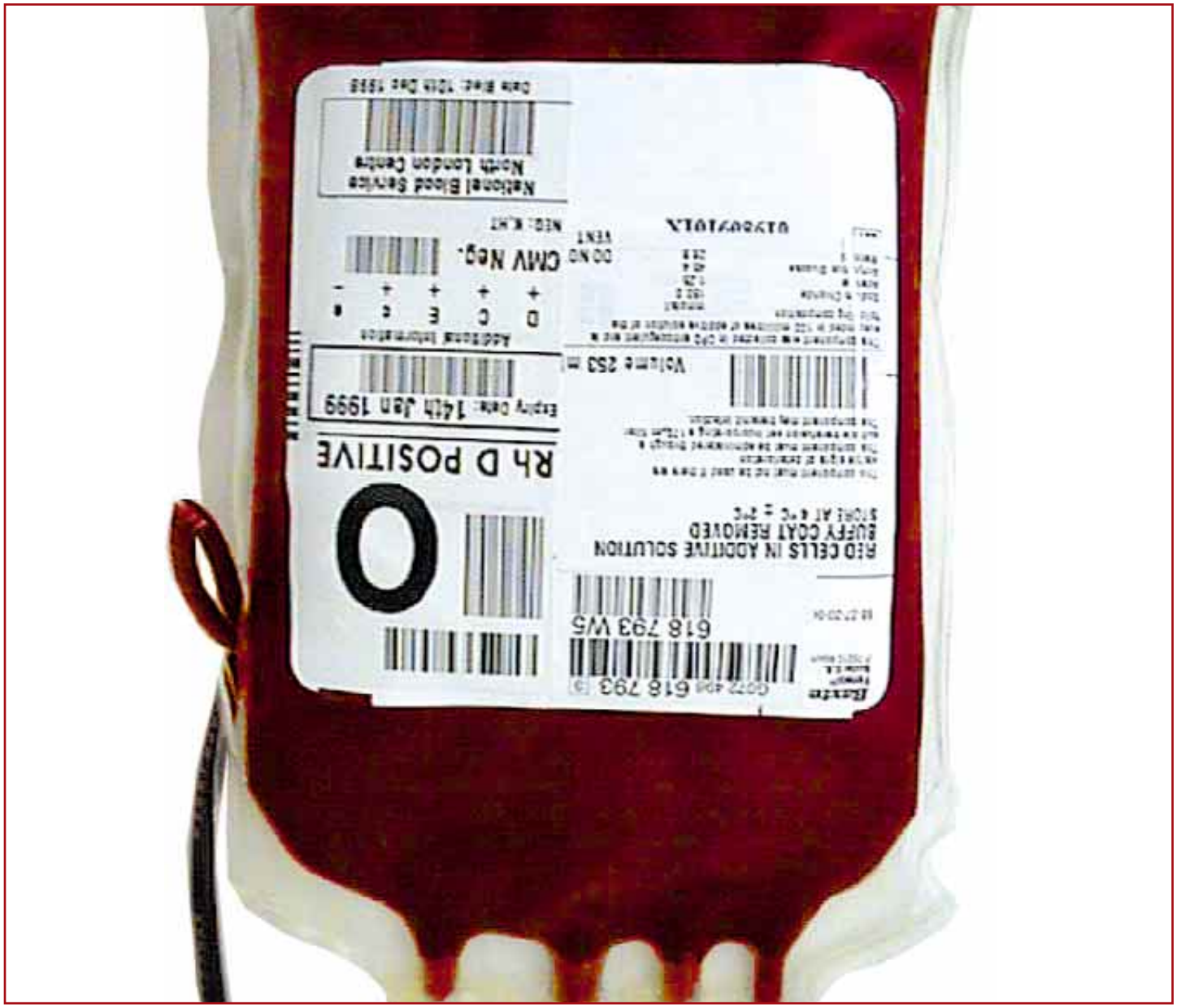
Triple Helix

JW blood ban
Creating healthier communities
Stress and burnout



Is the life in the blood?

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editorial:

premillennial tension

Receiving her BAFTA award as Best Female Actress (for her role as Queen Victoria in *Mrs Brown*) Dame Judi Dench quoted:

> The past is history
> The future is mystery
> The present is a gift -
> Which is why it is called 'the Present'

As this last year before the new millennium begins, there is perhaps a greater sense of change, a greater sense of stress, and greater concern about the uncertainties of the future than ever before. Articles in this edition demonstrate the point. Yet the transition from 23.59 on 31st December next through 00.00 to 00.01 on New Year's Day 2000 is an arbitrary arithmetic thing without necessarily any significance in the heavenly places. Indeed it might have little significance in earthly places either were it not for a little millennial microbe lurking in some of our computer systems . . .

Whether we are all subconsciously if not consciously afraid of the Y2K bug, or whether we are all falling under the curse of 'the deathwish of helplessness' described by critics of the growing stress management industry, all of a sudden, where this new PMT is concerned, there is a lot of it about.

How helpful therefore to be reminded that we cannot change the past, and that (mercifully) we know little of the future. While we must learn the lessons of history, and while we must plan prudently in our professional, church and family lives for the future, we should cultivate the art of making the most of that special gift, *the Present*.

'Be still, and know that I am God' was a message that came through the psalmist. May we find stillness this year amidst whatever premillennial tension comes our way, and may we come to know God more intimately in 1999.

Andrew Fergusson

Is the life in the blood?

Does the writing on the Web mean the writing's on the wall for the Jehovah's Witness prohibition of blood transfusion?

The Jehovah's Witness movement was originally known as the Zion Watchtower Society and was founded in the USA in 1884 by Charles Taze Russell, who had been a member of a conventional Christian church but then came to disagree with much of its theology[1]. The movement preaches a literal belief in the Bible but denies amongst other things the Trinity, the deity of Christ, the personage of the Holy Spirit, bodily resurrection and a visible second coming.

To most lay people and certainly to most health professionals Jehovah's Witnesses (hereafter JWs) are best known for their absolute prohibition on members receiving blood transfusions. This is based on their interpretation of three Bible passages: Genesis 9: 4, Leviticus 17: 10-14 and Acts 15: 20,29. Their key theological arguments are that 'the life . . is in the blood' and that the decision by the Council at Jerusalem to 'abstain . . from blood' is a permanent injunction to all Christians against taking blood into their body in any form. The counter-argument that this teaching is clearly about eating blood from animal sacrifices has been expressed recently in a comprehensive Christian and medical review of the issue[2]. A medical argument which temporarily gave some apparent support to the JW case was the discovery of HIV transmission through blood transfusion.

The blood taboo

Prohibition of blood transfusion was introduced by The Watchtower Society towards the end of World War 2, following prior objections to all forms of vaccination and the principle of organ transplantation. (Since the 1950s acceptance of these has been left to the conscience of the individual JW.) The sanction used is 'disfellowshipping' - seen by individual JWs as equivalent to eternal damnation.

Many have asked why such a controversial doctrine was ever introduced? Bergman[3] concludes there was probably no one reason but the need amongst such a huge cult for worldwide cohesive unity and the re-establishment of a universal collective identity were clearly motivating factors.

The status quo among ethicists and health professionals has been clear for many years, until 1998. Adult JWs were accorded an absolute autonomous right to refuse blood transfusion even though death might result. This may have been irrational and irritating, but it was irrevocable and inalienable. There was no point arguing. Indeed the concept was so clearly established that the JW advance directive refusing transfusion[4] has been seen as a paradigm for the whole question of patient rights and refusals.

(Regarding children whose parents, perhaps under the influence of Kingdom Hall elders, would appear to wish to refuse transfusion on their behalf, UK practice has been to take the child temporarily under legal protection in order to transfuse and save life, though there have been harrowing recent reports of needless deaths overseas[5].) So what changed in 1998?

World Wide Web blows issue open

For a year or so a website has existed on the Internet called 'New Light on Blood'. It is the 'Official Site of Jehovah's Witnesses for Reform on Blood'. Originating from anonymous JWs, support flooded in from inside and outside The Watchtower, from such countries as Denmark, Finland, Germany, Poland, Portugal, Spain, Sweden, UK and USA. There is now extensive biblical and medical argument accessible, available in a number of languages. It is claimed the doctrine costs 1,000 lives each year. The essence of the protest is that at the very least blood transfusion be left to individual conscience.

The Reform Group is 'a diverse group of Witnesses from many countries, including elders and other organisational officials, Hospital Liaison Committee members, doctors, lawyers, child advocates and members of the general public who have volunteered their time and energies to bring about an end to a tragic misguided policy that has claimed thousands of lives, many of them children . .'

To date The Watchtower Governing Body has not responded. Plans are being laid for possible legal action against it.

Rapid response from ethics establishment

In 1998, with a speed of response hitherto almost unknown in ethical debate, the prestigious *Journal of Medical Ethics* carried no fewer than four major articles on these developments.

In the first[6], Osamu Muramoto, a neurologist in Oregon, argues 'this blood doctrine is being strongly criticised by reform-minded current and former JWs who have expressed conscientious dissent from the organisation. Their arguments reveal religious practices that conflict with many physicians' moral standards . . the author . . argues that there are ethical flaws in the blood doctrine, and that the medical community should reconsider its supportive position. The usual physician assumption that JWs are acting autonomously and uniformly in refusing blood is seriously questioned.'

A philosophical consideration[7] follows from Julian Savulescu of Australia of the ethics of patients refusing cost-effective medical treatments. Using the JW blood issue as an example, he describes a case at Oxford's John Radcliffe Hospital where one JW received a two week course of erythropoietin (a hormone to stimulate red blood cell production) as an alternative to transfu-

Richard Cotton and his wife were JWs, but are now both Christians. Richard 'came to a saving understanding of Jesus while in the cult by reading the works of Martyn Lloyd-Jones'. Trained as a nurse, he has been a drug rep and now works in a general practice in Nuneaton. A member of the Reform Group, he writes:

'It began in a very small way, just a few individuals sharing thoughts, expressing doubts, just talking on the Internet. The JWs who did this found that for the first time in their religious lives they could be open with each other. True, they were careful not to reveal their identities. E-mail made for total anonymity. It allowed each one to speak freely without any personal risk.

Before the emergence of the WWW, contact between JWs usually meant keeping in step doctrinally, saying the right things, thinking the right thoughts. Individual thinking, warned The Watchtower, was sinful. Anyone expressing doubts or alternative views from the edicts of Brooklyn could land himself in big trouble with a visit from the local elders to help you 'adjust your thinking on certain matters'. The Net changed all that for good.

Among those utilising this new medium were a few Hospital Liaison Committee members, part of a team of specially trained elders whose job was to liaise with doctors whenever a Witness entered hospital under circumstances where blood transfusion might be considered. The intention was not to be confrontational but to make clear to all concerned just what was or was not acceptable to the patient. These elders also acted in a supportive role which was fine when things went well but heartrending when disaster occurred and the Witness died as a result of doctrinal restrictions.

To encourage someone to stand firm and then see them slowly die must be devastating to anyone with a grain of compassion in them. To some of these men it was to become unendurable; they had to carry the emotional load. It was very easy for the Governing Body in Brooklyn to make the doctrinal bullets, it was left to others to fire them - often with lethal results.'

A booklet is available from the Reform Group to all interested health professionals:

Website: http://www.visiworld.com/starter/newlight/homel.htm
E-mail: jwreformers@anon.nymserver.com

sion and at a cost of £2,916. He estimates blood transfusion would have cost £270 and asks 'How far does justice constrain autonomy?'

Muramoto's second paper[8] proposes that 'physicians discuss the misinformation and irrationality behind the blood doctrine with the JW patient by raising questions that provide new perspectives. A meeting should be held non-coercively and in strict confidence, and the patient's decision after the meeting should be fully honoured (non-interventional). A rational deliberation based on new information and a new perspective would enable a certain segment of JW patients to make truly informed, autonomous and rational decisions.' He calls this 'a novel approach based on rational non-interventional paternalism'.

David Malyon is Chairman of the Jehovah's Witnesses Hospital Liaison Committee in Luton and his response[9] is a robust defence of JW autonomy and the current system of liaison about alternatives to blood transfusion. The paper is interesting in what it ignores . . .

Conclusion

Can this revolution let loose within the JW cult by the Internet succeed? Can compassion and common sense prevail? At the very least, will The Watchtower Society have the courage to respond to the heartfelt cry in one moving Web testimony: 'Please, please reform this doctrine to a matter of conscience - please!'

If the writing on the Web may be the writing on the wall for this particular doctrine, are we also seeing the writing on the wall so that absolute patient autonomy in all areas will no longer go completely unchallenged? Is there a future for 'rational non-interventional paternalism'?

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Stressed OUT

‘I can only do what I can do and God is my boss’ decides pressured occupational therapist **Rachel Field**

Monday morning. Six new referrals on my desk. I go to the wards and find two more. The doctors want these patients discharged home this week. They need the beds. I make a face and sigh ‘Just what I need. Do I really have to see them?’ A few more questions and we decide one does not need an OT assessment. I am relieved - just another referral form to file. I stop a moment. These ‘referrals’ are people made in God’s image, and I am here to serve God. Instead I have a complaining spirit and stress levels are rising.

Overworked and underpaid?

Technological advances mean more can be done. More hospital treatment means a greater demand for therapists for assessment, equipment provision and rehabilitation following treatment[1]. New OT services are developing and the demand is there, but as yet there are few staff in post to meet this.

There is also the ‘recruitment and retention crisis’[2] for all health professions which adds to workload. All this results in waiting lists, and in the case of OT in a hospital ward setting, prioritisation decisions and some patients going without[3]. This in turn causes stress for professionals[4] facing heavy workloads and difficult decisions. A vicious circle is set up: ‘Waiting list pressures . . were of major concern to therapists with regard to . . their retention within employment’ in a recent survey[5].

I previously worked in community paediatrics, which has particularly long waiting lists for OT[6]. I took phone calls from parents who were sometimes irate, wanting to know when their child would be seen. Perhaps one of us should see them, to stop the endless phone calls? Perhaps with one assessment and some advice one child would be off the waiting list. However, would it be just to see these children sooner because their parents are vocal? Philippa Hickie has pointed out ‘those parents who have children with great needs are not always the ones who can or do speak up’[7].

There are increasing concerns about litigation. My record-keeping needs to ‘cover my own back’. It is difficult to have right motives in this environment, but we must avoid conforming to the world and instead be ‘transformed by the renewing of (our) minds’[8].

There are biblical principles to guide us in our decisions at work and David Cook has recently written about them[9]. He advocates a framework which is dynamic, holistic, person-based, inspired by God’s Holy Spirit, and not individualistic.

Christian concepts

1. We have department standards and professional codes of conduct. Where right, we need to work to these. We submit to authorities, under God[10,11].
2. We serve God at work, as in all aspects of our lives[12]. Even when no-one else will know what we have done or omitted to do, God sees. We are answerable above all to him.
3. Our decisions should show we are working towards loving God with all our beings and loving our neighbour as ourselves[13].
4. As we prioritise, we need to remember each patient is made in the image of God[14]. They are people, not bed numbers, diagnoses, or referral forms. They are all equal, although they may not equally need our service. We are ‘servants of all’[15], so we serve our patients. This means listening to them, as Jesus did with Bartimaeus[16].
5. Our responses under pressure, with the help of the Holy Spirit, should show ‘love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, self-control’[17].
6. We are witnesses to the gospel, even at work[18]. As we act in a Christian way, even under pressure, people will notice and God will be glorified[19].

Pressure pointers:

God is in control: we may not be, but we are ‘working under God . . as he remains in overall control of his creation’[20].

God understands: Jesus knew what it was to have many people needing his help at once[21].

Praying helps: commit the situation to God[22], and ask for the wisdom he has promised to give[23].

God loves you: and nothing can separate you from that love[24]. He has planned your work, even the tasks you need to do today, especially for you to do[25,26]. He knows all that is being asked of you and will not ask more than you can do with his Spirit’s help.

Take breaks: if you have a choice, do not work more hours than is good for you, and take breaks - Jesus took time out and encouraged his disciples to do so too[27].

Rachel Field is an OT currently working at University College Hospital, London

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a mind to *change*

GP Janet Baldock wonders whether the Parable of the Sower has lessons for health promotion

Both as a Christian and as a GP, I am often inviting people to change their ways. 'Repent for the kingdom of God is near!' 'Give up smoking, it shortens your life!' Of course, I dress these statements in softer language, but the challenges remain. And my success rate?

'Motivation for change is an important predictor of outcome.' I was struck by this statement and a six-stage model which followed it, in a recently published book about psychotherapy in primary care[1]. The model resulted from research work done in America in connection with recovery from addictions[2]. In many ways the statement is obvious, but as I reflected on the model and my own work in general practice I realised that I paid little attention to the issue of motivation before giving advice. I wondered if the model would enable me to be more effective in helping people to change and would cost me less in terms of time and energy?

The model proposes that people fall into one of six categories in terms of personal change:

1. Pre-contemplation: the person is not really interested in changing

2. Contemplation: aware that current behaviour is harmful and change might benefit, but has not yet decided to do anything about it

3. Determination: poised on the brink of change and ready for suggestions as to how to go about it

4. Action: actively seeking help

5. Maintenance: struggling to maintain the change. Years can pass before a person no longer feels the problem is lurking in the wings

6. Relapse: most people have at least one relapse

As I pondered this model the Parable of the Sower[3] came into my mind. Jesus had, in some ways, a similar task to ours. He was challenging people to change course, yet not nagging and feeling unhealthily responsible for people in the way some of us in the caring professions do. On the contrary, Jesus shows a deep understanding of human nature and is very realistic about the effects of his preaching.

He compares preaching with sowing seed. Some seed fell on the path and the birds ate it! Perhaps this typifies the people who do not want to change? Then there is the seed that fell on the rocky ground and because it had no root it died very quickly. Perhaps this represents those who seem to want to change but they are not yet committed to it at a deep level and do not do anything of significance? The picture of the seed that grew and then became choked by the weeds shows us what a hard struggle 'maintenance' is. Reassuringly, some seed grew until it produced a crop. Change is possible and therefore, in hope, we go on sowing the seed.

How does this work out? Certainly once we've identified a path we can stop throwing seed on it! An exploratory question such as 'You have heard me describe the risks attached to smoking; have you any interest in giving up?' prompts the patient to reflect honestly on his or her attitude to the proposed change. Further gentle prodding at this stage may uncover the real attitudes of those too polite, embarrassed or guilty to admit that they really love smoking and do not want to stop. Some patients want our approval and like to give us the responsibility for their health. These answer the question with 'I should like to but . . !' At best, such patients are in the 'Contemplation' stage. Maybe we help them most by avoiding 'parental' nagging advice. Instead, we could remind them that some choices in life are very important and cannot be made on their behalf by someone else.

Jesus took that view. In the story of the rich young ruler[4], Mark reports that a young man said to Jesus 'Good teacher, what must I do to inherit eternal life?' The reply Jesus gave disappointed the young man and he turned away sadly, having decided it cost too much to respond to Jesus' call. Jesus respected that decision and made no attempt to change it, although the Gospel records that Jesus loved him. When patients ask us a similar question 'What must I do to live longer?' they may similarly turn away saying 'That is too hard'.

Finally, I just wonder how much change we can bring about without the help of the Spirit of God?

Janet Baldock is a GP in South West London

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Do gays die younger?

Developing controversial earlier work, Cameron et al have 'examined four different contemporary databases for evidence that homosexual activity might be associated with a shortened lifespan'. Their conclusions from data from the USA, Scandinavia and the UK lead them to confirm 'a lifespan shortened by 20 to 30 years' and they comment 'the personal and public health implications are considerable'. (Source: *Psychological Reports*, 1998; 83: 847-866)

Has serial killer Kevorkian finally gone too far?

On CBS news programme *60 Minutes* millions of Americans watched a tape of Jack Kevorkian giving a lethal injection to a 52 year old man with motor neuron disease. Thrice acquitted previously on charges of assisting suicide (where his tally exceeds 120), Michigan prosecutors are now considering whether he should face a murder charge. The militant campaigner promised on television that if convicted he would starve himself to death in prison. (Sources: *The Times*, *The Independent*, 24 November 1998 and *Chicago Tribune* reported in *The Independent* 26 November 1998)

Patter of tiny hooves

On 12th November a US biotech company announced that three years earlier it had created a human-cow hybrid by fusing the nucleus of a human cell from one of its own scientists with an egg cell taken from a cow. After 51 earlier failures this hybrid developed to the stage of a 32-cell embryo. A cartoon accompanying the newspaper report showed a newly expectant mother announcing: 'Darling, we're going to be hearing the patter of tiny hooves'. (Source: *The Independent*, 13 November 1998)

Altruism on the way out?

Religious fears about receiving blood are featured elsewhere in this edition, but the UK's National Blood Authority fears there may not be enough blood to go round anyway. With demand rising at 3-4% per year, research into supply found that altruism is slowly declining as a feature of British society. The number giving to charity is falling as is the proportion of people doing voluntary work, yet Jesus said 'It is more blessed to give than to receive'. (Sources: *British Medical Journal*, 21 November 1998; 317: 1405 and Acts 20: 35)

The Pill for men

MRC trials in Manchester are investigating whether a combination of 4-monthly testosterone implants with a daily oral prolactin inhibitor could be an effective contraceptive for 'new-millennium man'. The problems ahead are not only pharmacological: 'Joanne, 42, married with two children' comments 'Tell a man to get something out of the freezer and he forgets. No way would I rely on him to remember a pill.' (Source: *The Independent*, 3 November 1998)

Jabs against babies: Indian women protest

Women's health group activists protesting outside the opening of the 10th international congress of immunology in New Delhi in November described immunological routes to contraception as 'scientifically unsound and inherently unsafe'. Six contraceptive vaccines all intended to produce antibodies against reproductive hormones have reached phase 1 clinical trials in different countries. (Source: *British Medical Journal*, 14 November 1998; 317: 1340)

Fewer teenagers in the USA are having sex

Perhaps all this contraceptive creativity may become less necessary in the next millennium anyway? The US Centers for Disease Control and Prevention report that the percentage of American teenagers (especially boys) who have had intercourse has declined in the 1990s. (*Morbidity and Mortality Weekly Report*, 1998; 47: 749-752)

Time chiropractic took its hands off?

A large long term study compared patients receiving chiropractic for back pain with a group receiving conventional physiotherapy and a group who just received a booklet about coping. After two years there was no difference between the groups. (Source: *New England Journal of Medicine*, 1998; 339: 1021-1029) In the same issue, a second study funded by chiropractic groups found no evidence that spinal manipulation could ease asthma symptoms in children. (Source: *New England Journal of Medicine*, 1998; 339: 1013-1019)

Glen Hoddle's faith healer

Christians (and football fans?) aren't the only ones worried by England coach Glen Hoddle's appointment of a New Age healer to the squad. An editorial in a medical journal argues about the risks of this development in sport, particularly where children are concerned. (Source: *British Journal of Sports Medicine*, 1998; 32: 195)

Stress . . and nurses . .

Seeking explanations for examples of falling standards in nursing, Professor Hugh McKenna writes 'low numbers of registered nurses lead to poor quality of care, which leads to high stress and low morale; this in turn leads to high sickness rates, a shortage of nurses, and poor quality of care'. (Source: *British Medical Journal*, 21 November 1998; 317: 1403-1404)

. . and GPs

In a study of 131 GPs investigating 'individual and organizational predictors of depression', doyen of doctor stress Jenny Firth-Cozens found that 'relationships with senior doctors and patients are the main reported stressors, followed by making mistakes and conflict of career with personal life'. (Source: *British Journal of General Practice*, 1998; 48: 1847-1851)

An oldfashioned miracle

This title in the occasional *BMJ* series 'A memorable patient' caught the eye. Consultant anaesthetist Dr T Kirkpatrick describes a patient who had a cardiac arrest one Good Friday. There was concern he had sustained serious hypoxic brain damage but by Easter Sunday 'he seemed to be neurologically intact'. His wife 'had spent all night at a prayer vigil and was convinced that his recovery would be complete. Since then, I have seen several recoveries on the intensive care unit which could be described as miraculous, but none with such wonderful timing.' (Source: *British Medical Journal*, 17 October 1998; 317: 1053)

Among All Nations

Winter 1998/99
No. 6

Christian healthcare worldwide

Photo: Valerie MacKay

Opportunity or threat

There is a big difference between serving the 'selfish gene' and serving the Creator. The gene tells us other people must be divided into opportunities or threats. In global health nations may be seen in this light.

Health professionals who see medicine as an insight into the mind of the Creator, who made all things well but who made himself vulnerable by giving freewill to those he made, will be excited by all they discover of that mind. They will keep the patient at the centre of what they do because that centre is around their Creator and not around themselves. Care of the weak replaces 'survival of the fittest'.

A new baby and the new relationships which follow will be seen as part of divine providence. Responsible parenthood is part of the stewardship of creation and does not include killing any individual made in the image of God.

When a nation like China, long isolated but now growing in influence, invites foreign experts to serve among its poor the servant mind sees opportunity not threat. When people groups who might otherwise be seen as threats allow visitors to serve within their borders the opportunity should be welcomed.

Global history has reached a stage where weapons of mass destruction can destroy both sides. The advice of the selfish gene could destroy civilisation and above all could blind us to the God of all peoples who is able in Christ to break down the dividing walls between us and who will eventually do so.

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.

all you need...
...is love

Christian nurse **Jill Patient** working with Bombay's Aruna Project was glad to be mistaken for a prostitute . . .

At 15 Loma was offered a chance of a new life away from her homeland of Nepal. It seemed like a life line. Having been married off as a child, she had already borne and lost two children. Her husband had given up on her and was looking for a new wife, and his family treated her with ridicule and abuse. So when given the chance of a new life in the city, she was sure her life could only improve.

Sadly, Loma ended up in Mumbai (Bombay) where she was repeatedly forced to give her body over to men for what this world so often calls 'love'.

Loma is not alone in this situation as literally tens of thousands of girls are thought to be earning their living through prostitution, living and working in the brothels in the red light zone of downtown Mumbai. Most of them come there against their will, with thousands coming from Nepal every year, often as young as 12 years of age.

The girls are grossly abused and instilled with fear so they soon learn to trust no one. By the time they have paid off the debt (the sum paid for them by the 'madam') they are in theory free, but the stigma of what has happened to them means they cannot go home, and they don't know how to live a 'normal' life. They are often illiterate, uneducated and have no skills. They have poor access to health care, and studies show that over 40% are HIV positive.

When the girls reach their early twenties their ability to attract customers dwindles, as customers prefer younger girls, believing they are less likely to be HIV positive. Some of the girls manage to buy a set of rooms and become a madam, while others become, for example, 'maids' for the younger girls and madams. Those who are HIV positive and can no longer hide their HIV status are normally thrown onto the street, where often the only choice they have is to beg until they die. The plight of these girls seems hopeless and 'love' is a dirty word.

The Aruna Project aims to share the love and hope that only Jesus Christ can bring. The name 'Aruna' means 'Bright Morning Sun' - bringing the picture of hope after the dark night. The project is still in its infancy, but through regular visits to the girls, precious friendships have been built. When suitable premises can be found a Drop-in Centre will enable the girls to access help, either at the centre or through referrals for training, work experience, rehousing, repatriation and, when necessary, hospice care.

Getting to know the girls is a real privilege and we have been made to feel very much 'at home'. One day when visiting Loma, some other girls came to introduce themselves to us. Having asked us where we lived, they asked 'How's your business?' and 'Do you work from a bar or privately?' We had to smile, but it showed the positive level of acceptance, and we were encouraged.

There have been so many encouragements with the work, but the biggest encouragement has been the girls themselves. They are fully aware of the 'love' of this world and the lack of hope that it brings, and they long for real love - a love that encompasses hope and trust.

Jill Patient is a partner with Interserve and has completed a Master's course in Community Medicine at the Liverpool School of Tropical Medicine with the help of an MMA grant.

saving motherhood or destroying it?

From 25 years' obstetric experience in southern Africa, **David Clegg** asks: does abortion in the developing world really lead to 'safe motherhood'?

Gradually the carefree play of girlhood becomes interwoven with a more serious approach to life. She matures earlier than her brother. Her vision for the future which may have expressed itself in dolls and imitations of domesticity becomes larger than that. It is to care for the world as she sees it. The way she sees it also grows, and depending on character, culture and circumstance takes on a shape unique to her. Her vision includes the need to prepare, to protect, and to pass on. As her body develops she recognises new powers that are hers. Young men react to her in different ways. She has the power to tame or to inflame their competitive and territorial tendencies.

She may devote her motherhood to a family of her own, to a world wider than a family, or to both. A mother's face is normally the first symbol a newborn baby sees and hers are the first eyes with which it establishes contact. The new child comes to associate her face with motherhood. Society is attracted by motherhood and expects it to be gentle and protective, especially of children. Motherhood is cohesive and healing, holding a family around her, and bonding society together.

A Christian perspective

For the Christian, biblical teaching will add its own values to the patterns built into creation. This teaching may be seen as optional by a multicultural society, but Christians have a responsibility to protect the mechanisms built into creation for its smooth running as well as a responsibility to make the saving knowledge of Christ available to others.

Today, society is offered technology with the intention of separating sex from reproduction and is then offered abortion as a solution when the contraception fails or is forgotten. This may be destroying motherhood physically, socially and psychologically on a scale greater than any physical lives saved. A mother may have been educated by society to adopt a 'pro-choice' approach to life which is in conflict with all in her mind and her body that fits her for motherhood. She is trapped in a double bind by a secular humanist mindset and a human nature created in the image of God.

Mothers (and fathers) who have in the past agreed to abortion, sometimes against their better judgement, and who have subsequently found faith in God have reported suffering years of inner turmoil, pain and regret. Only in Christ have they been freed to bring these issues out into the open and deal with them. One scene from a video shown at the recent ICMDA Congress in Durban comes vividly to mind: the mother had had no peace for years until she got out of bed one night, went downstairs and wrote letters to her three aborted children asking for their forgiveness.

Is a cost-benefit analysis of abortion possible?

'Safe Motherhood' is a term coined to refer to methods of reducing maternal mortality and morbidity associated with pregnancy. It includes abortion legislation, which has been associated with a reduction in maternal mortality in some countries which carry enough controls on how it is practised. How much of that reduction would have happened without the law we do not know.

Similar legislation in low income countries is likely to have more complications as a direct result of procedures used without adequate controls on practice. However, the indirect long term complications may cause mortality and morbidity in ways that are not being measured. For example, young unmarried girls in the cities of developing countries queue for termination as a quick fix when they find they are pregnant. They may have no intention of changing their lifestyle, which brings them material rewards in a depressed economy, and their doctors busy in their private practice may have neither time nor inclination to warn them of such dangers of that lifestyle as HIV infection.

Valuing the gift of motherhood

Abortion is a cheap way of limiting births and some maternal deaths. Elimination of poverty would achieve much more. How do we discover abortion's indirect complications, and measure them and put a price on them? What are its effects on mother and child bonding, family stability, child and spouse abuse, and mental illness, not to mention wider effects on national and international welfare?

We must measure what we can but if we believe God made us in his image we should also treat ourselves and our patients according to this belief, even if we do not understand all this means and cannot measure all the consequences of its abuse. The gift of motherhood needs to be valued at least as highly as the gift of sex, for both are part of God's creation. The descendants of Rachel wept when King Herod ordered all boys in Bethlehem who were two years old and under to be killed. A nation that loses that ability to weep is a very sick nation.

David Clegg is the Overseas Support Secretary of CMF and the General Secretary of MMA

Friendship with th

Dr Reginald Tsang and **Dr James Hudson Taylor III** describe the work of Medical Services International

Medical Services International (MSI) is dedicated to serving the health-related needs of peoples in China and East Asia, as an expression of Christ's love and the Great Commission. MSI teams work in partnership with national, provincial and local authorities in developing services in needy areas and upgrading them. The approach is long term, low key, and culturally sensitive. Through the work MSI promotes friendship and understanding with the peoples of China.

Photo: MSI

Foreign experts welcome

Major changes are occurring in Asia. Over the past decade, under the policy of Four Modernisations, China has welcomed many foreign experts to share in its opening and development. This welcome extends to health services, especially in China's inland provinces, in its rural areas, and among its national minority peoples.

Photo: MSI

MSI is a channel through which skilled Christian health personnel from the United States, the United Kingdom, Canada, Australia, New Zealand, Singapore, Malaysia, Taiwan, Hong Kong etc can serve the medical, physical, and spiritual needs of these areas. MSI provides a programme of orientation and preparation for both short term and long term volunteers and sends these individuals in teams to needy areas.

MSI personnel are involved on-site in:

- hands-on care in needy and strategic areas
- lecturing on advanced medical techniques and health services and demonstrating them
- English language teaching, accountancy, and sheep farming
- developing training programmes for improving environmental hygiene and preventive medicine
- training 'village medics' and health personnel
- providing medicines and medical equipment and training in their use
- providing a Christian testimony of love and concern

Long term co-operation

Four years ago, leaders of the Sichuan Bureau of Public Health, Yenching Alumni Association and MSI joined in signing our first Memorandum of Long Term Co-operation. Since then MSI has enjoyed the privilege and challenge of partnership in an increasing number of programmes - medical, livestock, English and accountancy.

From the beginning Chinese officials and MSI leaders recognised that our joint efforts in community development and education should be 'long term'. This would involve long term planning, long term co-operation and long term commitment. For MSI such a focus also clearly called for the mobilisation of colleagues who were prepared to serve long term in order to see these programmes through to completion.

e peoples of China

Although MSI has seen more than 500 Christian professionals participate in short term trips, this commitment to long term service has not changed. Indeed, it has been strengthened as we have witnessed the encouragement of a growing number of professionals whom we describe as 'non-residential long term colleagues'. While they may live and work in Hong Kong, Singapore or the USA, by returning regularly for service, they are actually building on the foundation of their previous visits.

Long term commitment

Without doubt, however, the most effective service is being rendered by colleagues who are committed to living in China, mastering the language, identifying with the people, partnering with their professional counterparts and serving society's needs. It is marvellous to see their number growing steadily.

Photo: MSI

Photo: MSI

The long term medical team which is working among the Yi minority people in Sichuan has been able to assist in raising the standard of medical care in the Zhaojue County Hospital. From that base they have been reaching out to conduct health fairs for the community and train health workers for the villages. Lives have been saved, drug addicts rescued, and hearts transformed.

The long term livestock programme has already lifted some of the 50 families chosen in the first 'sheep on loan' project out of abject poverty. In July 1998, 40 of these families returned ten sheep each, thus enabling 40 new families to start in the expanding project. Gaining skills in sheep farming, these Yi families are now beginning to enjoy the dignity of self-reliance.

MSI colleagues who are teaching English long term have a privileged opportunity for service. Some are training local English teachers, others are teaching undergraduate students, working with MA and PhD candidates, or helping doctors and nurses improve their English. One MSI colleague recently reported that two of their students took first and second place in the university-wide English competition.

Long term service

The impact of the lives of these long term Christian professionals will be multiplied many times over through the students, farmers, professionals and patients they live among and work with day by day. Only eternity will reveal the full measure of God's grace.

When the Lord saw the crowds in his day, we are told he had compassion on them and instructed his disciples to use their resources to meet the people's need. They did. Will you not pray about using your God-given professional resources in long term service to meet people's needs in China? Whether you have just completed your professional training and a lifetime of service awaits you, or you already have a lifetime of rich experience and are considering taking early retirement, there is a place of fruitful long term service for you. MSI may be able to help you find it.

Further information

Dr Ronald Clements, 42 Telston Lane, Otford, Kent TN14 5JX. (Also see 'Vacancies overseas' on page 15.)

Spiritual Viruses

Dr Mouneer Anis, Director of the Harpur Memorial Hospital in Egypt, writes:

'We have started to hear about computer viruses, which if present in any software can spoil the programmes. Many companies are now very careful about using imported disks, while others have invented special programmes to check for and treat such viruses.

This led me to think about viruses of another kind which I call 'spiritual'; those that would come into our lives and spoil our ministry. They vary in type; here I would like to discuss 'the virus of the critical spirit'.

This is especially relevant for those serving in cultures different from their own. In a new culture there is an initial stage where we like and admire many things, and are keen to learn and be a part of it - the 'honeymoon stage'. After this often comes the 'culture shock', often when least expected. When this happens the person starts to see the difference between the new culture and their own, and experiences the stress that results from deeper involvement in the new culture and with the new people. This is when the spirit of criticism can start to creep in.

Left untreated, the spirit will grow unhindered and build a wall between that person and the people of the new culture. It affects the way the new arrival thinks, the way they interact and the way they involve themselves in their ministry. It can rob them of the joy of serving the Lord in the new culture until eventually those around them begin to experience the negative attitude at work in the person, through a lack of love and understanding. This would lead to an ineffective ministry.

Treatment of such a case depends on how alert the person is to this spiritual virus. Just as we check a computer disk, we need also to check ourselves openly in the presence of God. If we find we have this problem, we should commit it immediately to the Lord so he can help us get rid of the spirit and fill our hearts with his love for the people we are serving. If after everything a person cannot get rid of the critical spirit, maybe they should consider whether they are in the ministry God really wants for them.

Lastly, remember that God so loves the world with all its peoples and nations, and that he is able to give us the ability to love others.'

Harpur Memorial Hospital

(See 'Vacancies overseas' on page 15)

The Harpur Memorial Hospital in Menouf, Egypt was founded in 1910 by Frank Harpur, an Irish physician. It is a non-profit organisation under the auspices of the Episcopal Church of Egypt. The hospital is a 75-bed general hospital situated in the Nile Delta, one and a half hours north-west of Cairo. Including the 30 surrounding villages it serves a population of half a million people. Staff are committed to:

- providing health care to all, regardless of social, economic and religious status
- being a community-based hospital that reaches out to those who need health care
- providing a good standard of medical care, at a low cost for those who can afford it and free for the poor

In 1995 the Government of Sadat City offered Harpur Memorial Hospital a strategic location to construct a community health centre which will specialise in:

- industrial, occupational and emergency medicine, burns and trauma
- community, occupational, mother and child and general healthcare
- health education, including the creation of a healthy working environment

There is presently no institution in Sadat City with a mandate/commitment to meet the wider health needs of the population. The estimated cost of the project is US$ 3 million. In 1996 a temporary polyclinic opened in Sadat City by the invitation of factory workers who were previously seeking their medical care at Harpur, in Menouf. This clinic is accommodated within a block of flats and is regarded as a temporary arrangement.

Coming Events

Developing World Health Exhibition
Tuesday 26th January. Beveridge Hall, University of London Senate House, Malet Street, London WC1, 12.30-5 pm. Admission free. All welcome.

Second Medical Mission 'Summit' Meeting
Thursday 18th February, Partnership House, 157 Waterloo Road, London SE1. To introduce HealthServe, a proposed Resource Centre to mobilise and promote heathcare mission. Information, invitation, and framework document available from MMA.

Electives Days for Medical Students
Leeds, Saturday March 13. London, Wednesday April 28. Details from CMF/MMA.

Third Tentmaker International World Congress
Cape Town, 21-26 March. For Christians who use their vocation in response to God's call to proclaim Christ. Contact PO Box 5054, Belville, 7535, South Africa. Tel. +27 (21) 949 6118. Fax +27 (21) 945 3123. E-mail gcgroup@africa.com

Overseas Update (Residential Refresher Course)
for Christian doctors, nurses and midwives working overseas. June 21st-July 2nd. Oak Hill College, London N14. Brochure from CMF/MMA.

Notices

Dr Joseph Taylor Scholarship for Medical Student Electives
Two scholarships of £500 to be awarded yearly to Christian medical students in clinical years towards cost of an elective in an African mission hospital for a period of at least 6 weeks, including some time spent studying eye diseases. Application forms from CMF/MMA to be submitted in triplicate with a proposal of not more than 1000 words. Closing date 31st January. Scholarships awarded 18th February.

Dentaid
This dental equipment charity has a new address: Dentaid, Old Bakery, Mount Road, Llanfair, Powys SY21 0AT. Tel. 01938 811017. Fax 01938 811107. E-mail Dentaid@aol.com

vacancies overseas:

Please note that medical mission posts often require you to raise your own support (though some missions can help with this) and to have the support of your home church. A much longer list of Opportunities of Service mostly through UK-based mission societies is available in the MMA magazine *Saving Health* (see below).

AFRICA

Egypt

Harpur Memorial Hospital invites physicians, cardiologists, general surgeons, gastroenterologists, orthopaedic surgeons, paediatricians and dentists to visit for 2-6 weeks to share up-to-date knowledge with doctors through assisting in the clinic and lecturing (see articles on page 14). Contact Dr Mouneer Anis, Director, Harpur Memorial Hospital, Menouf, Egypt. Tel. 048 360011, 048 362834. Fax 048 362534 (Menouf), 02 340 8941 (Cairo). E-mail mouneer, INTERNET rumha@rusys.eg.nat

All Saints Cathedral, Cairo invites doctor to be medical manager responsible to the site co-ordinator of the Joint Relief Ministry for People from Sudan and the Horn of Africa. Job description flexible depending on skills but includes management of medical programme, some clinical work, admin, teaching and integrating medical practice with faith. See article on page 16.

Contact Bryan Kane, Relief Ministry Co-ordinator, All Saints Cathedral, PO Box 87, Cairo, Egypt. Tel. 20 2 3418391. Fax 20 2 3408941. E-Mail 'Bryan Kane' bryankane@hotmail.com

Tanzania

Christian Outreach urgently needs doctor for refugees in Western Tanzania as well as health co-ordinator, and nurse or pharmacist. Contact Mrs Kay Bugg, Personnel Officer, Christian Outreach, 1 New Street, Leamington Spa, Warwickshire CV31 1HP. Tel. 01926 315301. Fax 01926 885786. E-mail 100656.1612@compuserve.com

Church Mission Society has openings for doctors for hospital work in Tanzania. Contact Stuart Buchanan, Programmes Manager, Church Mission Society, Partnership House, 157 Waterloo Road, London SE1 8UU. Tel. 0171-928 8681. Fax 0171-401 3215. E-mail stuart.buchanan@cms-uk.org

Uganda

CMS has opening for Occupational Therapist for a school in Kampala. Contact CMS a/a

ASIA

Cambodia

Christian Outreach needs the following to provide healthcare in a district of 100,000: project leader (experienced healthcare professional), primary care co-ordinator, medical co-ordinator, nurse trainer/supervisor, primary care adviser, admin staff, finance officer. Contact CO a/a

Central Asia

Frontiers. Medical trip to Central Asia, 20 March-3 April. Qualified paediatricians, obstetricians, gynaecologists, endocrinologists, neonatal care specialists, anaesthetists and nurses needed to run 2-week clinic in needy part of Central Asia. Be part of an international medical team bringing care where it is really needed. Contact Stephen Wallace at Frontiers. Tel. 01604 233535 or email stephen.wallace@bsb.frontiers.org

Operation Mobilisation has many exciting opportunities for doctors and other health professionals in Central Asia. Contact: Medical Co-ordinator, OM, PO Box 660, Forest Hill, London SE23 3ST. Tel. 01959-701824. E-mail 113100.2675@compuserve.com

Vision International Healthcare:
Under Joint Venture (salaried at Mongolian rate with air fares, flat, and small health and pension payment provided) for: ophthalmologist, chief nurse, theatre nurse, pharmacist, 2 opticians, lab technician, cashier accountant, general service officer, dietician, hotel service manager, medical technician.
Under Humanitarian Agreement (for which support must be raised; but fares and flat supplied) for: project director, 2 secretaries, 2 relief workers, 2 workers with the blind, 2 teachers of English, 2 nurses (general), midwife, receptionist, administrator, provincial administrator, driver/mechanic, workshop manager, 2 GPs (one full time, one part time) 3 months, preferably on rotating system.

Contact Vision International Healthcare, PO Box 248, Tunbridge Wells, Kent TN2 5BZ Tel. 01892 518381. Fax 01892 518381. E-mail 100142.3521@compuserve.com

China

Medical Services International (see pages 12-13) recruits short and long term medical personnel and trainers in English and accountancy to work side by side in China; and also experienced admin personnel in the International Co-ordination and Training Centre in Hong Kong. MSI welcomes new and second hand medical instruments and equipment. Medical journals and books within three years of publication are needed as well. For long term service MSI needs committed Christian doctors and health professionals of all disciplines - those without Mandarin or the local dialect are expected to do at least one year of full time study in language before beginning. Contact Dr Ronald Clements, 42 Telston Lane, Otford, Kent TN14 5JX

Pakistan

Women's Christian Hospital, Multan. Marian Morrison is looking for female doctor locum cover during her home assignment for two periods: Jan-Feb and mid April-mid June. Need labour room management experience and ability to do caesarean sections. Contact Medical Superintendent, Women's Christian Hospital, 85 Nusrat Road, Multan, Pakistan. E-mail wch@wch.edunet.sdnpk.undp.org

CMS requires doctor or nurse for community health work from a hospital base in North West Frontier of Pakistan. Contact CMS a/a

Among All Nations is produced by the **Medical Missionary Association** and **Christians in Health Care** in partnership with the Christian Medical Fellowship as the international section of the CMF publication *Triple Helix*. The MMA also publishes its own magazine *Saving Health* which is designed for those wishing to know more about, pray for, give to, and take part in medical mission. *Saving Health* is currently produced about four times a year alternately as a magazine and as a newsletter. *SH* and/or *AAN* are sent to MMA supporters who donate £5 or more a year (£3 for students and missionaries). MMA is building up a database of those wishing to hear of specific types of service opportunities in medical mission and who may be available as locums at short notice. Please ask for a database 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 howard-lyons@msn.com Website: http://christian-healthcare.org.uk

Reaching Refugees at Cairo Cathedral

Bryan Kane describes a joint relief ministry for people from Sudan and the Horn of Africa

The country where Joseph, Mary and the infant Jesus fled 2000 years ago today receives many Sudanese fleeing a seemingly never-ending war in their homeland. They come to Egypt and its capital Cairo, now the largest city in Africa with a population predicted to reach 20 million by the new millennium.

Medical work at All Saints Cathedral began when a pregnant Sudanese woman collapsed. She didn't want to go to an Egyptian hospital, as she was unable to pay the costs at foreigner's rates. This prompted Mark (our co-ordinator) and Annette Bennett (a midwife) to start the antenatal clinic in 1995. Last year it saw 120 pregnant women. It serves Sudanese women not helped by the UNHCR Cairo office and provides consultation, home visits and some small tests on site. We refer major work including delivery to nearby contracted hospitals and we cover all the costs. Our paediatric clinic is open the same hours, to save the mothers' time. The general medical clinic open two days a week held approximately 2200 consultations in 1997, seeing cases from TB to peptic ulcers to mental instability.

'The greatest privilege of working in the clinic' says Annette 'is how we can serve the Sudanese community with a complete ministry. We try to keep prayer as the main focus. It is exciting to offer that as part of our normal care . . when we register, when there is a threatened pregnancy or when a mother reaches term . . we stop the clinic and pray for her. Although we've had people from many different backgrounds we've never had anyone say no to prayer.

When we took on Sala (not her real name) we referred her to a good obstetrician who sees some of our hard cases for free. When she came to us in subsequent pregnancies I talked with her about God's love and how her previous miscarriages were not because God was punishing her. Many times we sat with her, laid hands on her and prayed. After three more miscarriages we were still puzzled why this was happening but each time we gave her the opportunity to grieve and acknowledge the loss of life, and we would weep together. In the midst of it all we continually reminded her of God's love for her.

After her last miscarriage, she went alone to the hospital for a D&C. A few weeks later she came to me at the church. 'I came to talk to you about Jesus' she said. In hospital she was very lonely and sad. As she came out of the anaesthetic she was struggling emotionally. She was all alone and had no one to cry with. She closed her eyes for a bit, and when she opened them again, there stood Jesus, touching her hand. She knew it was him although he didn't speak. She had this incredible feeling inside her and felt her heart change. She thought about some of the things we'd talked about and realised the most important thing was to love Jesus. She is now trusting Jesus although she may never have a baby. When she first came to the clinic, she said she had put all her hope in me. Now she realises she has to put all her hope in Jesus. It is a great joy and privilege to be part of something like this.'

Bryan Kane is ministry co-ordinator at All Saints Cathedral, Cairo. See 'Vacancies overseas' on page 15.

RevieWWWs

CyberDoc reviews the Medical Web and initiates a new service for interested Christians

The Internet is attracting interest even in such periodicals as the *British Medical Journal*. In 1997 a *BMJ* article available online at **http://www.bmj.com/cgi/content/full/314/7098/1875** examined the Internet's advice on the treatment of feverish children. The research, which involved two search engines (readers can do this themselves at **http://search.xtn.org/engines.htm**) discovered the advice found was inconsistent with official guidelines.

This finding should cause no surprise - eavesdropping on parents discussing treatment would produce similar results. The real concern is, whose advice will people follow?

More recently, the *BMJ* article found online at **http://www.bmj.com/cgi/content/full/317/7171/1496** reluctantly acknowledged that the role of the Internet in 'fostering open debate without censorship' meant that filtering of information before it was published was impossible. To attempt this would be like trying to stop someone spreading misinformation by telephone.

The Internet allows anyone with access to a computer a potential mass audience worldwide. Rapid distribution of misinformation can occur. An official medical site like the Royal College of Psychiatrists can look rather unimportant compared with a site like **schizophrenia.com** put together by volunteers. But we cannot totally rely on such a site.

The more recent *BMJ* article suggests that web page reviews by suitably qualified readers be used by Internet software to deliver appropriate information. This is some way off and at the moment it is hard enough to find information that is relevant let alone guaranteed accurate! It can be even be hard to find journals such as *The Lancet*, the *Journal of the American Medical Association* or the *New England Journal of Medicine* on the web. As a result, links to these journals, as well as the *BMJ* and a long list of other medical journals, are now available on the CyberDoc website at **http://xtn.org/cyberdoc/links.htm**. Of the journals the best is probably the *BMJ* site with its ability to search their site and other electronic journals, and notify you of new articles on any subject.

Unfortunately, the *BMJ* does not tend to major on subjects that *Triple Helix* readers are especially interested in, and it does not review Internet sites. This column will attempt to fill this gap. However, it is impossible for one individual to trawl the whole Internet, hence another new feature on the CyberDoc website. It is now possible for you to draw other readers' attention to good pages on any subject of interest. This should prove easy, as it only involves filling in an electronic form, not forgetting to include the URL of the site (this begins with **http://** and could be copied and pasted from your browser). Electronic forms are not much different from paper ones, so with all your experience working in the health service you should manage! Requests for CyberDoc to review certain subjects can be left there too.

This new links page also includes links to other medical sites. The General Medical Council site is confusing but will soon offer on-line confirmation of doctors' registration which makes it worth a visit. The NHS Confederation web pages include information on health management and some useful links.

The Department of Health offers the text of all the DOH circulars but is hard to use, so links to the front page, the search page and 'The Patient's Charter' page are available.

The British Medical Association has some uninspiring self-promotion but the excellent Medline and *BMJ* sections more than make up for this.The Royal Colleges are all represented online but are rather variable in webpage quality. If you are in a specialty, even if you are not a doctor, it is worth visiting the relevant College site.

The Oxford University Press 'handbook' series electronic updates give useful brief summaries of advances like the discovery of 'Internet addiction disorder'! The Human Genome Project pages and The Cochrane Library are both interesting, well thought out sites.

The American sister organization to the CMF, the Christian Medical and Dental Society (CMDS) publishes particularly informative position papers on subjects such as abortion. These can cause controversy among Christians and non-Christians alike.

Finally, showing the bias of the author, there are some useful psychiatry links including the National Schizophrenia Fellowship pages, some on-line journals and the excellent but brief Nigel Turner's HyperGUIDE to the Mental Health Act - a good example of effective html links at work.

Visit **CyberDoc** online at
http://xtn.org/cyberdoc/links.htm

CyberDoc is Adrian Warnock, an SHO in psychiatry based in London who also leads a small group in his church.

helping create healthier communities

Jon Brewer describes the health-related work of the Shaftesbury Society

As a privileged schoolboy at Harrow, Anthony Ashley Cooper (later the seventh Earl of Shaftesbury) came across a pauper's funeral. The scene changed his life. He not only became the leader of the evangelical movement of his day, supporting foreign missions, founding the Bible Society, the Church Pastoral Aid Society, and numerous local YMCAs but as a Member of Parliament from 1826 he became one of Britain's greatest industrial and social reformers. Shaftesbury steered through factory reform, limiting the shifts of textile workers to ten hours a day. He took a special interest in the care of the insane. His Mines Act (1842) banned women and children under 13 from working underground.

For 39 years he was president of the Ragged School Union, an enterprise now known as The Shaftesbury Society. This tackles issues of unemployment, homelessness and the problems of low income families. Many of the programmes run by Shaftesbury are directly health-related, including the care and education of people with physical or learning disabilities.

People with disability

Shaftesbury runs three schools and two colleges for young people with disabilities. In each case the staff work closely with visiting health professionals, as part of each pupil's individual curriculum. Health professionals play a key role in the Society's provision of residential, domiciliary and respite care.

In Harlow, for example, Donna Spooner is key worker to Valerie Hart at Shaftesbury's Keefield Close. Valerie, who contracted meningitis at age 11, has been a resident at Keefield since the beginning of 1997. She has both learning and physical disabilities. Before, she lived at home with her mother in Loughton. This could not be sustained when her mother became ill and had to go into hospital.

The aim is for Valerie to achieve as much independence as possible and this aim is being pursued according to a care plan. Donna oversees Valerie's personal care and arranges visits from her doctor, dentist, physio and speech therapist. Donna listens to their suggestions and shares the ideas with colleagues at Shaftesbury.

The care and education support Shaftesbury provides for each individual often includes ensuring healthcare support. However, the overall care provided by Shaftesbury in itself has immeasurable health benefits. The same can be said of the families Shaftesbury supports, many of whom have been through great stress.

Low income

Homelessness and unemployment have obvious health effects. Unemployment often leads to loss of confidence and isolation from others, and can result in depression. Low income and financial difficulties often lead to stress and dietary problems. Shaftesbury runs training courses for people who are long term unemployed. The aim is to help them gain the skills and confidence they need to re-enter the workplace.

Lena Fox House in south London offers direct-access accommodation for homeless young people, and also provides a resettlement service. Working with the nearby Shaftesbury Resources Centre it helps break the cycle of homelessness.

The Resources Centre helps with quality secondhand furniture for people who have been given unfurnished accommodation. It provides cots, toys, stair gates and clothes, helping make home life a safer and more stimulating environment for children. The project as a whole seeks to promote emotional and psychological stability among parents and children alike.

Church-linked community development

Shaftesbury works in partnership with a number of associate churches to provide day centres, community centres, and nurseries. In the process it enables the church concerned to respond effectively to community needs.

Photo: Shaftesbury

Chrissie Hayman

A key part of the work with local churches is Shaftesbury's Community Worker scheme. Chrissie Hayman is one of these workers, based in Crouch End, north London. She has worked at this church centre since it was opened ten years ago.

'I love working with people and getting around in the community' Chrissie explains. 'Working face to face with people is the most fulfilling part of the job and it is really rewarding to meet needs. It helps form a bridge between the

church and the community and helps local people to fulfil their dreams.'

Shaftesbury works with Chrissie and her development worker colleagues to ensure that high standards of practice are maintained through a professional development forum, regular supervision and annual performance reviews. This ensures that Chrissie is never completely isolated and alone in her work.

At Crouch End a wide variety of services is delivered. This is not due to Chrissie's efforts alone. Her presence plus support and training from Shaftesbury have helped unlock the skills of local people. Chrissie has helped develop a team of volunteers at the centre. Local Health Visitors are supportive and gladly refer people to the centre.

Among the programmes at the centre are parenting classes for pre-nursery children: birth to 16 months and toddler to two and a half years. Groups of 15-20 parents meet twice a week in the afternoon for two hours. They hear speakers and discuss health-related issues such as diet and health and safety in the home.

Topics include weaning, milk allergies, asthma and eczema. Reflecting the ethnic make-up of the community the centre has helped Asian children over difficulties with the acidic spicy diet served in their households. Dietary issues in the postnatal group include the need to avoid sweet drinks from bottles and for a better balanced diet with more fruit and vegetables.

'Health and safety' is another key topic covered at the family centre. They are discussed in group meetings and there is the offer of home visits as appropriate. Chrissie and the team ensure they have built a relationship with parents before commenting on things around the home: safety gates (or lack of them) and the unsafe positioning of furniture. They look out for other hazards, including the need to keep bleach and shampoo away from children.

Discretion is important. There are issues that Chrissie may not feel able to tackle during a visit. She may opt, instead, to raise

Photo: Shaftesbury

Photo: Shaftesbury

the issue as part of group discussion when that parent is present. It may open up an opportunity for the issue to be followed up gently with a 'what do you think about . .' over coffee at the end of the session. Chrissie and the team also work directly with older children in an after-school club run at the centre.

Motivation

Across the spectrum of Shaftesbury's work, partnership with other agencies such as health professionals can make all the difference. This is especially the case when these health professionals share Shaftesbury's Christian motivation.

How can Shaftesbury help you?

• Get in touch to see if you might refer people to us. There are many programmes throughout the country that may be able to offer assistance.

How can you help Shaftesbury?

• With much needed finance.
• Bring Shaftesbury into your church. *Shaftesbury Sunday* falls every year at the end of April. Shaftesbury can provide information packs and speakers and can help your church consider Christian social action issues.
• If you live within the M25 the Resources Centre will collect donated furniture.
• Pray for Shaftesbury. Join the Prayer Partner Scheme. Use the prayer calendar.
• Become a governor. Our schools and colleges are always looking for committed Christians to get involved as local governors. Can you help?

Jon Brewer is on the staff of the Shaftesbury Society

For information on any of these issues please ring 0181-239 5555 or write to: The Shaftesbury Society, 16 Kingston Road, London SW19 1JZ.

readers' letters:

Genetic counselling

*Biochemistry graduate **Louise Ray** plans to move from general counselling and work with special needs children into genetic counselling, and is asking for interested Christians to contact her:*

Over the last 15 months God has very obviously and with many confirmations called me to be a genetic counsellor. Being fully qualified is still several years away but is something I am making progress towards and am certain will happen.

From the beginning I have known how hard it will be to get on the Master's course in Manchester and how difficult it may be ethically. I am only just discovering however that the informed sector of the church views genetic counselling as a force for negative eugenics. Genetic counsellors are meant to be impartial and in practice that isn't always the case. There is bad practice; often reinforced by doctors and social workers. It doesn't have to be this way.

I see genetic counselling as an opportunity to support parents and to empower them with information and the space and time they'd need to talk through how they'd cope with each eventuality. I want to defend the rights of people with disabilities by being as realistic as possible regarding quality of life, and by dispelling the disproportionate fear and panic associated with hearing your child is imperfect.

So many people with disabilities have enriched my life that it is unacceptable to me on finding similar disabilities only to give serious thought to termination. There is very good reason for Christians in this field to be balanced professionals and I hope we will be supported by other Christians.

If you are a genetic counsellor and a Christian please get in touch so that we can support one another:

Louise Ray
51 Hadley Road
Enfield
Middlesex
EN2 8LA

Jubilee 2000 campaign

*Responding to the critique in the Autumn 1998 edition of the proposal for a jubilee-style cancellation of debt owed by the developing world, paediatrician **Chris Cooper** from Stockport argues 'it is making a start':*

You give considerable space to the reply by Stephen de Garis, outlining his objections to the Jubilee 2000 campaign. I welcome criticism as this helps to keep a balanced view and tempers idealism.

However, I think a reply is warranted. Poverty in the developing world is surely the major injustice of our times and it is becoming clear that our trading and financial systems are helping to keep the poor poor. The huge debts incurred by the developing world began in earnest with irresponsible lending by Western bankers during the oil boom of the 1970s.

The original amount has been paid off many times over, but the debt will never be paid due to mounting interest. The World Bank has admitted that this is true for the Highly Indebted Poor Countries. Debt repayment is having a crippling effect on ordinary people in developing countries. Christians cannot stand by and do nothing.

It is true that many governments in the developing world are dictatorial and corrupt, but let us ask ourselves what government is free from scandal and irresponsible deals? Our own government was exposed in the Pergau Dam affair in misuse of foreign aid, and currently sells arms to Indonesia's regime.

The World Bank and the IMF impose and closely monitor Structural Adjustment Programmes which force cuts in public services in order for debt payments to be made. Could they not monitor the use of money redirected from debt repayment towards health and education services, possibly through the United Nations - a sort of opposite of sanctions? Governments would be accountable to independent arbitrators both for use of released funds and for any future loans. This is one of Jubilee 2000's proposals.

I do not think the Jubilee 2000 movement are so naive as to think that by writing off debt, world poverty will end. It is making a start to address the huge problems faced in the Third World. Other means such as Fair Trade and long term development work are needed, but will never be effective without debt relief.

The poorest people in the world are powerless in the face of huge international financial forces. The amount of money to write off the twenty poorest countries' debts is not great on a world scale, but the political will is lacking. Surely this is the new slavery of our times? Just as the misery of slavery in the last century was eventually ended by the weight of public opinion, the debt crisis can also end. Let Christians lead the way in standing up to this challenge!

The Editor welcomes original letters for consideration for publication. They should have both Christian and health-care content, should not normally exceed 400 words, and if accepted may have to be edited for length.

Write to:
Triple Helix
157 Waterloo Road
London SE1 8XN
Fax: 0171-620 2453
e-mail: CMFUK@compuserve.com

Counting the Cost

Pamela Evans invited a group of Christian doctors to ask their families: 'What is the cost to you of my professional and church commitments?' and then to listen carefully to their response . . .

The nervous laughter which followed led me to suspect some found the idea extremely threatening and were unlikely to translate it into action. One GP even asked me what he should do if his wife's answer was wrong! Highlighting the cost of professional and Christian commitments is not intended to provoke anxiety or shame. Pursuing any cause or activity will have a cost, even if it only means less time, energy or other resources to devote elsewhere. If we are willing to count the cost, here are some questions to consider:

Am I fully aware what my commitments cost others as well as what they cost me?

A pressurised lifestyle often leads to impoverished communication with those around us - colleagues as well as family. If 'How are you?' is asked with a hand on the door handle or an eye on the clock, we are unlikely to be told all we need to hear. The busier we are, the easier it is to neglect others' concerns until they reach boiling point. If anxieties about our health or sanity are expressed only in the context of the heated rows which disrupt our schedule or ruin what little free time we have, we may dismiss them as the product of ragged emotions instead of taking them seriously. Jesus was clear that discipleship had a cost, and urged the crowds who followed him to give it serious thought. Today's followers are also required to make informed choices.

Have others agreed to their part of the cost...or are they making unacknowledged and/or unwilling sacrifices?

Many families are willing to put themselves out to support members in the frontline professionally and/or spiritually. However, if the sacrifices seem never-ending, and good intentions and promises about taking time off are seldom fulfilled, the supporting family members may feel powerless against the juggernaut of someone else's commitment. In addition, if colleagues feel they are always being pressurised into swapping duties to accommodate church commitments, working relationships may suffer.

Is the cost a consequence of following God's call...or a result of being driven beyond it?

Some who suffer the physical or relational consequences of drivenness feel a sense of pride, seeing themselves as 'honourably wounded' in the course of duty. Yet I believe we do our fellow Christians a disservice if we allow such an attitude to pass unquestioned. Christians must expect suffering to come their way, but it does not follow that all suffering which afflicts Christians is a consequence of their faithfulness to God. We are fallen human beings; we sometimes misunderstand what God is asking of us, and when we do understand we sometimes disobey. When Christians have told me the breakdown of their relationships or health was part of the sacrifice God was calling them to make, I have often felt uneasy. Were they responding to God's call, or did they find it easier to risk their family or their health than to lay down any of their cherished positions of responsibility?

Have friends or colleagues commented on the pace we set ourselves? - or are they all engaged in the same headlong rush?

We need to be willing to hear and ask the sorts of questions which keep us honest about the extent to which God controls the pace and direction of our lives. We also need to scrutinise our motives. Are we really serving others out of an overflowing compassion? Or are we driven by a need to be needed, a thirst for significance, an overwhelming desire to be the one who sorts everything out?

If we are permanently tired yet unable to sleep, with nerves like razor wire and a memory like a sieve, are we willing to spend a few minutes asking God if this is how he intends us to be? If our prayer times are a shopping list of concerns, often including a request for relief from a chronic headache or a dodgy digestion, how about practising the discipline of listening to God, so he can speak into our situation? If this feels too difficult, why not use the question with which I began? God can speak to us through those around us, if we're willing to listen.

In Matthew 11: 28-30, Jesus invites all those who are weary to come to him. *The Message* version adds poignancy to the familiar passage:

'Are you tired? Worn out? Burned out on religion? Come to me. Get away with me and you'll recover your life. I'll show you how to take a real rest. Walk with me and work with me - watch how I do it. Learn the unforced rhythms of grace. I won't lay anything heavy or ill-fitting on you. Keep company with me and you'll learn to live freely and lightly.'

As healthcare professionals we sometimes need to encourage patients to reflect on the pace and direction of their lives as part of promoting good health, and we do well to practise what we preach! We must make sure we are modelling healthy service and discipleship, walking in step with Jesus and watching how he does it, rather than leading fellow lemmings over the cliff to burnout and family breakdown.

Pamela Evans worked as a GP and then in epidemiology. Currently engaged in writing and pastoral work, her book *Driven Beyond the Call of God* is published by The Bible Reading Fellowship in March, price £7.99.

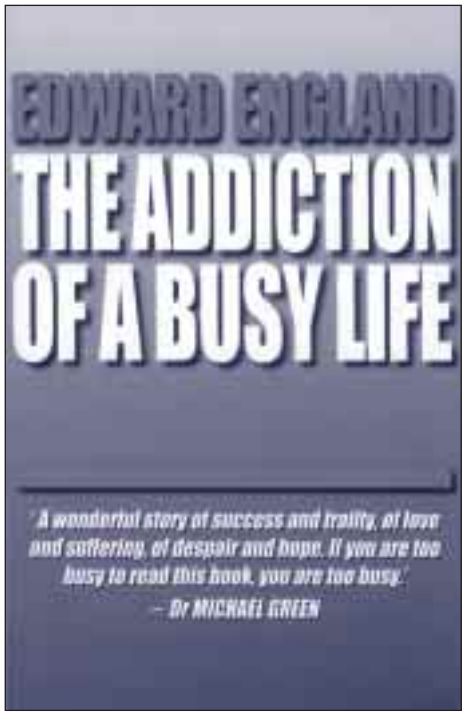
reviews:

The Addiction of a Busy Life

Edward England. Aviemore Books, Crowborough. 1998. 160pp. £5.99 Pb. ISBN 1 901387 09 7

I was initially asked to write this review for the Autumn 1998 edition of *Triple Helix* just as we were leaving for our family holiday. I said 'no'!

A devastating heart attack is the megaphone God uses to wrest publisher Edward England from his addictive busyness. This book is an extraordinarily honest account of four years in the life of this successful man. We feel his physical, mental and emotional anguish as he struggles with the lessons God has for him during a period of enforced inactivity. He fights with denial, pride, embarrassment and fear of losing honour and reputation and is brought painfully to the realisation that he is not indispensable. From here he finds the freedom of living with God's limits, appreciating the joy of each day's blessings.



Though a personal journey (at times with too much detail for me), the lessons Edward England learnt through great trauma have much relevance to busy health professionals. It is easy to rationalise our frenetic lifestyles as commitment rather than addiction. I found myself nodding in agreement at times. Non-stop activity always has consequences. For ourselves it brings restlessness and satisfaction only in doing more, it squeezes out intimacy with God and others, and ultimately brings burnout or premature illness.

While 'we may be foolish enough to think we do not need to change the pace for ourselves . . non-stop activity places an intolerable burden upon those we love'. Diary entries from Edward's wife Ann (a doctor) poignantly illustrate this. Unfortunately this addiction is so widespread that there is often little point in asking colleagues or friends for help.

The last brief chapter, 'A Final Word', is an excellent distillation of the book's message and ends with a prayer asking God to be our pacemaker - words all busy people should make their own.

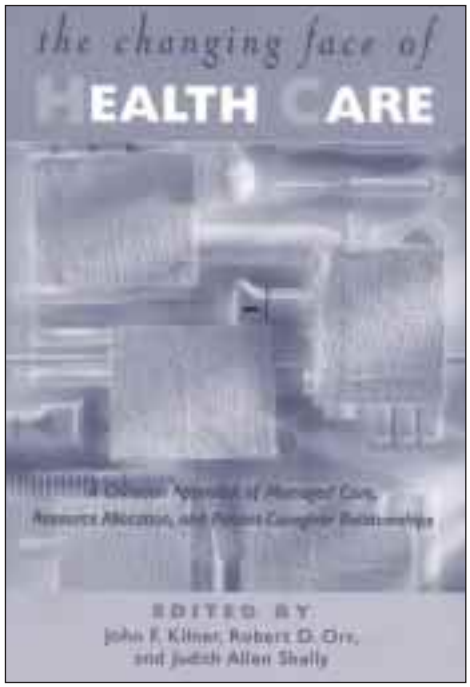
Kirsty Saunders
(Community Paediatrician, St Albans)

The Changing Face of Health Care

Eds John Kilner, Robert Orr and Judith Shelly. Eerdmans, Grand Rapids, Michigan/Cambridge - Paternoster Press, Carlisle. 1998. 314pp. £19.99 Pb. ISBN 0 85364 864 6

The words 'Trust me, I'm a doctor' may no longer reassure doubting patients, yet one recent survey suggests that 75% of UK 16-21 year olds continue to hold the medical profession in the greatest respect. This millennial generation is found to value personal honesty and caring above ambition and independence. However, these young people are sceptical both of politicians, as a group, and of the power and effectiveness of governments. This is the tax-paying generation who will pay for our medical care and old age, unless of course they change the rules.

The Changing Face of Health Care ponders questions of how to provide for the USA's health needs, both present and future. It brings together 22 essays written by those who participated in a conference held in 1997. Currently, there is a shift in the USA to a system of controlling cost by managed health care. The focus of the book is therefore, inevitably, on rationing and how to make sense of it, and its authorship is both overtly Christian and multiprofessional in nature. The book



deals exclusively with one country's system of health care, how it has developed and where it might be going. A thoughtful afterview, by the British public health physician and ethicist Stuart Horner, provides a helpful perspective on the issues within the book for the non-American reader.

So, should we still trust doctors? Robert Orr paints a picture of new medical graduates swearing ethical oaths, but these are post-Hippocrates and post-modern and place less emphasis on protecting the vulnerable. Are nurses better placed? Both Barbara White and Judith Allen Shelly raise the spectre of over-stretched nurses unable to perform their caring vocation whilst being forced to cut corners. Compromising professional values is also a risk for administrators, although William Atkinson is robust in defending a middle way between profit and professionalism, between idealism and realism. As he points out, bad health care is also bad business!

Ultimately, this book must be judged on its handling of the ethical questions that surround managed care, resource allocation, and the subject of rationing. Rationing means different things depending on your geographical perspective. From the UK perspective, a country which disenfranchises 41 million of its subjects from full participation in its health care system looks unhealthy. From the US perspective, waiting lists and black-listed drugs provoke similar feelings. Governments the world over are grappling with cost containment, quality

improvement, and fairer systems of access to health care, not least through an emphasis on primary care.

This book gives much food for thought on these matters, not least on how to meet the needs of the most marginalised in our societies - the poor, the old, the mentally ill, and those from the ethnic minorities. The 'Good Samaritan' receives two thoughtful essays. Economist Kenman Wong suggests that the Samaritan might just have coped with the business ethics of a first century managed care organisation. Bioethicist Edmund Pellegrino isn't so sure. Perhaps you should buy the book and decide for yourself.

Jamie Harrison
(GP Tutor, Durham)

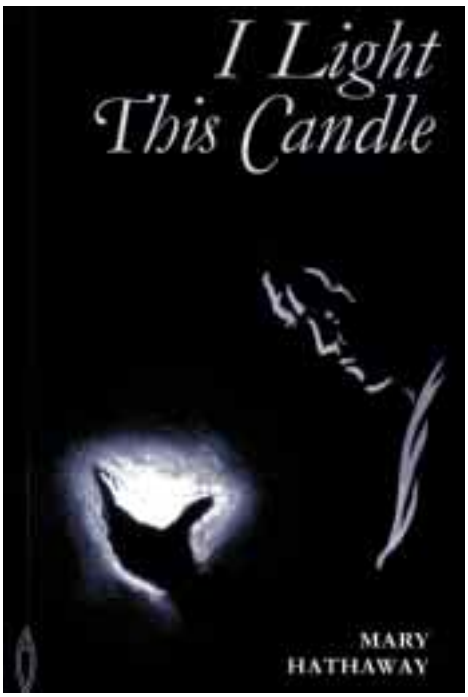
I Light This Candle

Mary Hathaway. Arthur James, Berkhamsted. 1998. 91pp. £4.99 Pb - all royalties to cancer research. ISBN 0 85305 476 2

This beautiful and profoundly moving book of prose, poems, prayers and reflections chronicles with great honesty and integrity Mary Hathaway's journey through despair and hope. Her story begins with her son's diagnosis of a rare form of cancer which required months of intensive treatment. As he recovered Mary was then told that her father had only days to live. A week after his funeral she herself began treatment for breast cancer.

Her writing brings to life often painful and sometimes terrifying feelings, expressions of 'pain, anger, despair, fear, weakness, panic, beauty, hope and love'. Most of all *I Light This Candle* is about Mary's relationship with a travelling companion who never left her, though it often felt to her as if he had, Jesus Christ. There are poems of lamentation and angry questioning - often echoing the Psalms and parts of Job. There are also outbursts of love and joy acknowledging that the cycle of faith requires both resurrection as well as death and dying. Thus whilst it is born out of pain the book is nevertheless also a story of hope. As such I have no doubt it will benefit anyone who is faced with the challenge of life-threatening illness as well as those who grieve.

My one hesitation is that of commending the book to the person who knows they are



dying and for whom the possibility of cure expressed in the message from The Cancer Research Campaign might be just too painful. That said, Mary Hathaway has written with both courage and sensitivity, giving us a privileged insight into the experience of bereavement and cancer, one that can be shared with those who are going through their own times of darkness.

Guy Harrison
(Chaplain, Dorothy House Foundation, Bradford-on-Avon)

The Safe Sex Hoax

Margaret White, edited by Joanna Bogle. Unity Press, London. 1998. 40 pp. £3.90 Pb. ISBN 0 9533454 0 8

This is a challenging read, highlighting some of the blind spots of social policy and their consequences. It points out that 'if any Chief Medical Officer had recommended a drug for preventing pneumonia and after 10 years the result had been to increase the prevalence of the disease, the policy would have been rapidly abandoned'. However, there has been no recognition that since prescribing contraceptives for teenagers there has been an increase in teenage pregnancies, sexually transmitted diseases and later in carcinoma of the cervix. There is pressure to extend this policy.

In the nineteenth century poor children were sexually abused as prostitutes until the Salvation Army and others campaigned to outlaw this evil, and made it illegal to have sex with a child under 16. Are we going backwards? There is an 'almost schizophrenic attitude' on the part of authorities, treating paedophilia very severely whilst subsidising sexual activity in those as young as 12. When girls have sex they are generally looking for love, whereas boys crave excitement. Sex without lasting relationship inevitably leads to anticlimax. Teenagers are not good at lasting relationships and so become disillusioned.

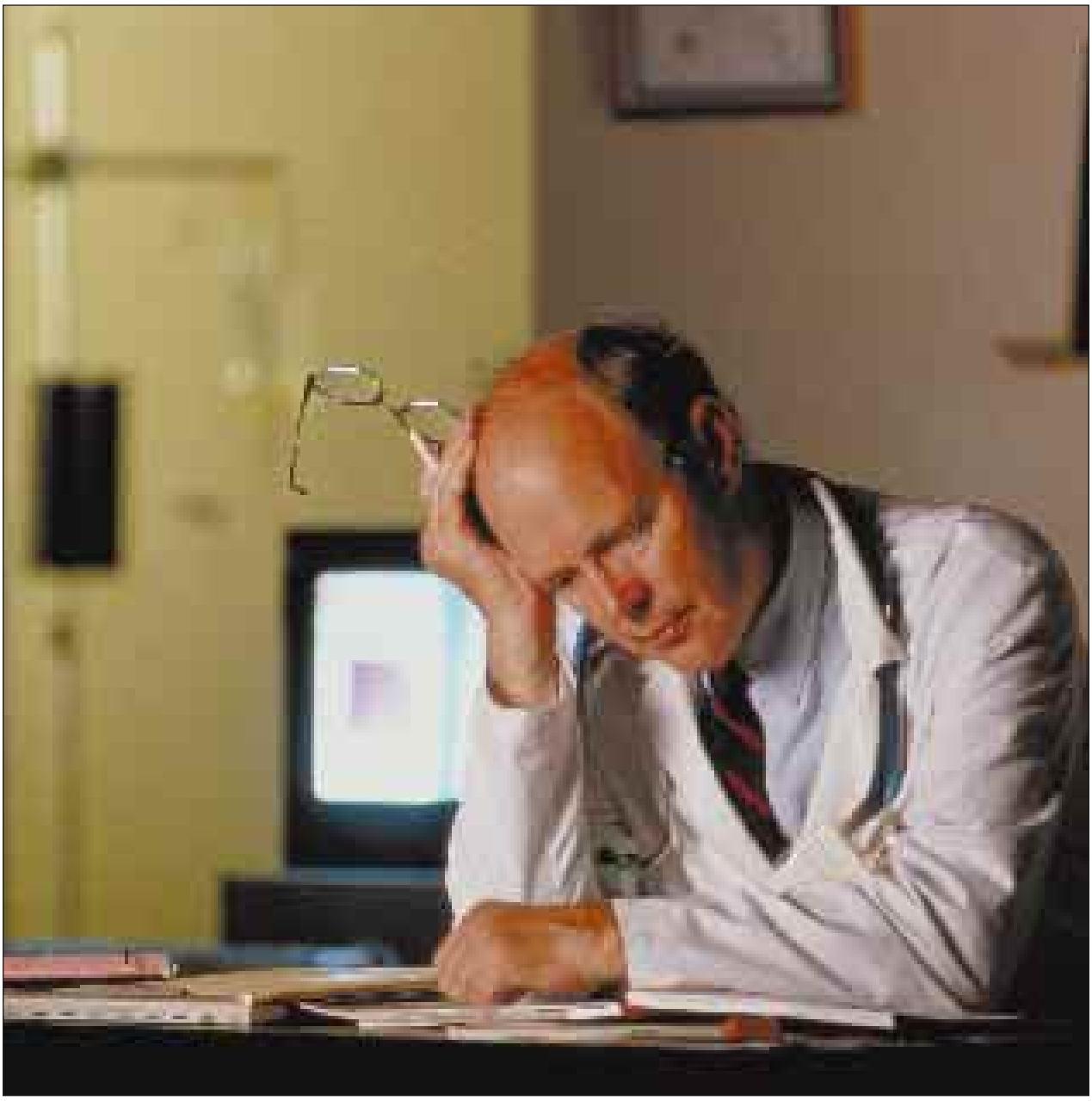
We know the effects of tobacco on health; hence the TV heroes and heroines do not smoke. Yet despite all the evidence, these role models are often in bed together on an early date. It seems ironic that the feminist lobby, so keen to give women 'the right to choose' has, by increasing the volume on the 'everybody's doing it' message,

effectively made it a lot more difficult for young women to choose to say 'no'!

This booklet cuts through political correctness most refreshingly, and challenges us to action. My only disagreement was with what I felt to be an overstatement of some problems associated with the use of the oral contraceptive pill.

Maggy Spence
(GP, Essex)

burnout.....



‘Be still, and know that I am God’