept that, in my turn, I will hold myself ready to share precepts and oral instruction in the art of healing, as I have learned them, with any students by me seeking to equip themselves for the practice of the art of healing in their generation.
6. Whatever house I may visit, I will enter for the benefit of the sick therein, remaining free of all intentional injustice, of all mischief, and in particular, of sexual relations with both female and male persons, be they servants or of the family.
7. What I may see or hear in the course of treatment, or even outside the treatment, in regard to the life of persons, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.
8. I will ensure patients receive the information and support they need to make decisions about disease prevention and improvement of their health. I will answer their queries as truthfully as I can, and respect their decisions unless that puts them or others at risk of harm. If I cannot agree with their requests, I will explain why.
9. I will exercise my professional judgment as independently as possible, and not allow it to be influenced by political pressures or factors such as the social standing of the patient, skin colour, religion, race, or gender. I will not put personal profit or advancement above my duty to patients.
10. I will seek to encourage fair and humane distribution of health resources. I will discourage policies harmful to public health, and I will oppose policies which breach internationally accepted norms of

human rights. I will seek to have laws changed which are contrary to patients' interests, or to my professional ethics.

Binding myself to the pursuance of the aforesaid policies, numbered 1-10, I hereby append my signature . . .

Dr Huw Francis *of Ealing has taken a more radical approach. His Oath is part of a critical essay, and in brackets are optional brief Christian affirmations:*

(In the Name of Almighty God) I solemnly pledge myself to the service of humanity and to the well-being of all I meet in my life and the Art.
In my life and the Art I will act with integrity, kindness and compassion and especially towards any in need. Remembering our common humanity, I will regard all men and women as my equals whatever their colour, race or creed, whether they are young or old, rich or poor, free or imprisoned, my friends or my enemies. Mindful of my own frailty, I will not be judgemental of the failings of others. I will be truthful, honourable and just in all my dealings, but especially in the practice of the Art and the pursuit of knowledge.
I will maintain the high traditions of the Art. All physicians shall be to me as my brothers and sisters. I will do nothing to sully their good name or that of the Art.
The welfare of my patients will be my first thought always. I will diligently give attention to their needs, seeking to understand their suffering and to restore them to health. I will respect the life of my patients and of all I meet, from its genetic origin and throughout the natural span. Never will I act so as to harm or to cause suffering; and I will not countenance the cruelty of others.
I will respect the autonomy of my patients and others. I will always explain the nature of illness, and of any investigation, treatment or research. I will do none of these things without the prior consent of the patient or subject, and I will accept any refusal with good grace. With children, the unconscious and those of limited understanding I will act in all things so as to respect their autonomy and the dignity of their person.
Whatever I learn about my patients or others in the practice of the Art or my daily round, I will not divulge without their consent, holding such knowledge in trust and confidence.
I will treat my patients with the best of my knowledge and skill. I will keep abreast of scientific and medical advances. I will not use any ineffective or harmful treatments. When any patient needs care greater than I can give, I will not hesitate to consult my colleagues.
If caring for my patients places me in danger through war, pestilence or disaster, I will not shirk my responsibilities or abandon them.
I make this commitment freely and faithfully (in the Name of Almighty God), seeking the understanding and help of all physicians as together we seek the good in life and the Art.

Withholding or withdrawing life saving treatment in children

Dr Peter Sidebotham*, a consultant in community child health in Bristol, comments on new ethical guidelines in paediatrics:*

In 1997 the Royal College of Paediatrics and Child Health produced a document *Withholding or Withdrawing Life Saving Treatment in Children*. This report provides a clear framework for thought and practice in an area which is far from clear. It outlines five situations where the withholding or withdrawal of curative medical treatment might be considered:

1. The brain dead child. The profession agrees that treatment in such circumstances is futile and withdrawal of current medical treatment is appropriate.

2. The permanent vegetative state. It may be appropriate to withdraw current therapy and to withhold further curative treatment.

3. The 'No Chance' situation. The child has such severe disease that life sustaining treatment simply delays death without significant alleviation of suffering.

4. The 'No Purpose' situation. Although the patient may be able to survive with treatment, the degree of physical or mental impairment will be so great that it is unreasonable to expect them to bear it.

5. The 'Unbearable' situation. The child and/or family feel that in the face of progressive and irreversible illness *further* treatment is more than can be borne.

The committee which drew up the document takes an unequivocal stand against euthanasia, which is welcome in the current climate of opinion. This is matched by an important emphasis on palliative care, stressing that 'withholding or withdrawing life saving treatment does not imply that a child will receive no care'. Withdrawing treatment is not intended to make survival a lottery, but rather to allow a child to die knowing we can manage that process in a respectful, sensitive way.

The five situations presented, along with examples and discussion of the background, do clarify what is probably common practice. On the whole I think this document will facilitate a sensitive approach to such decisions. I am nevertheless deeply disturbed that in its ethical framework the committee makes no statement on the ultimate value of each individual human life. Instead it concentrates on three principles of 'duty of care and partnership of care', 'legal duty', and 'respect for children's rights'.

As Christians we believe that all mankind is created in the image of God, and therefore of inestimable worth, irrespective of ability or status. Neglecting this, we tread dangerously into the realms of expediency. It is the 'No Purpose' situation I am most concerned about. Decisions on when another's life is not worth living should never be entered into lightly. Such decisions cannot be ignored, but I fear that this document, being based not on a biblical view of mankind created in God's image but on a humanist perspective of respect for children's rights, may encourage these decisions to be made prematurely and with insufficient regard for the child's life.

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 250 words, and if accepted may have to be edited for length.
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Among All Nations

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Christian healthcare worldwide

Photo: CMS

On a journey

'They admitted that they were aliens and strangers on earth . . If they had been thinking of the country they had left, they would have had opportunity to return. Instead, they were longing for a better country . .'
(From Hebrews 11:13-16)

When, in the creation story, Adam and Eve were turned out of the Garden of Eden, they were not turned out of an enclosed garden. They were turned into an enclosed wilderness, and became confined to the limitations of time and space. They saw things in physical proportions and felt overwhelmed. Their smallness made them feel meaningless.

God can turn this meaningless existence into a journey of hope. Abraham and Sarah left home and became too old to have children, but Abraham believed God's promise that he would have children as numerous as the stars he saw in the desert sky at night. They had one son of their own but many descendants, and countless spiritual children of Abraham and his God are still being born again today.

This issue includes several stories describing journeys of faith and obedience. One reports 'I changed my whole life's plans in two months'. Others have gone on journeys lasting a professional lifetime. Andrew Potter, working in Benin, visited colleagues in Nepal and found himself 'on a bit of a high'. Returning to his own work was 'Oh! so depressing'. Asking 'why are we here?' his answer on reflection was 'I am here to serve'. We hope the following pages will help you with some ideas for journeys of service.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

Highs & Lows *in Nepal and Benin*

Andrew Potter, an ophthalmologist, recounts feelings prompted by a visit to Nepal

One Sunday afternoon in Nepal two colleagues and I drove about six miles to visit a twelve hectare piece of land owned by the hospital. It was open farm-land. Now, a few years on, it is thickly wooded, as thousands of young trees have been planted. Several large ponds have been dug and stocked with fish. The sky was cloudless, the sun brilliant and, with a gentle warm breeze, it was idyllic.

I was in Nepal to upgrade my surgery. Christian Blind Mission has decided to offer blind people intraocular lens implants after cataract extraction so that they will no longer have to wear those thick, heavy glasses. Working alone for over twelve years I've not benefited much from meeting others who serve in the developing world. After walking through dense clumps of tall bamboo we sat down on a wooden veranda to chat. First to speak was Dr Margaret Hogeweg. For three months of each year she works with CBM visiting hospitals and clinics in South East Asia, including China, Mongolia, Tibet, Vietnam, Thailand, and Burma.

Eye camps

For seven weeks she works for the Lions Club of Holland, holding eye camps in Nepal in remote mountain villages. She and her eye nurses and a string of porters carry all they need: food, bedding, clothes, medicines, instruments, equipment. They walk for two or three days up valleys, over mountain passes, through snow, across rope bridges, along slopes where landslides have obliterated the footpaths, and fording streams, until they reach their first village.

They set up the clinic in any available building. For four or five days they examine patients, selecting those who need surgery, then operate and, leaving a couple of eye nurses there to look after the surgical patients, trek for a further two or three days to the next isolated hamlet. Over seven weeks she operates on between 350-400 patients (the number of operations for an 'average' ophthalmologist in England in a full year). She has done this for ten years - and is now in her fifties. Her work has been recognised by the Nepali government and she is to be decorated by the King.

For six weeks she visits Nigeria on behalf of the Dutch Leprosy Association. She travels for six months each year, leaving her husband in Holland. While at home she works for part of the year in a university department of ophthalmology. It makes one breathless just listening to her.

Next Dr Albrecht Hennig described how in 1983 he was sent to set up an eye department in a small general hospital in Lahan, south east Nepal, about twelve miles from the border with northern India. The population of Nepal is around 19 million, but India's 900 million seem just a stone's throw away. Annual outpatient attendance has soared from 17,000 to 72,000. Last year they operated on over 12,000. This puts into perspective my recent boasting in Benin, when I reached just over a thousand! CBM built him a 270-bed eye hospital next door to the general hospital and they employ a staff of sixty including two Nepali eye surgeons.

Dr Hennig's two sons are now in a boarding school in India. Before that they were in Kathmandu, which takes over a day to reach by car, so for several years his wife and sons lived in the capital during term time and the family endured long separations. That takes commitment.

And the woods and fish ponds? They are to help the hospital support itself financially. The timber can be sold and new trees planted. The fish will go to market and all this will provide income to enable the fees to be kept low. Meeting Dr Hogeweg and Dr Hennig was stimulating and enriching. I salute them.

Back in Benin

I was on a bit of a high in Nepal and not just because I was in the Himalayas. It is good for us to ask occasionally 'Why are we here?' Today in church, during the incomprehensible translation from French into Fon, my attention was drawn to verse 12 from Ephesians chapter 4: '. . to prepare God's people for works of service . .' Aha! 'Service' is not a word one hears very often these days. We hear of 'fulfilment', 'reaching one's potential', 'doing what feels comfortable'. Even among the so-called caring professions few talk of vocation.

Returning to Benin was oh! so depressing. I felt close to writing a letter of resignation. Somehow I didn't. A dreadful nurse left. Better ones took his place. Patients began to arrive in larger numbers. After six months without rain the heavens opened. But above and beyond all the difficulties is the sense from which I am unable to free myself. It is that I am here to serve. Should I leave, resign, or be fired, nothing will remove that vocation.

Dr Andrew Potter works in Benin and this article has been extracted with permission from his newsletters.

modern medicine modern mission

David Clegg looks back to Jesus to set a standard for contemporary Christian health-care with mission.

Jesus healed those he met who needed to be healed, and at the same time he spoke to them about the Kingdom of God[1]. Their healing was part of the evidence for his authority, but apart from that he had no hidden agenda.

No disgrace in the diagnosis

Whether the illness or disability was the result of their lifestyle, or that of their parents', or had no connection with either, their healing did not depend on repentance. On just one occasion[2] he did delay healing, as first he debated with the crowd about whether it was easier to heal the body or to forgive sin. In this case the paralysed man had been lowered through the roof by his friends in order to jump the queue. There was no danger of his being embarrassed further by this little bedside tutorial.

The only pre-condition for healing seems to have been faith in Jesus[3,4,5]. People asked him to heal them. No failure to heal nor complication of the cure is recorded. His disciples failed to cure an epileptic boy[6] but Jesus took over and healed him.

Once when a woman with menorrhagia secretly touched Jesus in a crowd[7] and was healed, he did ask her to say what had happened in order to teach that it was her faith in him that had healed her. Sometimes [8,9] he told the patient to tell no-one else because he wanted to avoid being delayed in his preaching ministry by his healing ministry. Moreover, he did not at this stage want his divine identity to cause open conflict with the authorities.[10]

Jesus healed people out of compassion.[11] They did not owe him anything. When he had cured ten men with leprosy[12], only one bothered to come back and thank him. Those he healed were under no obligation to follow him as a result of their healing.

If a physical cure of disease or disability is all that happens through healthcare, there is only a temporary benefit. Jesus' gospel teaches that whether we are sick or healthy, there is always sin to be forgiven, self to be abandoned and eternal life to be received. Following him means confessing his name and living a life of service. So, the healing practice of Jesus challenges a secular health service that may heal the body, but ignores the healing of the soul.

John the Baptist spent his life telling his nation, Israel, then under Roman occupation, that God would send the promised Messiah to deliver them. John, imprisoned by Herod, and seeing no sign of Israel's release, wondered whether he had made a mistake in pointing to Jesus as the one who would fulfil this prophecy. Jesus sent John's followers[13] back to him with the message: 'The blind receive sight, the lame walk, those who have leprosy are cured, the deaf hear, the dead are raised, and the good news is preached to the poor. Blessed is the man who does not fall away on account of me.'

Jesus' healing was evidence of the coming of the Kingdom of God, but his authority does cause some to fall away. Since his life on earth, a healing ministry to the poor has developed wherever that gospel has been preached. Jesus had taught his followers that they would do greater things than him. Scientific medicine could have controlled and eliminated diseases of poverty and affluence world-wide, but instead, lifestyles have seldom changed for the better. Technology has failed to control many potentially controllable diseases. And new ones have replaced those that have gone. Meanwhile curative medicine has priced itself beyond the reach of the world's poor.

In many churches in the developing world there has been a resurgence of faith healing. It may not always be honest but when it is honest, something greater than the cures is happening - 'the poor are hearing the good news preached'.

A diagnosis that disgraces us

As healthcare professionals, we and the societies who have raised us face a diagnosis that disgraces us. The gospel has not been preached and a healing ministry has not been taken to all the world. We may also face a therapy that is threatening to the economy on which our professions have been built, for when the poor are empowered the rich are disempowered. This was what Jesus wanted. It made him unpopular and led to his death.

In some places the emergent churches are using scientific medicine according to the values of the Kingdom of God. They are combining it in a holistic ministry that includes Kingdom preaching and teaching. In spite of opposition, partnership in these projects is the way medical mission should be going.

David Clegg has worked in southern Africa for 25 years, and is now the Overseas Support Secretary of the Christian Medical Fellowship and the General Secretary of the Medical Missionary Association.

References

1. Luke 9:11
2. Luke 5:17-26
3. Luke 7:9
4. Luke 8:50
5. Luke 18:42
6. Luke 9:37-43
7. Luke 8:43-48
8. Luke 4:43
9. Luke 5:14
10. Mark 3:12
11. Luke 7:13
12. Luke 17:11-19
13. Luke 7:18-23

Healing in the Killing Fields

A few hundred yards from the Church of Uganda mission hospital in Kiwoko stands a simple memorial. It marks the mass grave of 372 people killed by government soldiers in 1985. That atrocity was one of many perpetrated during the bush war in the Luwero Triangle in the 1980s.

These people were summarily shot, accused of sheltering members of Yoweri Museveni's National Resistance Army. In a poignant moment our Ugandan guides open the cover and we peer down into the darkness at a pile of skulls. 'Were any of these people your relatives?' we ask. All four of them nod silently.

Photo:John Crone/CMS

Moses (left) inspects a chicken coop

Luwero, Uganda's 'Killing Fields', was a byword for violence and inhumanity. In the wake of the bush war it was almost depopulated. Now the people are returning and Kiwoko Hospital, founded at the end of the war, is one of the signs of hope in the area. It began as a simple local clinic. Under the energetic leadership of Dr Ian Clarke of Church Mission Society, Ireland, it grew into a major hospital, offering a full range of services including a commitment to community based healthcare.

Dr Nick Wooding of CMS UK has been at Kiwoko for just a few months. Nick and his wife Kate are 'old hands' as far as Uganda is concerned. Between them they did five short term placements in Uganda before becoming CMS mission partners. One of Nick's tasks is to supervise community health care. 'I could stay at the hospital all the time, treat people and make them better. But that would do nothing to prevent disease', he says.

Community health workers

What is important, however, is the way he is going about it. There was already a team of local community health workers before Nick came to Kiwoko. His task is to help them set clear goals and to give the support they need to do the job. 'I try to stay in the background and can offer advice if asked. It is important that they know they can count on the support of senior staff at the hospital.'

That means working alongside the community health care team, in particular its leader Moses Ssekidde. Moses heads a team of six trainers and 30 community health workers. The community health workers are voluntary people selected by the community to mobilise and educate the community in health matters.

Moses says that the community's long term aim is to have a qualified community healthcare facilitator for every square kilometre in Kiwoko's catchment area. His team walk their beat or travel on bicycles provided by Friends of Kwiwoko.

Preventing disease is more than half the battle. The team has identified a number of key areas that will make a difference in the fight: nutrition, water and sanitation, AIDS prevention, economic development, mother and child health, prevention of communicable diseases, self help for the disabled, and evangelism. The problem of AIDS is growing. In 1986, according to Moses, there was just a single case in the Kiwoko district. Currently there are 35 sufferers.

Food and water

Proper nutrition is top of the list. The Ugandan government says that 19 per cent of the population is too poor to buy adequate food. 'Another problem is that even where families can grow enough food for their needs, they don't always know how to plan a balanced diet for their children', says Moses.

Next most urgent is provision of clean water and proper sanitation. Government surveys a decade ago in Luwero found that five out of 10 waterholes for domestic use were contaminated and only half the households had a properly constructed pit latrine.

Photo:John Crone/CMS

Dr Nick Wooding works the pump

Moses and his team have been systematically trying to put the situation right. Each member of the team has set clear goals of how many new water safety projects and pit latrines they expect to see in place over the coming months. Driving amid banana and coffee groves, along muddy tracks impassable by other than four-wheel drive vehicles, we are taken to see some of the latest projects.

We stop at a recently installed bore hole with a simple hand pump. The water is drinkable without the need to boil and serves around 300 people. We are taken to a house where the family has constructed a pit latrine, a wooden rack to store cooking utensils off the ground, a chicken coop to keep animals out of the family living area, and a walled-off oven. Falling into open fires is a source of horrendous injuries, and it happens far too often here.

It all sounds very basic. People in Britain would take these facilities (or better) for granted. Here in Luwero the fight to get them in place has a long way to go. Moses suggests that a network of 200 voluntary community health workers is needed to complete the job.

A new breed of educators

Recently Kiwoko sponsored Moses on a teacher training course. It has equipped him for one of the most important parts of his work, visiting the 22 schools in the district to teach health and hygiene.

He is one of a new breed of educators. Traditionally Ugandan schools emphasise rote learning, not suprisingly when classes can be as big as 60 and teaching resources are scarce. He breaks moulds, using mime, role play and music to get across his message.

We visit two schools. Our visit coincides with a local polio immunisation campaign. Moses is keen to promote it. In Uganda 69 per cent of disability is due to polio and could have been prevented.

He has devised a mime to show how immunised people can ward off disease. The message is simple. Immunisation protects you. A child stands out at the front. A group are given masks proclaiming they are antibodies. Another group play the role of germs, putting on suitably lurid masks made by Moses.

Photo:John Crone/CMS

Health messages under a mask

With no antibodies to protect him the lone child is easy prey for the germs who descend and wrestle him to the ground. But when he is surrounded by antibodies, the germs can get nowhere near him and they are wrestled to the ground. Everyone laughs, but few will forget the lesson.

We go to another school, a simple mud hut set among a grove of trees. There are 160 children on the roll and just four teachers. Recently a dentist on a short term elective in the Kiwoko district looked at the teeth of 2,000 children and found 500 needing dental work. We sit out in the open while Moses demonstrates the fundamentals of dental hygiene, improvising with the skull of a wild pig. He demonstrates use of sticks and charcoal for those without access to toothbrushes and paste.

Where evangelism comes in

Afterwards I asked Moses about an issue that intrigued me throughout our visit: where does evangelism come into all this?

'We do it by running community Bible classes', he tells me. 'Here we believe that health is a state of complete well-being, physical and spiritual. So that is why evangelism is included.'

'If someone is suffering from headache, that person has to be treated physically. But if someone has a negative attitude to other people, that is a spiritual illness and it has to be "getatable". We have found that since evangelism helps change attitudes it has played an important role in bringing better health.'

John Martin is a journalist and broadcaster, and is also Associate Editor of *Triple Helix*. He spent three weeks in Uganda in August 1997.

reviews:

Stop Check Go A practical guide for cross-cultural teamwork A short-term overseas projects checklist Ditch Townsend. OM publishing, Carlisle. 1996. 160pp. £7.99 Pb.

This book is written for Christians planning short trips (several weeks to several months) in teams overseas. The author was born to missionary doctors in Thailand, is married with three children, and has qualified in medicine. He set up and ran the Tear Fund Short Term Overseas Programmes (STOP) and has experience of a stressful short-term project himself. He has travelled widely and has been involved in providing critical incident debriefings. The difficulties of working overseas short-term as a health professional are such that at some stage most people will find themselves asking whether they have made a mistake. However, many of the disappointments and frustrations can be avoided with adequate briefing and planning.

The author deals succinctly with these difficulties within the space of a short book, divided into 67 subsections, each having space for notes. The four main sections each conclude with a checklist. The book reviews both established missions and newer para-church groups and has had support from the Evangelical Missionary Alliance and the Saltmine Trust.

Health, Healing & Wholeness Salvationist Perspectives
Ed Graham Calvert. Salvation Army IHQ, London. 1997. 191pp. £5 Pb.

This is not a book about how to cure specific illnesses. The biomedical model of medicine tends to be blamed for its failure to 'stem the tide of human misery' and has a limited place in the overall healing of individuals and communities.

The opening chapter sees the Salvationist answer - personal commitment to Christ - as 'the essential step through which healing occurs'. After a review of the theology of healing, there follow case studies in a wide variety of cultural and religious situations. Ian Campbell, International Health Programme Consultant, then interprets these stories. Implications for health programmes include:

1. Care is not enough unless it is incarnational. It is present in the home in the *favellas* of Rio de Janeiro, building trust with community leaders, and in the communities being submerged by HIV/AIDS.

2. Community is not simply a tool to get things done. It is a spiritual entity, a reflection of God's intention in creation. Consistent practices of facilitation, participation and teamwork should be seen in us by those we serve.

3. Change is not brought about by moralistic imperatives. Where values can be shared respectfully, an often heightened spiritual sensitivity is the result.

4. Hope is a programme goal. We need to speak out against false hope which may be projected through reliance on technologies and treatments. Hope comes from belonging, caring, changing, and knowing that goodness exists. Care, community, change and hope are transferable and transcultural concepts. The essence of mission is participation with others in growing to know God better in the grace of Christ.

The book is intended for non-medical readers but could serve as a catalyst for reflection by professionals in healthcare mission work who are searching for the meaning of 'development'.

resources:

Dentaid collect and refurbish dental equipment discarded in the UK, and distribute it in less developed countries. Funding is needed to service the equipment. Contact: Dentaid, The Old Baptist Chapel, Watergate Street, Llanfair Caereinion, Welshpool, Powys SO21 0RG. Tel. 01938 811017. Fax 01938 811107

ECHO International Health Services Limited provides Equipment for Charity Hospitals Overseas, and sells them equipment and drugs. The booklet *Selecting Medical Supplies for Basic Healthcare* is available from ECHO, price £3. Contact: ECHO, Ullswater Crescent, Coulsdon, Surrey CR5 2HR. Tel. 0181-660 2220. Fax 0181-668 0751. E-mail echo.intnlhealth@ofl. btx400.co.uk

Ichthus Motor Mission provides the cheapest possible cars for mission partners who have returned home on leave. Present fleet of over 100 is almost entirely donated. If you have a car to donate please ask for a leaflet. Contact: Grove Close, Forest Hill, London SE23 1AS. Tel. 0181-291 5144. Fax 0181-291 1652

TALC (Teaching Aids at Low Cost) is a charity that sells books, slide sets, videos, flannelgraphs, library packs, scales and child health cards. The books are appropriate, easy to understand and not normally available in bookshops. Ask for catalogue. Contact: TALC, PO Box 49, St Albans, Herts, AL1 5TX. Tel. 01727 853869. Fax 01727 846852

UNIMATCO Ltd offer a procurement service, giving advice and helping supply Christian workers and relief agencies with key supplies. Contact: Bulstrode, Oxford Road, Buckinghamshire SL9 8SZ. Tel. 01753 886105/880230. Fax 01753 889378

RESIDENTIAL REFRESHER COURSE

For Christian Doctors, Nurses and Midwives Working Overseas

June 22-July 3, at Oak Hill College, Southgate, London. Jointly organised by Christian Medical Fellowship and MMA.

Cost: Single from UK or a developing country £240, married couple £380. Single from developed country £350, married couple £600. Brochure and booking form available from:

Dr David Clegg, General Secretary MMA, 157 Waterloo Road, London SE1 8XN. Tel 0171 - 928 4694 Fax 0171 - 620 2453
E-mail 106333.673@compuserve.com

requests:

Sponsor sought: Chris Maddox, the subject of the biography *Turbulence and Toe Holds*, writes from his home in Thailand about a young man from Laos whom he has supported for many years and who needs a sponsor to enable him to study medicine. Further details available from CMF, 157 Waterloo Road, London, SE1 8XN. Tel. 0171-928 4694

vacancies overseas:

Please note that medical mission posts often require you to raise your own financial support, though help is given with this.

AFRICA

Benin (On board the Mercy Ship *Anastasis*)

Urgent need for anaesthetists February 2-April 3. For information, and other opportunities on the *Anastasis*, contact Jelly van der Wal, Medical Registrar, Rotterdam. Tel. 00 31 10 410 2877. E-mail MNSL@mercy-ships.org

Kenya

Kijabe Medical Centre. Short-term physicians and surgeons needed regularly to cover expanding needs and home assignments. This 220-bedded hospital, situated overlooking the Great Rift Valley in Kenya, has been a Mission Hospital since the beginning of the 20th Century. It has an exciting intern programme and is at present, along with two other mission hospitals, developing a 3-year Masters Degree Course Programme in Family Medicine. Doctors needed willing to come for 2-3 month periods or longer, to perform clinical work and to teach. Especially: GP/family medicine; general/orthopaedic/rehabilitation surgery; internal medicine; O&G; paediatrics; anaesthetics.
Contact Dr Raymond Givan, Medical Director, Kijabe Medical Centre, PO Box 20, Kijabe, Kenya. E-mail Raymond_Givan@aimint.org

South Africa (Kwa Zulu, Natal)

Dr and Dr Thirsk are desperate for anaesthetists. Ngwelizane Hospital has 960 beds and just over 50 doctors. They work under great difficulties and some dangers but describe themselves as 'one big family' in a hospital where everyone supports the other. Help with paediatrics, medicine, obstetrics, orthopaedics and primary health care would also be welcome, especially from senior people who could teach and attract junior staff. Contact: PO Box 4855, Hulett's Tea Room, Owl Road, Empageni, Kwa Zulu, Natal, South Africa. Tel./Fax 00 27 0351 921800

Tanzania

Mvumi Hospital requires a pharmacist immediately. As well as serving the Health Centre in Dodoma with its four doctors, another institution, and many patients from the Government hospital and outlying village dispensaries, the job requires a large element of training a national counterpart. National law requires there to be a qualified pharmacist, if the work is to continue. Expected length of time needed: 4-6 years. Necessary to learn Kiswahili. Requires a committed Christian responsible to the Bishop, to work with the diocese and take part in the life of the local church. Housing is provided. Schooling (in English) up to GCSE.

Kigoma Region. Christian Outreach require doctor to support district health services. Previous overseas experience essential. Some experience in obstetrics and surgery required. Situation available immediately. Contact: 1 New Street, Leamington Spa, Warwickshire CV31 1HP. Tel. 01926 315301

ASIA

Nepal

United Mission to Nepal: ICU nurse with at least 5 years' experience needed to help set up an ICU at a city hospital in the Kathmandu valley.

Urgent need for GPs for hospitals and also community health programmes. MRCGP desirable but for community work DTM&H an advantage. Applications: Dr Bill Gould, Health Services Director, UMN, PO Box 126, Kathmandu, Nepal. E-mail hso@umn.mos.com.np

International Nepal Fellowship: Urgent vacancies within the Hospitals Assistance Project (HAP) for doctors; nurses; paramedics; directors; managers; administrators.

The HAP project has input into training of nurses, surgeons, dentists, laboratory technicians, the Technical Assistance Programme (basic maintenance for medical equipment appropriate for district hospitals) and into a community health programme.

Contact INF, 69 Wentworth Road, Harborne, Birmingham B17 9SS or e-mail Neil Hamlet: md@inf.wlink.com.np

Papua New Guinea

Male ophthalmologist urgently needed for Government hospital in Goroka, in the PNG highlands. Present one leaves in June. Work based on the hospital but involves travelling, often by Mission Aviation Fellowship (MAF) aircraft. Preferably single and prepared to stay for 4 years. Contact: Dr Bill McAllister, Christian Blind Mission, Orwell House, Cowley Road, Cambridge CB4 4WY. Tel. 01223 506321. Fax 01223 506320

EUROPE

Albania

The ABC Clinic at Tirana needs a doctor to provide short-term cover and possibly long-term appointment. Job description available. Best contacted by e-mail: ABC@maf.org and david wheeler@maf.org. Information available from CMF, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694

WORLDWIDE

The Church Mission Society is seeking to increase its team of mission partners. Many openings relate to the CMS Healthcare and Community Development Strategy Panel. Openings in:

Uganda: doctor for hospital work, community development worker. Tanzania: doctor for hospital work, dental surgeon. Pakistan: doctor or midwife for hospital and community health work. Central Asia: primary health care. North Africa: midwives, nutritionist (need to learn Arabic and French). Nepal: community development worker. Philippines: community development worker.

Contact: CMS, Partnership House, 157 Waterloo Road, London SE1 8UU. Tel. 0171- 928 8681

Among All Nations is produced in partnership with the Medical Missionary Association and Christians in Health Care as the international section of *Triple Helix*.

They also produce *Saving Health* which has more material on healthcare with mission, and a more comprehensive list of multidisciplinary opportunities for service. This is currently produced two to three times a year, and is available for a minimum donation of £5 per annum (£3 students, missionaries and retired).

MMA has a database of people who would like to be contacted when a suitable opening in a mission or church hospital is notified. Please contact for a form.

Medical Missionary Association
Registered Charity 224636
General Secretary: Dr David Clegg. 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453. E-mail 106333.673@compuserve.com

Christians in Health Care
Registered Charity 328018
Director: Howard Lyons MSc FHSM. 11 Grove Road, Northwood, Middlesex HA6 2AP. Tel. 01923 825634. Fax 01923 840562. E-mail howardlyons@msn.com

Website: http://christian-healthcare.org.uk

a world of *opportunity*

Two students in different disciplines were changed by their electives

Deborah Roberts was a final year nursing student in Liverpool when she did her elective in Uganda in February 1997

I have long wanted to nurse and travel. Here was my opportunity to combine the two. I applied to a number of organisations who have links with hospitals in India, South America, Africa and Israel. Africa Inland Mission International (AIM) offered me the chance to nurse in Uganda with only six weeks to go.

Photo:John Crone/CMS

Inside the chapel at Kagando

Kagando is located in the foothills of the Ruwenzori Mountains, bordering Zaire, in the south west of the country. It is a very remote but beautiful place with which I instantly fell in love. Kasese is the nearest town, about 45 km to the north, and the equator is just five km away. The hospital was established about 30 years ago by AIM and serves a district of some 250,000 people, despite only having 280 beds. It has a reputation for providing good and comprehensive services to the local community. Patients have to pay for their treatment here, but are free from the rumoured bribery of government hospitals. People will travel considerable distances for treatment at Kagando. During my four weeks I assisted in theatre, helped deliver babies, and expanded my (limited) paediatric knowledge. Most of my colleagues were Ugandan. Westerners are in the process of handing the running of the hospital over to a Ugandan leadership team. The staff were extremely welcoming and supportive, and I gained significant insight into nursing in Uganda, where the relatives take a very active role in caring (so different from Britain).

I am glad I took the plunge and went to Africa for my elective. It was a time of consolidation and reflection on my training so far and a chance to consider future options. Once I have qualified I hope to return to Africa to work, to Uganda if possible.

Scott Farmery was a medical student in Aberdeen when a two month elective changed his life plans

I arrived in Bangladesh the day the rains finished. Waterlogged fields made the final approach to the airport look like we were touching down on a swamp. The temperature was warm, the air humid but bearable. Airports are thankfully the same the world over.

Day two found me on a domestic flight north to the mission hospital at Parbatipur. The hospital is recent compared with the public health scheme founded by the same mission nearly thirty years ago, but its main emphasis is still prevention and community health. The staff are a mixture of nationals and expatriates. Recently the directorship and the medical team leadership positions were allocated to Bangladeshis. All made me feel very welcome.

Before I came I had tried to define what I wanted to achieve:
1. To make a contribution to the hospital, whether by helping in clinics, analysing statistics or building latrines.
2. To undertake a project acceptable for my degree.
3. To understand what it meant to be a medical missionary.
4. To get an insight into the Bangladeshi culture.

I deliberately decided against using my time to gain clinical experience or to learn about medical problems peculiar to Bangladesh. I managed all my ambitions, and also assisted a little on ward rounds.

My project involved assessing the mortality figures for the hospital. The importance of primary prevention was nowhere more clear than in those pathetic figures and tragic case notes. Infants dying from infections almost unheard of in the UK, mothers presenting with advanced pre-eclampsia, widespread TB, and malnutrition. At the root of 101 diseases is poverty in all its cruel aspects.

I changed my whole life's plans in two months. Surgery, my original ambition, would have saved just four of the 214 lives lost in two years. Based on my research I discovered that public health was the most needed specialty in situations like this. It was a lesson I wasn't expecting. I would rate my elective as one of the most incredible and constructive periods of my life. It was certainly stressful at times, but the value of experience in the developing world cannot be over-emphasised.

RevieWWWs

with CyberDoc

In a regular series, CyberDoc will review and critique websites relevant to you as a health professional interested in the Christian dimensions, trusting this will help you trawl through the web and find what you really need. But first, for anyone who's been asleep for the last year or two or who hasn't yet dared to ask, what is the Internet?

Introducing the Internet

Tony Blair's recent meeting with Microsoft magnate Bill Gates and then extolling the virtues of a 'National Grid for Learning' is just one development that makes the Internet topical at the moment.

The Internet is a network of computers which was originally designed by the United States military to withstand a nuclear war. One part of it, the **world wide web (WWW)** is an electronic magazine with no editor or contents page and over 50,000,000 pages published by different organisations and individuals.

Every page has a unique address which starts with 'http://'. All programs to access the WWW (eg *Internet Explorer* or *Netscape*) will have a space near the top of the screen where you can type an address in yourself. By clicking the mouse on a highlighted word, you are transported to another page which could be anywhere in the world. This process, which can be frustratingly slow and unproductive, is called 'surfing' - maybe one day it will become more like the real thing.

E-mail is the other most important aspect at the moment. This electronic equivalent of a letter is 'posted' via the phone line at local call rates and can arrive on the other side of the world seconds later.

The Internet is growing faster than the telephone did when it was introduced. Most people agree it will incorporate all our communication needs in the 21st century. One company plans to use existing electricity power cables as a pipe for computer data, providing connections that are twenty times faster than at present. Before much longer you will be able to send an e-mail to your computerised fridge to cancel its regular order for your weekly supplies as you have decided to stay an extra week on holiday. Then, most of your week's work could be carried out in your hotel room and no-one need know. Tele-medicine, tele-shopping, tele-banking . . . where will it all end?

Some people dislike the invasion of computers into our everyday lives. Because of the pornography and pae-dophile material on it, some Christians shy away from the Internet. The fact is, the Net is simply another morally neutral technology. Like the television and the phone it certainly will have an impact on our lives, but not necessarily the dire one predicted. The real question is: will Christians allow 'the world' to dominate the fastest global communication tool known to man? If we believe in the power of the Gospel, we need to see it released more and more into these media.

With the Internet, national boundaries become irrelevant to the passage of infor-mation. It is virtually impossible to censor, and whilst this can be unfortunate, inter-ested individuals are consequently reading Christian webpages in the hearts of countries where Bibles are unobtainable.

Dr Patrick Dixon's website http://people.delphi.com/patrickdixon

Patrick Dixon is one of the most well-known and energetic Christian doctors in the UK. He founded the AIDS charity ACET and has written more books in the last five years than most people would in a lifetime. Patrick passionately explores issues of interest to Christian health pro-fessionals. Genetic engineering, corrupt politicians, and even a ride in the Royal London Hospital's helicopter are included on his site.

Each article is well written, although the whole site is fairly basic to look at. He extols the virtues of the new technology, at times with an almost evangelistic zeal. For example, the *Nokia communicator* is hailed for its ability to access the Internet from anywhere. He described the joy of being totally in contact. So now, not only do we have pagers and mobile phones, even our e-mail can follow us wherever we go. To be connected to the Internet at all times would not be my idea of fun! I am sure that Patrick quickly came to realise that the Internet like everything else needs to be switched off from time to time.

There is certainly some good information on Patrick's pages. My one criticism is the lack of links to other sites. Anyone who has spent any time on the Internet knows that finding relevant information is the most difficult aspect to it all. Ironically, the sites I repeatedly return to are the ones that lead me to others containing subjects I am inter-ested in. Without these links even the best website can seem like a dead end street. Even ACET don't get a link; in fact they hardly get a mention! However, don't let this criticism put you off visiting this excellent site, as it is by no means the only good site with very few links to other pages.

Ratings (out of five)

Appearance **
Content ****
Ease of finding other information *
Summary: an up to date site that is well worth a visit

If the web still confuses you and seems like an endless sea, Dr Adrian Warnock has produced a guide called 'Get Fishing'. To read it, visit http://home.ml.org/warnock/getfish.htm on the world wide web. You can contact Adrian by e-mail: thedoctor@bigfoot.com

CyberDoc is Adrian Warnock, a locum SHO in psychiatry based in London. He leads a small group in his local church, and maintains his own website on the Internet.

Who and what should come first?

The New Testament[1] *describes a day when Jesus faced competing healthcare demands. A synagogue ruler named Jairus asks him to hurry to the deathbed of his 12-year-old daughter, believing that if Jesus gets there in time she will be healed. On the way, a woman with heavy vaginal bleeding for 12 years touches his cloak and is healed. A discussion with Jesus ensues, ending with him commending her for her faith, but during this delay, news comes of the girl's death. Jesus goes anyway, and raises her from the dead.*

Simon Steer comments on the principles and encouragements this passage holds for health professionals under pressure.

'I feel pulled in so many directions. Today I needed to be in several places at once. It's so hard working out who and what should come first.' My wife was reflecting on another fairly typical day in her work as an NHS speech therapist. Listening to her responses to my 'How did it go today?' these past couple of years has been quite an education. The world of conflicting healthcare demands is now partly my world as well. Many jobs involve balancing priorities but the task seems particularly challenging when the goods at stake are people's health and even their lives.

Thinking about my wife's experience has given me a new appreciation for the biblical incidents described. It's a remarkable story about Jesus being faced with a conflict of demands in healthcare provision. While the episode does not give us a model to be imitated slavishly, it does suggest a pattern of response from which we may be able to draw important principles and encouragement in our own situations.

As is common in Mark's Gospel, the passage tells two stories, with one interposed in the middle of the other. This brings them into a relationship of 'compare and contrast', thereby providing the narrative with a cutting edge. I have been greatly helped in my appreciation of this story by the little book *Mark at Work* by John Davies and John Vincent[2].

In the inner story, the woman is in a continual and chronic state of haemorrhage, a constant menstruation. She is not only unwell but unclean according to Jewish law, excluded from the community - the religious purity of the respectable requires that the woman be ostracised. And whose job is it to ensure that the rules are kept and the woman excluded? It is Jairus', the ruler of the synagogue. These two individuals whose interests are fundamentally incompatible are brought face to face in the presence of Jesus. Davies and Vincent point out some fascinating contrasts between the two:

Jairus	The woman
He is in authority in the religious system	She is a victim of the religious system
He is a person of privilege in the culture	She is rejected by the culture
He is named	She is anonymous
He is male, father, surrounded by family	She is female, isolated, with no support
He is a public person who makes a public request, but gets healing in private	She is a private person who makes a secretive appoach, but gets healing in public

There are also striking differences between the two patients:

The daughter of Jairus	The woman
She is 12 years old	She has been losing lifeblood for 12 years
She is an acute emergency	Her condition is chronic
She is at the age of starting to be menstrual	She is continuously menstrual
She, the daughter of privilege, has to wait for Jesus' attention	She, the outsider interrupts and Jesus attends to her first
She is restored to a place in the sharing of food in the household	She is restored to a place in the 'shalom', the peace and justice of God

What are some of the principles emerging from this Jesus-encounter that we might apply to our own contexts of competing demands?

1. Give priority to the poor and marginalised

The person on the margins of society is given priority. As Christians we are to reflect God's particular concern for the poor, the oppressed, the socially excluded. It is 'the least of these' who should be at the top of the list to receive healthcare.

2. Emphasise our unity before God

The privileged and the unprivileged become part of what Davies and Vincent call 'a common fellowship of the healed'. As Christians we must emphasise that 'we are in this together' and that the gospel breaks down socio-economic barriers. Christian prayer and healing ministries can be an effective means of emphasising our unity before God.

3. Pursue holistic healthcare

Jesus provides a model of holistic medicine. Physical healing is insufficient; there is a spiritual and a communal dimension. The woman must be affirmed in her faith and incorporated into the community; the girl must be nourished physically and relationally.

4. Be confident that God is with us

We worship a God who has, in Jesus Christ, experienced the challenges of multiple needs and competing demands. We can, therefore, face the challenges of our own professional lives in the power of the Spirit, in the presence of Christ who has been there before us.

Rev Simon Steer is Education Director at the Institute for Contemporary Christianity in London.

References
1. Mark 5:21-43
2. Davies J and Vincent J. *Mark at Work*. BRF 1986

Saying ‘No’

Yesterday I had a four-year-old visitor who clearly knew her own mind. She was able very decidedly to express her views, especially when her parents had different ideas. The word ‘No’ featured prominently and had probably done so since before her first birthday. The ability to say this powerful little word is one of our earliest linguistic achievements. Why then, as we get older, do we find it so hard to say?

Earlier this century, a popular slogan against alcohol said: ‘Have courage, my boy, to say No’. A message about marriage was similarly emphatic: ‘If in doubt, don’t.’ In today’s moral climate such advice may still be needed but is less likely to be heeded. That the best contraceptive is ‘No’ may be preached without being practised.

Yet it is often those who already have the highest standards of personal morality who find ‘No’ such a hard word to say, not (perhaps) so much in sexual matters as in professional and public life. Christian professionals are particularly vulnerable, aware not only of the need to maintain moral behaviour in personal and family life, but wanting to be shining lights in the workplace as well. Add to this the likelihood of the local church pouncing upon us as potential leaders and there are far too many opportunities to say ‘Yes’ when we should say ‘No’. The temptation is not to do wrong but to try to do too much good.

We cannot meet all the needs

‘A need does not constitute a call’ was another old slogan, this time addressed to Christians considering service overseas. It was sometimes used as a ready excuse by those unwilling to obey a call even when they heard one, yet there is some truth in the adage. None of us can meet all the needs we know of already, let alone those further afield. Even Jesus, told the crowds were out looking for him, said ‘Let’s go’ (Mark 1:37-38).

Significantly for us, this surprising response came after a night of prayer. We may sometimes get ourselves utterly tied up in action (and reading through Mark 1 can leave us a bit breathless) without the balance of seeking the Father’s wisdom. There are times to call it a day and move on, even if it sometimes seems like leaving a need unmet. I have often been consoled (and chastened) to find that I am not indispensable and that God has other servants around, as well as a different timetable from mine. Saying ‘Yes’ when he would have preferred ‘No’ means this particular activity is not being done with his blessing. It will probably not be done very well either, if it signals my being too stretched already to have taken time to tune in to him first.

In the pressures of modern life, with faxes and e-mails as well as the ever-intrusive telephone, people expect quick responses and all too often get them. Try never to commit yourself to taking on something extra when the request comes by phone. Take time to think, pray and ring back. Often, that first inner sense of reserve does not go away on reflection and the answer has to be an apologetic ‘No’. The Holy Spirit has promised to guide us and this may be by giving a nudge in the right direction, but we must be willing to be nudged.

Pride and pressures

One of the hidden motives that makes us say an inappropriate ‘Yes’ can be simple unadulterated pride. We feel quite someone to have been asked. We may rationalise our reaction as taking up an opportunity for witness via the lecture room or from the pulpit, when at root we are responding to flattery. There are times when the pride has to be repented of but the job still taken on. There are also times to suggest another name, perhaps someone whose gifts have hitherto been underused but who could be encouraged by this opportunity.

Alternatively, we may fear that our stock amongst our colleagues will fall if we decline. Peer pressure can be enormous, but is not the last word in guidance. Our peers are under pressure themselves. It may take the courage of one person digging in their heels, presenting a better strategy, approaching an authority, refusing to participate in some dubious activity, and so on, to help turn the tide and reduce the pressure. Naturally (or rather, supernaturally) this ‘No’ must be said graciously and backed with reason. It will then be an informed response, not an emotional outburst, and this itself may act as a shining light.

Our God is gracious. Some duties are inescapable, and our days and diaries do fill up, but he also knows our frame and our inclinations. He gives us wiser Christians, sometimes as colleagues, who can be honest with us and help us talk about and pray through our dilemmas and decisions.

He offers us little spaces where we can listen to his Spirit’s prompting - though we have to take up these opportunities. He has also been known to arrange for a meeting to be cancelled, or for patients not to turn up, providing some ‘elastic’ in the tension of an exhausting day. He may sometimes have to allow us to fall ill or have an enforced rest before his messages can get through.

When we have learned to listen to him we will have greater confidence in ‘letting our No be No’. We will also be enabled to say a glad ‘Yes’ to the tasks he has earmarked just for us to do.

Janet Goodall is a retired consultant paediatrician who has written extensively about children, and the lessons we can learn from them.

Three tips for saying ‘No’

1. Guard your time - Schedule family, leisure and personal time into your diary. Then you can truthfully say ‘Sorry, I already have a commitment then’.

2. Choose your time - Don’t say ‘yes’ in the corridor, when you may be in a rush with your mind elsewhere. Instead: ‘Please phone me later so I can concentrate on what’s best for both of us’.

3. Take your time - No-one will deny you an opportunity to sift what’s really important. ‘Please give me a little time to think this over. I’ll let you know by Tuesday.’

reviews:

Good Enough for God

Anne Townsend. Triangle (SPCK), London. 1996. 121pp. £5.99 Pb.

Our image of God, the pursuit of perfection, and holiness are examined and reinterpreted in the light of psychology in this latest book by Anne Townsend, a doctor and former missionary in Thailand who is now a psychotherapist and an Anglican priest.

The author sees people undergoing psychoanalysis as searching for something similar to sanctification - 'a searching for the holy grail of wholeness, completion and healing'. In this book she attempts to merge the insights of psychology, particularly those of Carl Jung, with Christian beliefs to help people become 'increasingly whole, moving towards integration, becoming more and more the people we truly are'.

The examples she uses are probably painfully familiar to any who have dealings with emotionally distressed Christians, and all of us will recognise elements of our own struggles in them. We may all be reluctant to enter dark areas of our personalities and Christians are not immune from using spiritual language 'to avoid facing the reality of what they themselves are really like under the outer respectable mask they wear most of the time'.

Through psychoanalysis and psychological insights Anne Townsend sees a way to face this reality. She sees most people as suffering from emotional hurts experienced from infancy onwards, and many of us as needing deep healing of the kind she believes can be provided by the psychotherapeutic approach. Psychotherapy or counselling from well-trained professionals, who are not necessarily Christian, is seen as complementary to Christianity, not in competition with it. It can provide understanding of emotional and psychological struggles and help with them. Anne Townsend speaks of her own crisis of faith and period of despair, and how she came to a faith rather different from her previous evangelical certainty - one in which she finds more room for doubt and uncertainty, with a view of God less influenced by the projections of internal conflicts and more in harmony with people's emotional needs.

Freud suggested getting rid of God. Anne doesn't see that as necessary but it is as if religion is but one way to find help in the journey of self-understanding, and so the uniqueness of the Christian gospel and of Jesus Christ are diminished. Jesus is considered a symbol - in Jungian thought a symbol is something rooted in the unconscious mind with power to bring order out of inner chaos. The insights of psychoanalysis seem ultimately more important than the biblical revelation and objective truth takes a back seat to the driving power of the symbols, archetypes and metaphors of psychoanalytical thinking.

However, the author gives the final word to John Calvin who advocated first beholding God's countenance and then contemplating self as the way to self-knowledge. If we can behold God as he is and face the reality of our inner selves in the light of that, we should find we are becoming more and more the people we are meant to be - truly good enough for God. This book will help some to do that, particularly if they are interested in Jungian psychology, and can give all of us valuable insights into our own views of God and of ourselves.

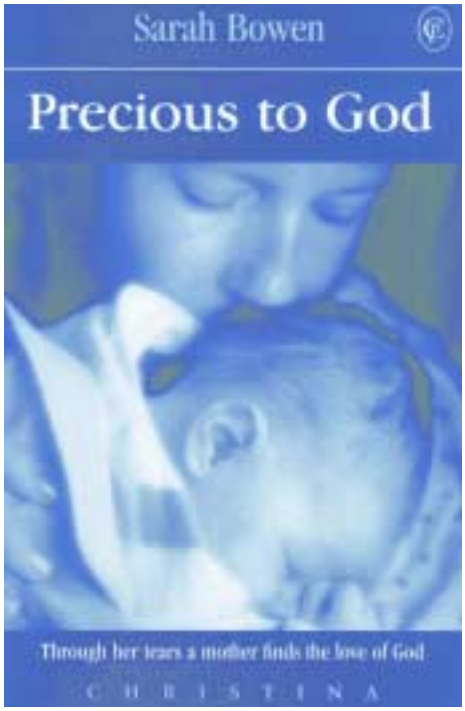
Evelyn Sharpe
(Consultant Psychiatrist, InterHealth)

Precious to God

Sarah Bowen. Christina Press, Crowborough. 1997. 124pp. £5.99 Pb.

Coming to terms with one child with cerebral palsy, let alone two, is an achievement in itself. Being able to share the pain, the frustrations, the joy and the love in such a highly readable way is remarkable. Sarah Bowen's book vividly describes the all-too-short lives of Claire and her brother Jimmy. She shares with humour and honesty the trials and tribulations of having two children with severe physical and mental handicaps. Her book gives a very good insight into the realities of life with two handicapped children, with all the practical problems and stereotyped attitudes from some people, including health professionals.

As a nurse myself, it was salutary to read the approach of some of the professionals whom Sarah and her husband Dick encountered. When one or other of their children became ill, there were doctors and nurses who clearly thought that 'they knew best' and did not listen to the devoted parents who cared for the children day in and day out. On the other hand, the understanding and the sensitivity of several GPs and the calm continuing presence of their consultant paediatrician shine through as great contrasts to other colleagues' insensitivity.



The book is also about a journey in Christian faith from the desperate prayers in the first few days of Claire's life when she started to have convulsions, through the lifting to God of the heavy burden of caring, to a quiet acceptance of death when it came first to Jimmy and then to Claire. 'Claire and James brought the love of God into our lives - that is the greatest gift that one person can give another.'

Sarah and Dick received another gift from God - Alice, a normal daughter born the year after Claire died. Read this book. It will make you smile and bring tears to your eyes, but you will see God in what many people would regard as a double tragedy.

Sarah Whitfield
(Chief Executive, Dorothy House Foundation, Winsley, Wiltshire)

Darwin's Black Box The biochemical challenge to evolution

Michael Behe. The Free Press, USA. 1996. 307pp. $25 Hb.

Michael Behe is an Associate Professor of Biochemistry at Lehigh University in the USA who believes that biological diversity derives from common descent but who is sceptical that the Darwinian processes of natural selection are sufficient to generate such complexity. Behe, a Catholic, does not hold to young earth creationism, but instead believes that there are 'irreducibly complex systems' in cellular biochemistry which can only be explained by invoking a God of design.

These systems, such as the clotting of the blood and the molecular mechanisms involved in the immune system, only function correctly as complete systems, and so Behe thinks they could not have evolved gradually.

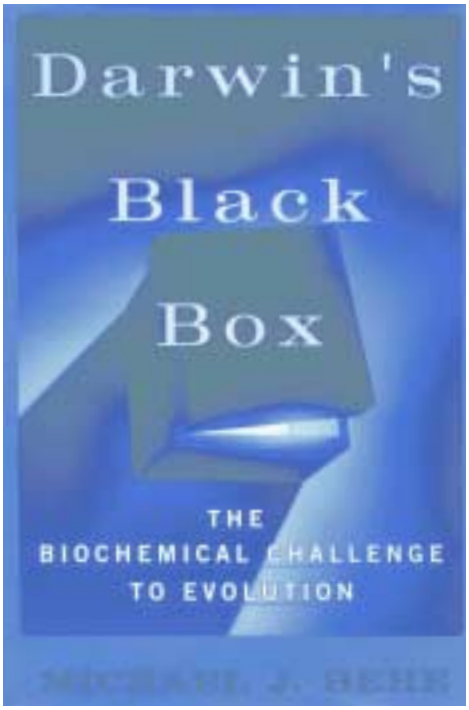
Curiously this position leads Behe to suggest that 'Some features of the cell appear to be the result of simple natural processes, others probably so. Still other features were almost certainly designed' (p208). 'Design' is therefore presented as one of a range of options for explaining biological phenomena. 'The fact that some biochemical systems may have been designed by an intelligent agent does not mean that any of the other factors are not operative, common, or important' (p230).

There are, I think, at least three fundamental flaws with the position that Behe adopts. First, the phrase 'irreducibly complex' simply describes our current ignorance of how a particular biochemical sequence of events evolved.

A century ago biologists were convinced that many systems, such as the molecular basis for inheritance, would never receive adequate scientific explanations, but today the complexities of DNA have been largely uncovered. To describe a system as 'irreducibly complex' is to be held a hostage to fortune.

Second, Behe's position is the classic 'god of the gaps' argument of pointing to natural phenomena which science is currently unable to explain and then presenting these phenomena as evidence for god's existence. The problem is that as scientific explanations become adequate for the task, so the postulated 'god' shrinks in stature.

Third, design as a mode of explanation operates on a different level from biochemical explanations. It is perfectly possible to understand all the components of a molecular system in great detail and yet still believe that the system as a whole has been designed. These are complementary not rival understandings of the same entity.



Biblically minded Christians will not see the created order as divided into some portions which have been 'designed' and some which 'occur by natural processes', because they believe that its every aspect has been created by God and is continually sustained by him (Psalm 104).

The created world is a seamless cloth of God's activity. There are no 'gaps'. Scientific descriptions represent our limited human attempts to describe God's activities as truthfully as we can. Whether science can currently explain a particular biochemical phenomenon is irrelevant to our faith in God as creator.

Denis Alexander
(Head of the T Cell Laboratory at The Babraham Institute, Cambridge, and Editor of the journal *Science and Christian Belief*)

Who Owns Our Bodies? Making moral choices in health care

John Spiers. Radcliffe Medical Press, Oxford. 1997. 97pp. £17.50 Pb.

This short text is based on a lecture given to the Institute of Health Policy Studies at Southampton University in 1996 with the addition of an introduction and afterword. Overall I found the book very disappointing since I expected a much deeper and less biased examination of the ethical issues relating to euthanasia and the care of patients.

I tend to agree with the discussion of the ways in which doctors see patients, and how medical training and career progression may make it harder for the patient to be seen as a person. Also, we do need to provide adequate information for patients so they can make a decision regarding their treatment and refuse it if they so desire. However, the majority of the text is a circuitous and fragmented philosophical argument relating to personal autonomy, and is widely referenced from other works, since the author recognizes that his original training was as a historian.

Although issues of autonomy and personal choice clearly relate to the title, and have to be included in such a discussion, I found the presentation very one sided with opposing views mentioned only very superficially (if at all) and then dismissed without further comment. The author suggests there is a greater need for more palliative care, but leaves an uncertain impression of its significance since the only mention of it is in the introduction. The overwhelming emphasis is placed on 'self' and 'rights' under the politically correct term 'autonomy', with no place for 'relationship' and 'community', be they Christian or otherwise. To quote the author, is the only basis of our relationship with others 'That we should not merely live passively with a stranger'?

There seems no medical input into the text, which means that it offers very little help in tackling the difficult ethical questions around the issues of life and death. In addition there are gross inaccuracies which display a singular lack of understanding, and/or disdain for the opinions of others. There are no references to, and therefore no discussion of, the

Report of the House of Lords' Select Committee on Medical Ethics, although it is listed as other source material.

This Report clearly stated that the phrase 'passive euthanasia' should no longer be used and preferred 'treatment limiting decisions' in order to recognise that intention is of major importance and that 'double effect' should not be interpreted as euthanasia. The author has not only ignored this advice, but has also incorrectly used the terms 'involuntary' and 'non-voluntary euthanasia', leaving the reader uncertain as to his meaning.

He also discusses brain death, coma and persistent vegetative state as being synonymous and argues that death needs to be redefined. The impression he gives is that the majority of doctors still hold the view that 'everything possible should be done to maintain life'. Surely most recognize that there is a dying process and it should not be prolonged unnecessarily by instituting treatment without hope of cure for the patient? Therefore, the medical definition of death is sufficient.

Perhaps the book has the wrong subtitle and it should read 'making personal choices in health care'? Morals are personal but they have to be set out in an ethical manner to provide the basis of life for society as a whole. There are aspects of this work, which is from a health policy advisor and the Chairman of The Patients' Association, which make me fear for the future of medicine within our health service.

John Peacock
(Senior Lecturer and Consultant Anaesthetist, Royal Hallamshire Hospital, Sheffield)

Euthanasia - Issues for the Nineties - Volume 4

Ed Craig Donellan. Independence Educational Publishers, Cambridge. 1997. 40pp A4. £5.95 Pb.

Craig Donellan is an editor well-known to students of A-level Religious Studies who are following any ethics course. This volume is a collection of material from other sources, attractively presented and illustrated, with a number of eye-catching articles. Closer inspection reveals some very interesting and often undebated aspects of the issue, such as what doctors think ('Till Death Us Do Part?') and how nurses feel ('The Quality of Death'). Certainly a number of the articles will be ones to which students and teachers have had no access.

The volume is split into three chapters - the moral dilemma, the medical debate, and living wills. Each comprises a number of related articles, which actually overlap in chapters one and two, so are not as exclusive as the Contents page suggests. These try to give a whole range of aspects, and anyone reading the volume will feel more enlightened.

The intention is to make people think, and to suggest ways in which to learn more about the various stances, once these have been demonstrated briefly. Do not expect to be shepherded through the issue as textbooks often do, nor expect to become a specialist on the subject. This volume sets out to do neither.

The article on religious attitudes is disappointing - too many groups, too few details on each. Every major Christian group has published material on euthanasia; this would have been welcome.

The language level of the articles varies, reflecting the many sources in terms of specialised vocabulary and style. This will put off most students below A-level, and teachers in schools will have to be very selective in using articles from it. A few useful addresses are included at the end, where the Christian Medical Fellowship is erroneously called 'Federation'. Students should have been directed to send an SAE when requesting information.

Overall, a useful book to have on a library shelf, but I do wonder how much use students will make of it, given its difficult language (putting off GCSE candidates) but lack of depth (putting off A-level candidates). Perhaps it needs to be in the hands of teachers.

Lesley Parry
(Head of Religious Education, Bedford High School, Leigh)

The Medical Consultation

A practical guide for the hospital specialist

David Short. BJHM Occasional Series, Quay Books Division of Mark Allen Publishing Ltd, Salisbury. 1995. 129pp. £14.95 Pb.

This book is a welcome addition to the literature, covering as it does an area of practice which is fundamental to all clinical specialties, yet is rarely discussed and less still written about. Perhaps in this modern age of technology the importance of the medical consultation tends to be sidelined and there is a temptation to investigate before taking a detailed history. The author gives many helpful hints on establishing a diagnosis through careful history taking.

Perhaps the main benefit of the book however, is the emphasis on the medical consultation from the *patient's* perspective, with many intriguing insights into the *therapeutic* effect a caring and skilfully conducted consultation may have. It is a reminder to all busy hospital practitioners that time spent in this exercise is well spent.

The book is more than a guide to successful history taking. It also offers advice on a holistic approach to patient care. The author gives examples on maintaining high professional standards in, for example, letter writing and prescribing, and he also provides wise counsel about the general conduct and attitude of the consultant. There is a helpful chapter on private practice.

It is written in a very readable style, helped by the inclusion of chapter subheadings and 'bullet points'. Each of the 15 chapters is quite short and is liberally sprinkled with interesting quotations, which are well referenced.

I have no hesitation in recommending this book, and think any hospital doctor would benefit from reading it - as would their patients!

Paul Stonelake
(Consultant Surgeon, City Hospital NHS Trust, Birmingham)

network news:

‘Solomon’s Thought for the Day’ Desk Calendar

The Bible book ‘Proverbs’ contains many nuggets of wisdom to challenge and encourage health professionals and 366 such thoughts have been collected into an attractive daily desk calendar. Each biblical insight is accompanied by some contemporary wisdom from Derek Kidner or Michael Schluter.

One calendar costs £11.50 plus £2.50 p&p, with reductions for further sets. Contact: The Jubilee Centre, 3 Hooper Street, Cambridge CB1 2NZ. Tel. 01223 566319

diary dates:

Student Nurses’ Conference

January 30-February 1. The Quinta, Shropshire. Cost £29. Contact: Annie Leggett, UCCF Nurses Staffworker, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694

Social Workers’ Conference

13-15 March. ‘Let’s Get Close - relationships, intimacy and sexuality’ is the title of the SWCF annual conference at Swanwick where Elaine Storkey will be the main speaker. Enquiries: Valerie Dickens, 3 Sandy Croft, Kings Heath, Birmingham B13 0EP. Tel. 0121-604 6085

CiCP Annual Easter Conference

10-14 April at Swanwick. ‘The Cross above the Nation.’ Multidisciplinary, for all health professionals and their families. Contact: Christians in Caring Professions, 175 Kings Road, Reading RG6 1LT. Tel. 0118 966 0515

CMF National Conference

24-26 April, Swanwick. ‘Love One Another.’ For doctors and their families. Active children’s programme. Contact: Christian Medical Fellowship, 157 Waterloo Road, London SE1 8XN. Tel 0171-928 4694

Courses from International Communication Counselling Skills

ICCS have several 1998 courses health professionals should consider: 28 March ‘Death: Essential Preparation for Living’; 28 April ‘Free to Fail’; 12-14 June (South Wales) and 10-12 July (London) ‘Called to be Human’. Contact: ICCS, The Fire Station, 140 Tabernacle Street, Suite 3.1, London EC2A 4SD. Tel. 0171-336 6197

International Conference for Doctors and Dentists

14-19 July. The XI World Congress of ICMDA will be held in Durban, South Africa. Details from ICMDA, 82-88 Hills Road, Cambridge, CB2 1LQ

Science and Christianity: into the New Millennium

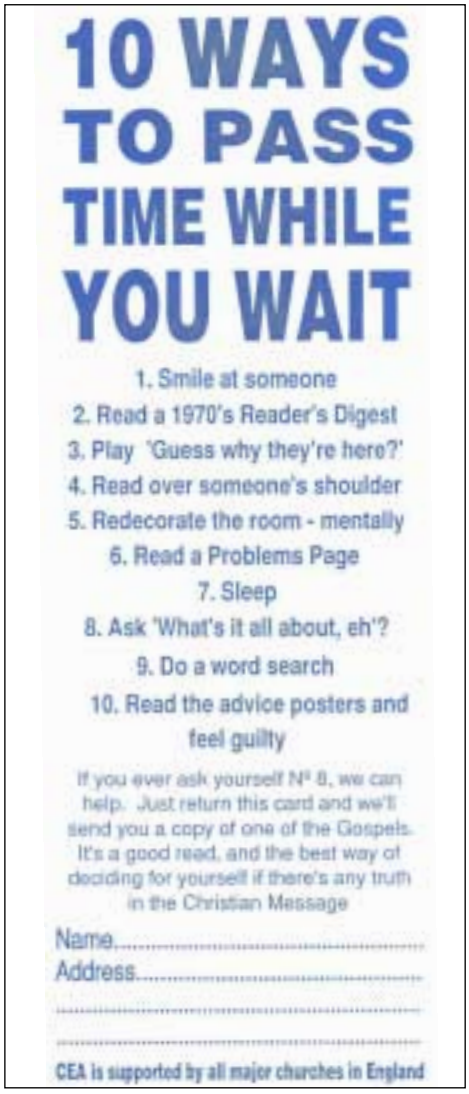
2-5 August, Cambridge. An international conference organised jointly by Christians in Science and the American Scientific Affiliation. Contact: Christians in Science, 5 Knockard Place, Pitlochry, Perthshire PH16 5JF. Tel. 01796 472615

For the waiting room

This attractive red replycard comes from the Christian Enquiry Agency and could be used in health professionals’ waiting rooms, alongside the other help and advice leaflets on display.

CEA is an interdenominational agency working with all the churches to help people who want to find out more about the Christian faith, providing enquirers with gospels and other helpful booklets, or linking them with Christians in their own area or with a local church, but only if they request this.

For further information, samples or supplies, contact: The Director, Christian Enquiry Agency, Interchurch House, 35-41 Lower Marsh, London SE1 7RL. Tel. 0171-620 4444 (ext 2123).



DEATH ON THE ROADS

a century of silence...

Antony Porter, who trained as a hospice librarian, asks some tough questions about our love affair with the car

Why is it that consideration of collisions on the roads is outside the field of medical ethics? Is this strange omission because they are seen as 'accidental', when by contrast euthanasia, suicide, infanticide and abortion are seen as 'intentional' and therefore worthy of investigation?

Admittedly, few drivers set out to kill anyone. Yet closer study reveals that most road crashes are not 'accidents' at all but are crimes, namely being dangerously inconsiderate of other road users, speeding, drink driving etc. Describing the results as 'accidents' effectively removes the moral dimension from driving. Often the victims themselves are blamed.

Britain's first motoring tragedy was called an 'accidental death' by a coroner and the offending driver was allowed free. In August 1896 Bridget Driscoll was killed by a speeding driver as she walked to a Catholic event at the Crystal Palace. Coroners still label dramas involving pedestrians as 'accidents' before these get to court.

The Home Office states that 'the unforeseen consequences of a road traffic accident, which may tragically result in death, may be disproportionate to the seriousness of the offence and the culpability of the offender' and that 'the court's duty is to sentence the offender for what he has done, careless driving, and not for the consequences, however tragic they may be'.

The victim currently does not have 'the last word'. Road safety pressure groups have suggested that new terms need introducing - such as 'road abusers' or even 'road pirates'. It has been found that in some cases drivers who have killed do not even appear in court, while in others the victim's name is never mentioned, thereby adding to the pain of the 'road-bereaved'.

Laws make no provision for including the manufacturer in traffic crimes. Furthermore, 'road safety', or more accurately 'road danger reduction', has nothing to say about vehicle design or construction. Instead, emphasis is always upon driver behaviour. Yet in recent years many dangerous items have been added to cars - blackened windows which reduce vision and are believed to increase the temptation to crime, 'bull bars' which kill about 70 people a year, and loud sound systems which distract other road users and which can harm the driver's hearing and health.

Many situations of today can, like the word 'accident', be traced to actual events. Thus Walter Arnold of East Peckham, Kent, the first Briton to make petrol engined cars, was also the first to be convicted of speeding. In January 1896 he went through Paddock Wood at 8mph instead of 2mph.

In November 1896 the speed limit in Britain was raised from 4mph to 14mph and was 'celebrated' with the first London to Brighton Rally, an event which also led to the first injury to a child by a speeding car. By 1903 motoring clubs helped raise the limit to 20mph. Speeding soon became commonplace and in 1905 Sir Arthur Conan Doyle was fined for going too fast.

Between 1896 and 1996 half a million people were killed on Britain's roads. This averages out at 5,000 per year, over 96 each week, or at least 13 every day. Even more disturbingly, Government statistics refer only to those who die within 30 days of a crash, others being labelled as 'seriously injured'.

Meanwhile, the *UK Christian Handbook* publishes statistics of births, abortions, deaths and cremations, yet disregards road deaths. The Christian churches, too, have little to say about the negative side of motorisation. Prayers sometimes appear in magazines and a few churches hold memorial services for the road dead, but otherwise there is indifference.

Elsewhere, Greece has long led Europe's league of traffic related fatalities. Every year, more than 2,000 die on Greek roads, over 38 a week. Ethiopia has the worst roads in the world, with about 175 road deaths per 10,000 vehicles. A car in a Developing World country is 20 times more likely to kill than a car in Europe.

Worldwide, every time your heart beats, yet another car rolls off the production line. Is it not time the car was subjected to thorough ethical scrutiny? It cannot be right that such a dominant aspect of modern life is completely ignored by medical ethicists. If you have any ideas, I should like to hear from you.

Antony Porter OSB can be contacted at Catholic Roadwatch, PO Box 1580, London W7 3ZP