nucleus

the student journal of the christian medical fellowship | christmas 2008

homelessness

prayer for healing | climate change | doctors' rights

nucleus

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christmas 2008

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editorial...

Richard Dawkins argues that the Christian God is petty. Why else would he 'torture himself' on a cross for human sin (pp4-6)? Dawkins is wrong, because he does not understand the severity of sin – an appalling rejection of God's rightful rule as the creator, sustainer, and giver of all life.

In stark contrast, the psalmist sings gratefully of God's generosity: 'When we were overwhelmed by sins, you forgave our transgressions. Blessed are those you choose and bring near to live in your courts! We are filled with the good things of your house, of your holy temple.' (Ps 65:3,4)

At the same time, Dawkins is partly right in accusing the Christian God of being petty. Our Lord is petty enough to care about 'trivial' and 'unimportant' people in society:

For he will deliver the needy who cry out, the afflicted who have no one to help. He will take pity on the weak and the needy and save the needy from death. He will rescue them from oppression and violence, for precious is their blood in his sight. (Ps 72:12-14)

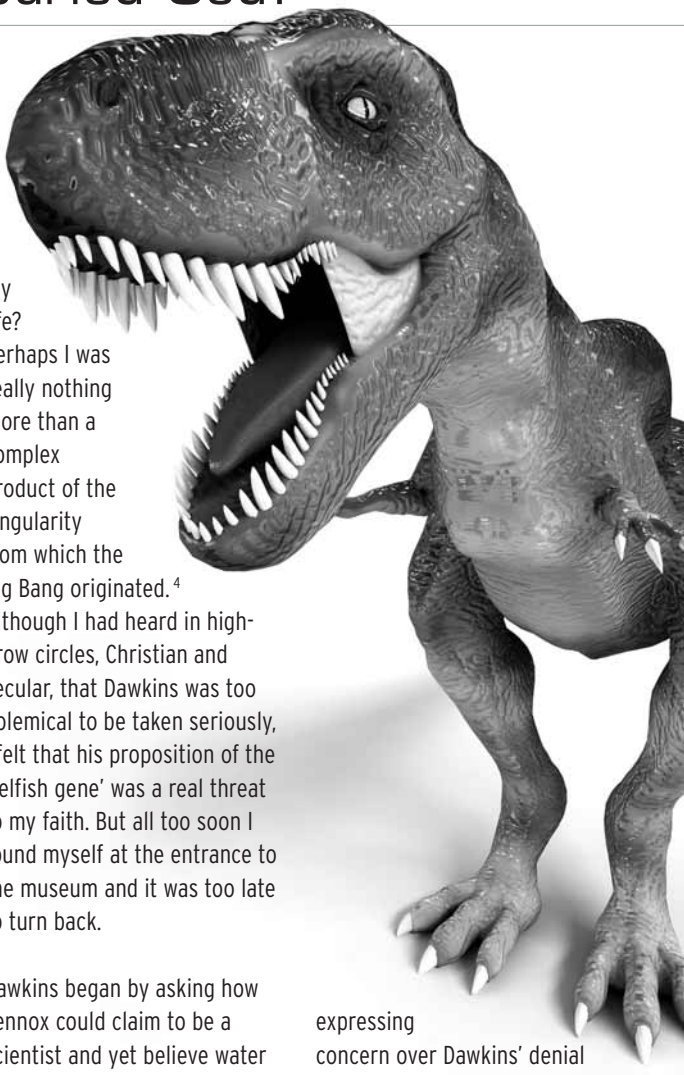
I am struck by how the psalmist's words still ring true today. While I take comfort in God's unchanging faithfulness and compassion, I realise that there are still many amongst us who are needy, afflicted and weak. And they still need rescuing from oppression. For homeless people and asylum seekers, 'access to proper primary health care is jeopardised by the negative reaction of care providers', even though their right is enshrined in law, writes Peter Campion (pp15-19). I pray that we will have the courage and conviction to serve vulnerable groups rightly when we become doctors, responding to a true vision of God's justice and mercy.

Even as medical students, we can take steps to understand the needy. Awareness produces compassion, leading to service. In Cardiff, three Christian medical students designed their own special study module to investigate healthcare provision for the homeless (pp20,21). Andy Meeson goes out with a medical van to tend to Manchester's homeless each week (pp22,23). I was personally encouraged and challenged by their testimonies. In both cases, they were motivated by the love of Jesus; they depended on God's strength; and they sought to glorify God in their actions. This is what the Lord requires of us all – whatever we are called to do, and whoever we are called to serve.

Hugh Ip

has science buried God?

***Camilla Day** reports on the exciting debate between Dawkins and Lennox*



I queued up outside Oxford's Natural History Museum clutching a coveted ticket to the sold-out event on 21 October. It was only the second time for Richard Dawkins and John Lennox to debate the existence of God, and the first on English soil.

Richard Dawkins is the well-known author of *The God Delusion*,[1] recently retired as Professor of the Public Understanding of Science at Oxford University, and sponsor of the atheist bus campaign.[2] His opponent, John Lennox, is Professor in Mathematics at the University of Oxford and Fellow in Mathematics and Philosophy of Science at Green College, Oxford. He is a Christian who wrote *God's Undertaker: has science buried God?*[3] in response to *The God Delusion*.

questions in my mind

Was I going to be persuaded by 'the Dawkinator'? Had I been infected with a 'religious mind virus' for the past four years of my life? Perhaps I was really nothing more than a complex product of the singularity from which the Big Bang originated.[4] Although I had heard in high-brow circles, Christian and secular, that Dawkins was too polemical to be taken seriously, I felt that his proposition of the 'selfish gene' was a real threat to my faith. But all too soon I found myself at the entrance to the museum and it was too late to turn back.

Dawkins began by asking how Lennox could claim to be a scientist and yet believe water can be turned into wine.[5] After putting Jesus in the spotlight, he did not grant his opponent the same courtesy. Whenever Lennox spoke about Jesus, Dawkins accused him of fanciful digression from science and he was reluctant to engage. Lennox took that in his stride, expressing concern over Dawkins' denial of Jesus' existence, not to mention his death and resurrection. Cornered, Dawkins was forced to concede that most historians did think he existed. But he attempted to dismiss the point by saying that the whole story of Jesus was petty.

jaw-dropping moment

Dawkins was adamant that he did not believe in the petty Christian God who cares about sin and 'tortured himself' on the cross. Lennox's rebuttal was that sin and consequent alienation from God are in fact the most important questions in life. Nevertheless, Dawkins admitted that 'a serious case could be made for a deistic god'. This concession almost went by unnoticed, but journalist Melanie Phillips explains its gravity:[6]

Here was the arch-apostle of atheism, whose whole case is based on the assertion that believing in a creator of the universe is no different from believing in fairies at the bottom of the garden, saying that a serious case can be made for the idea that the universe was brought into being by some kind of purposeful force…True, he was not saying he was now a deist; on the contrary, he still didn't believe in such a purposeful founding intelligence…Nevertheless, to acknowledge that 'a serious case could be made for a deistic god' is to undermine his previous categorical assertion that: '…all life, all intelligence, all creativity and all "design" anywhere in the universe is the direct or indirect product of Darwinian natural selection…Design cannot precede evolution and therefore cannot underlie the universe.'[7]

While Dawkins could contemplate a god, he said that this was incompatible with 'a god who cares about our sins', 'what we do with our genitals', and what we think about. This implies that his objection to the Christian God is not scientific but theological.

evolution and design

Lennox argued that evidence of design in the universe implied that there must be a creative mind behind it. Dawkins countered by saying that it is mindless Darwinian evolution, the 'blind watchmaker', giving the impression that life was designed. Lennox said that he believed in evolution as a *mechanism* but that it was a separate assumption that there is no *agent* behind the mechanism. He cited the example of his watch; it 'is blind and automatic but that does not mean it wasn't designed, far from it'. Dawkins argued that if a stone fell to the ground, one would acknowledge that it fell by gravity, not because God caused it to fall in the same way time and again. An agent is superfluous to the explanation of life. But Dawkins admitted that he had no explanation for the origin of life; he believes that a naturalistic explanation will one day be discovered by a 'Darwin of the cosmos'. However, Dawkins said some surprising things to Melanie Phillips after the debate:

…rather than believing in God, he was more receptive to the theory that life on earth had indeed been created by a governing intelligence – but one which had resided on another planet. Leave aside the question of where that extra-terrestrial intelligence had itself come from, is it not remarkable that the arch-apostle of reason finds the concept of God more unlikely as an explanation of the universe than the existence and plenipotentiary power of extra-terrestrial little green men?[8]

Darwin, himself an agnostic, wrote, 'it seems to me absurd to doubt that a man may be an ardent theist and an evolutionist'.[9] Lennox said that the stunning Natural History Museum they were sitting in had been built by such Victorian

theists for the glory of their God. Dawkins rejected this proposition, but he was wrong. The Regius Professor of Medicine at the time of construction, Sir Henry Acland, explained that the building was for obtaining the 'knowledge of the great material design of which the Supreme Master-Worker has made us a constituent part'. In fact, the funds for the building came from the surplus in the University Press' Bible account!

hear them for yourself!

Unlike the rigid format of their first debate (see box), this event was a more fluid conversation between the two. In addition to the topics I highlighted above, they expounded on subjects from their books along the lines of rationality, morality, and justice.

Both speakers were remarkable communicators. Lennox certainly held his own, even while Dawkins was articulate and logical. But even so, Dawkins disengaged with the conversation at certain points and disappointingly resorted to emotive dismissals of God as 'petty', an 'imaginary friend' of those who need to grow up, and faith as 'fantasy'. Consequently, I not only felt substantially less threatened by his ideas; I was disappointed by his ignorance of the historicity of Jesus Christ. Science certainly has not buried God! But you do not need to take my word for it; make up your own mind. The audio recording of the debate is available for sale online.[10] It is well worth your time; you don't even need to stand in line!

***Camilla Day** is a final year student at Warwick Medical School*

Dawkins versus Lennox, round one – The God Delusion Debate

October 2007, University of Alabama (USA)

The two Oxford professors first debated each other a year ago. The free online video[11] is an easy way in to understanding the key arguments in Dawkins' book and the Christian riposte. It is also an excellent opportunity to spark off debate with non-Christian friends on the topic. I thought that Lennox finished the debate ahead on points but with no knockout blows.

The structure is a little strange, hampering the flow of the arguments. Dawkins expands on six theses, from *The God Delusion*, one after the other. These include: 'science supports atheism not religion' and 'religion is dangerous'. Lennox then responds to each argument. The format puts Lennox at an advantage as he can always critique Dawkins' arguments, whilst Dawkins does not have the opportunity to reply. Having said that, both speakers are engaging and often amusing as they stake their ground – it is well worth watching!

***Will Taylor** is a CMF student intern*

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John Patrick's UK Tour

***Will Taylor** reflects on a thought-provoking lecture series*

the man

John Patrick is a well known speaker in North America where he has lived in Canada for much of his life after training as a doctor in the UK. He was a main speaker at the CMF student conference in 2003 and is a frequent speaker at international ICMDA conferences, so we jumped at the chance of having him tour around the UK from 13-17 October, all the way from frozen Aberdeen in the north to sunny Brighton in the south.

the tour

Having helped in the organisation of the tour but never heard him speak I wasn't quite sure what to expect. But he spoke very well across all the venues. In total around four hundred people heard John speak in nine talks at eight different universities on subjects like 'Much more than a baby dies in abortion' and 'Can we be good without God?' I heard him speak on 'What Hippocrates knew and we have forgotten' at University College, London.

the talk

John started by stating that everyone wants a doctor they can trust. He went on to point out that your tutors and deans don't know which of your year group are trustworthy - they only know the people who pass exams; but you will know within weeks the people who you would not want near your granny.

Trust is a vital part of Hippocrates' oath. In ancient Greece the doctor and the assassin were one man; so you could not trust your doctor because someone else may have paid them more to kill you. What Hippocrates and his oath did was guarantee that the doctor would try his utmost to cure you, and never kill – including abortion and euthanasia. Patients voted with their feet and the only doctors that survived in the western world were those who followed the oath. This has been lost as abortion is commonplace and euthanasia may become so; doctors can easily become technicians of a service rather than holistic healers.

The other vital aspects of the oath are: transcendence (acknowledging a higher authority than humanity), the sanctity of life and the moral integrity of the physician. John outlined why the current trend to 'update' the Hippocratic Oath actually removes some of its core values.

more information

John has previously expanded on the Hippocratic Oath in *Nucleus* and you can read it online.[1] His website is well worth a look, with several of his papers and talks, including the ones he gave on this tour - *www.johnpatrick.ca*. We also hope to have him back in the UK before long, so watch this space!

***Will Taylor** is a CMF student intern*

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meet Vicky Lavy

Vicky Lavy wants to help us look beyond our borders

you've just started working for CMF as Head of International Ministries. What is the job about?

It's all about raising the profile of global health issues in CMF and getting people interested in what's going on beyond our world of the NHS and the UK, particularly in the developing world where the health needs are so great. It's also about being a resource for those who are already working overseas, or are planning to go – providing information, advice, contacts and literature.

Another part of my job is developing partnerships between CMF and the many other national Christian medical associations around the world that are part of the International Christian Medical and Dental Association (ICMDA).

why should today's students be interested in medical work overseas?

I think every single Christian should be concerned about the poor because that's what God has told us. Did you know there are more than 2,000 verses in the Bible about poverty and injustice? For instance, Proverbs 21:13 tells us, 'If a man shuts his ears to the cry of the poor, he too will cry out and not be answered.' Then there is a surprising reference to the wicked city of Sodom in Ezekiel 16:49:

Now this was the sin of your sister Sodom: She and her daughters were arrogant, overfed and unconcerned; they did not help the poor and needy.

Christian doctors – and students – are in a prime position to serve those who are neglected by others. Of course we can do that in this country, but we simply can't pretend that the medical needs here are as pressing as those in the developing world. Europe and the USA have 20% of the world's disease but 72% of the world's health workers and 85% of the world's health budget. It's a terrible injustice – but as medics, we are in a position to do something to put it right.

what did you do before you started at CMF?

My background is in general practice but I spent ten years in Malawi where I did a variety of jobs – including running around after our three boys. I spent the last four years of our time there

setting up a palliative care service for children, which was one of the most fulfilling things I've ever done. Since we came back to England I have been doing paediatric palliative care at Helen House Hospice in Oxford, but I've given that up now to come and work for CMF.

I was also involved in getting a CMF going in Malawi, which was great fun and also very rewarding – it started with a small bunch of students in 1997, and now it's a national fellowship. It's been wonderful to be involved with medical students and watch them as they grow, progress, and qualify, then to see them in leadership positions in Malawi.

tell us about your family

My husband, Chris, is an orthopaedic surgeon. He works part time for the NHS and part time on various projects promoting orthopaedics in the developing world – such as research, training and also setting up hospitals where disabled children can have surgery to get them walking.

We have three boys who are 13, ten and eight. Some *Nucleus* readers may even remember them from the students' conference this year as they were conspicuously younger than everyone else there! They were the ones playing football and amassing vast piles of glow sticks.

what would you recommend as a first step for a student looking to get involved in international work?

Electives are a prime opportunity to get a taste of working abroad. There's lots of information on CMF's Healthserve website about planning electives and lots of useful addresses – *www.healthserve.org/electives*

I think everyone should at least consider going to a developing country, even if they have no intention of working overseas after qualifying. The way we live in the UK is the exception rather than the rule – two thirds of the world's population live in the developing world and have a fraction of the resources that we enjoy. It's important that we know what life is like for our brothers and sisters in the rest of the world.

do you plan to be involved with students in your new role at CMF?

Yes, definitely. I'll be at Swanwick in February for the national students' conference (along with my boys – they're looking forward to it already) and hope to meet lots of students. Then we'll be having an electives day in London (probably in March) where we'll have several experienced people talking about the issues of working in a different culture, and how to go about planning and getting ready. If other student groups want to hold an event like this, we can send a variety of resources from CMF and provide a speaker – if I can't come myself, I'll find someone good who can.

And don't forget, I'm there to answer any questions, big or small, about international issues and options for working overseas. You can email me on *vicky.lavy@cmf.org.uk* – I'd love to hear from you!

Vicky Lavy *is CMF Head of International Ministries*

the Yorkshire three peaks challenge

Cat Handforth *fundraised through wind, rain, and bog*

The Yorkshire three peaks walk is a substantial physical challenge. The circular route incorporates Pen y Ghent (691m), Whernside (728m) and Ingleborough (723m). The 26 mile walk, with a total ascent of over 5,000 feet, must be completed within twelve hours.

The National Students' Committee (NSC), in their wisdom, decided that this would be the perfect group challenge! On 8 August, we descended on a village deep in the Yorkshire Dales with three aims: conquer the peaks, have fun, and raise money. The funds would go towards subsidising our annual national students' conference.

in God's safe hands

The original accommodation plans fell through days before the event, so Foxwood Farm was a huge answer to prayer. Its spacious lounge, drying room, hot showers and comfortable beds met all our needs.

The 15 walkers, divided into three teams, included students and CMF office staff from Oxford, Manchester, Warwick, London, Hull and Leeds. We found out it was not a holiday when we were rudely awoken at 5am. Revived by a hearty breakfast and lots of caffeine, we were given rather simple instructions: not to lose one another or get lost by ourselves!

From 6am the teams set off at intervals. It was such a relief, for many of us city dwellers, to be in the middle of nowhere, enjoying fresh air and birds in full song. We were not surprised to see other 'three-peakers' setting out for the day; one man with a cigarette and beer can in hand. We wondered how his lung function and neurological control held out through the day!

climbing the peaks

The first peak (Pen y Ghent) was only a few miles from the start, but we had to endure the steep and blustery ascent to the summit. Once there, we were rewarded by stunning panoramic views; we could even see the twelve miles we needed to walk to reach the next peak. Unfortunately, the sky became dark and cloudy by 9am, while a fine drizzle swirled around us. The rain got steadily heavier, as we headed up the valley towards the second peak, turning the ground into an energy-sapping bog. A few

of us got stuck and needed help getting out!

By late morning we reached Ribblehead. The second peak loomed large above the viaduct where CMF marshals were stationed. We refuelled in the shelter of their car boots and umbrellas; we also applied plasters to blistered feet and joked about the rain not stopping.

Whernside had a series of big steps on a ridge; made more difficult by soaking wet clothes, waterlogged boots and icy cold legs! Even staying on the ridge

was a battle, as we were at the mercy of howling wind and pelting rain. We came down the other side with trepidation: slippery rocks, weary legs and impatience do not make a safe combination!

I thanked God for the café in the middle of nowhere, where we took a welcome break. The shelter, tea and chocolate psyched us up to conquer the final peak. Ingleborough was the steepest of the three and we found it tough work!

After getting up and down that peak, one final challenge remained – a ford separated us from our front door. What started the day as a gentle trickle had become a small lake! Somehow we crossed over, and all 15 walkers were back safely by 6pm. Our barbeque plans were thwarted by the elements, but we were just glad to be warm and dry inside!

if we can raise £5,000...

Our small group managed to raise over £5,000. It is exciting to think how much we could raise with more people! Charlotte Hattersley (CMF Northern Student Team Leader) capably masterminded this operation. The team was also blessed with a fantastic array of useful skills, including: porridge making, umbrella holding, taxi driving, human signposting, encouraging and the inevitable first aiding!

This weekend proved that fundraising together can be lots of fun. The NSC encourages local CMF groups to organise creative events at your own medical school. From cake sales to organising revision sessions, and even sky dives – the possibilities are endless and the cause is worthy! Have a look at *www.cmf.org.uk/fellowship/students* for more ideas.

***Cat Handforth** is a clinical student at the University of Leeds and an NSC rep*

Human Fertilisation and Embryology Bill

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

The 2008 Human Fertilisation and Embryology Bill goes further by bringing in more liberal embryo research, saviour siblings, animal-human hybrids, fatherless IVF children, and by making legal without explicit consent the use of tissue from children, mentally incapacitated adults and people who have died, in order to make cloned and hybrid embryos.

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

The Prime Minister was key when he wrote in May to support embryonic stem cell therapy and animal-human hybrid research, despite scientists worldwide turning to the ethical alternatives of adult and cord blood stem cells and induced pluripotent stem cells.

The bill completed its eleven month journey through Parliament on 29 October with a debate in the Lords and now needs only royal assent, a mere formality, to make it law. The only saving grace has been that the abortion law has not been further liberalised. It was a huge answer to prayer when liberalising amendments calling for abortion on request up to 24 weeks, nurse and GP surgery abortion, and extension to Northern Ireland fell. At the eleventh hour the government acted to prevent debate on these. The new HFE Act is certainly bad, but could have been even worse. (*services.parliament.uk* 2008; November, *guardian.co.uk* 2008; 18 May, *news.bbc.co.uk* 2008; 22 October)

one stop embryo test

Current tests for inherited diseases are specific; they can only identify a few hundred conditions. A 'one stop' gene mapping test may be available soon. It will tell parents if embryos are affected by almost any of 15,000 inherited diseases.

The test involves removing one cell from an eight-day-old embryo, created by IVF. The family's genetic map is produced using DNA samples from the parents, grandparents and often a relative affected by a specific condition. If a block of DNA has been passed on by the paternal grandfather to the affected relative, the test can determine whether this block is also present in the embryo.

The test is currently being trialled. If a licence is granted from the Human Fertilisation and Embryology Authority, this would set a worrying new horizon for pre-implantation genetic diagnosis. Furthermore, the test could potentially generate genetic profiles, indicating susceptibility to conditions such as heart disease and cancer. 'But obviously, the ethical question is, if you can screen for anything, where do you draw the line?' says Dr Mark Hamilton, chairman of the British Fertility Society. (*news.bbc.co.uk* 2008; 24 October)

genetically uncommitted?

A gene variation may contribute to commitment problems in men, according to a study from the Karolinska Institute in Sweden. Interest in the role of vasopressin (ADH) in human sexual behaviour arose after the discovery that variations in ADH receptor expression make prairie voles monogamous but meadow voles promiscuous.

The recent study looked at the gene coding for an ADH receptor, in 552 Swedes in heterosexual relationships lasting at least five years. Variation of the RS3 334 section of the gene was related to how well men bonded with their partners. Those with two copies (rather than one or none) were more likely to be unmarried than the others, and if married, they were twice as likely to have a marital crisis.

It is not yet clear how this polymorphism affects ADH receptor expression and consequently our intimate relationships. But unlike voles, human capacity for moral behaviour enables us to exercise choice no matter what our biological predispositions. (*New Scientist* 2008; 1 September, *Proc Natl Acad Sci* USA 2008;105:14153-6, *Emory Report* 1999; 7 September)

physician assisted suicide

Debbie Purdy, wheelchair-bound with primary progressive multiple sclerosis, may want to die at Dignitas (the Swiss assisted suicide facility) at some point. She believes the law is unclear and worries that her husband will be prosecuted if he accompanies her (around 100 Britons are thought to have committed PAS at Dignitas, and so far, none of their relatives have been prosecuted for assisting a suicide).

In October, High Court judges sat for a judicial review and decided that the law is enough. Mrs Purdy, a member of Dignity in Dying (formerly the Voluntary Euthanasia Society), which campaigns for the legalisation of PAS and euthanasia in the UK, is said to be appealing the decision.

Now though, the Crown Prosecution Service is considering whether to prosecute the parents of Daniel James, a 23 year old paralysed last year when a rugby scrum collapsed. His parents took him to Dignitas in September this year, where he died. Unlike most British patients choosing to die in Switzerland, Daniel was young and his condition, though distressing, was neither progressive nor terminal.
(*www.carenotkilling.org.uk*)

the credit crisis and health

The UK government's multi-billion pound bailout will inevitably leave the nation in debt. But the NHS should face little danger in the immediate future. NHS spending is guaranteed up to April 2011, but the long term effects will depend on the length of the credit crisis and the aftermath.

Tax raises and funding cut-backs, in an attempt to recoup borrowed money, may lead to a reduced workforce and increased poverty. Health services available to patients may decrease. Private sector suppliers may be affected and private finance initiative schemes may undergo re-evaluation.

The global impact of the credit crisis is predicted to leave 44 million more people malnourished in 2008 as a result of increased food and fuel prices. The Millennium Development Goals seem even less likely to be fulfilled by the target of 2015. (*BMJ* 2008;337:2259, *Lancet* 2008;372:1520)

placebo prescriptions are rife

Over half of US GPs and rheumatologists admitted prescribing 'placebo treatments' to some of their patients, in a recent survey. More than 62% believed this was ethical. They rarely called these treatments 'placebos', instead referring to them as 'a potentially beneficial medicine or treatment not typically used for their condition'. However, a 2006 American Medical Association statement reads, 'Physicians may use placebo for diagnosis or treatment only if the patient is informed of and agrees to its use'.

Most placebos were innocuous vitamins and over the counter analgesics, but antibiotics and sedatives were also prescribed by 13% of doctors surveyed. The use of placebo treatments remains a controversial topic for ethical and policy debates. While it may be physically beneficial for patients, this practice is paternalistic and jeopardises patient trust. (*medicalnewstoday.com* 2008; 25 October)

religion, pain and depression

Two recent studies explore the link between religion and health. The first, from Oxford University, addressed pain perception. When Catholics and 'non-believers' were subjected to electric shocks, Catholics experienced 12% less pain than the group of atheists and agnostics when viewing an image of the Virgin Mary. Brain scans showed that the ventrolateral prefrontal cortex was more active in Catholics. They engaged a 'brain mechanism that is well known from research into the placebo effect, analgesia and emotional disengagement', said the lead researcher. It 'helps people to reinterpret pain, and make it less threatening.'

An American study looked at religiosity and the risk of depression. Individuals with a higher level of religious well-being were 1.5 times more likely to have had depression than those with lower levels of religious well-being. The authors, surprised by the findings, suggested that this could be due to people with depression using religion as a coping mechanism. Consequently, depression is linked to praying more. (*guardian.co.uk* 2008; 1 October, *medicalnewstoday* 2008; 24 October)

evolution is complete?

Human evolution remains a controversial theory. But for those who believe it, it may be coming to an end in humans for three reasons, according to Steve Jones, Professor of Genetics at University College London. 'In ancient times half our children would have died by the age of 20. Now, in the Western world, 98% of them are surviving to the age of 21...Natural selection no longer has death as a handy tool.'

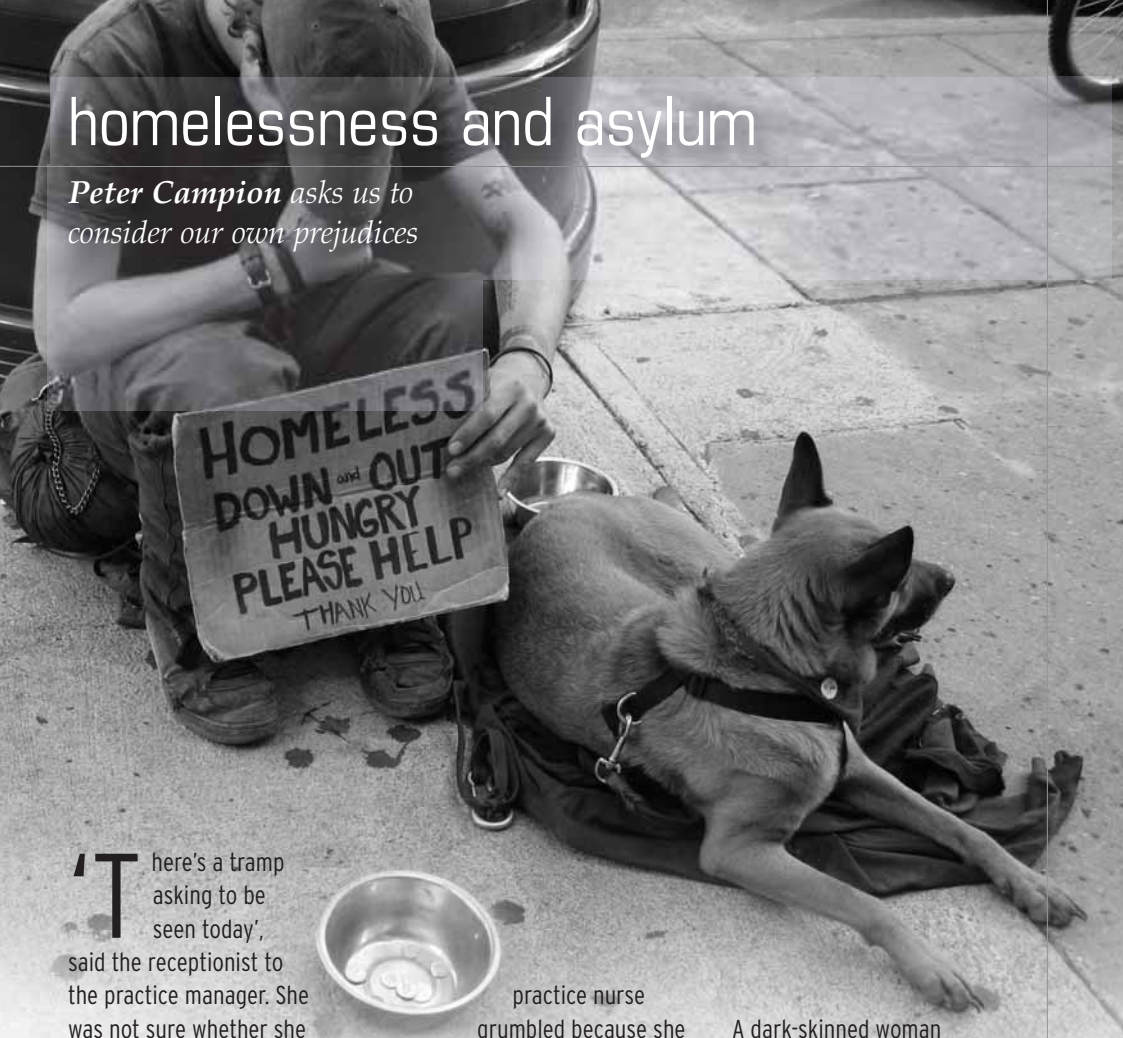
Secondly, there is less potential for random alterations to our genetic blueprint. '...The mean age of male reproduction means that most conceive no children after the age of 35,' said Professor Jones. 'Fewer older fathers means that if anything, mutation is going down.'

Thirdly, 'Small populations which are isolated can...evolve at random as genes are accidentally lost. Worldwide, all populations are becoming connected and the opportunity for random change is dwindling.' (*independent.co.uk* 2008; 7 October, *telegraph.co.uk* 2008; 7 October)

Jenny Chui, Sarah MacLean, Rachael Pickering, Peter Saunders, Sheldon Zhang

homelessness and asylum

Peter Campion *asks us to consider our own prejudices*



'There's a tramp asking to be seen today', said the receptionist to the practice manager. She was not sure whether she should register this man, and if so, how. Was he 'immediate and necessary', or a 'temporary resident'? What should she put for his address? He said he was sleeping in the park.

The last time she let a 'tramp' into the surgery, patients complained to the manager about the smell in the waiting room, the doctor complained to the receptionist because he did not like alcoholics, and the practice nurse grumbled because she spent half an hour dressing his leg ulcers! The last straw was when he managed to leave without completing the paperwork. The manager said to fit him in if there was a free slot, and otherwise suggested he went to the hospital.
As there were no spare appointments, the receptionist told him to go to accident and emergency (A&E), about a mile away. He limped away, looking sad.

A dark-skinned woman approached the window, saying, in broken English, 'I must see doctor'. The receptionist felt more confident here, because there was a policy. But she always found these people difficult, and she knew the doctors did not like them registering, because they took up so much time. She told the woman that she had to phone in the morning, to allow time to organise an interpreter. The woman did not understand, but

sensing a rejection, spoke more forcefully, '*I must see doctor now!*' The receptionist, conscious of the practice's zero tolerance policy towards aggression, thrust a multi-lingual leaflet into the woman's hands and closed the window. The woman could not read, and turned away in tears.

Do these scenarios resonate for you? Maybe your last encounter with a homeless person was during your A&E attachment, or in general practice. What about 'immigrants' who have limited or no English? Street homeless people and asylum seekers are among the more visible of the 'marginalised' or 'socially excluded' groups. But there are many others whose access to proper primary health care is jeopardised by the negative reaction of care providers.

laws and loopholes

Under UK law, both the Race Relations Act 1976 (amended in 2000) and the Disability Discrimination Act 1995 (amended in 2006) govern how we provide healthcare. While the less well known but highly relevant 'right to health' (found in article 12 of the International Covenant on Economic, Social and Cultural Rights, ratified by the UK Government in 1968)[1] adds a moral, if not a legal, dimension.

Under the NHS, healthcare should be available to all UK citizens at the point of need, regardless of the nature of the health problem, race, religion, occupation, sexual orientation, or any other label. That term 'citizen' highlights one of the issues – there are rules determining entitlement to NHS care for non-citizens, whether European Community (EC) citizens, non-EC visitors, asylum seekers, or so-called 'failed' asylum seekers.[2]

But neither a street homeless person who is a UK citizen, nor an asylum seeker whose case is under consideration by the UK Border Agency (UKBA), fall into the category of those who are not entitled to NHS care.[2] So why do these scenarios seem so familiar?

problems and prejudices

Consider the reasons why this hypothetical practice raised barriers to our homeless man:

- He had no fixed address
- He posed a threat to the waiting room environment and he might upset other patients
- He had a 'difficult' disease (alcohol dependence)
- He might increase the workload of the nurses
- He would probably not contribute to the practice's score in the Qualities and Outcomes Framework (a points-based system for payment to NHS GPs, largely focussed on chronic disease management)

We could add that he was not the sort of patient they wanted to include on their list. And what about the woman with limited English? She failed to get help, despite the receptionist trying to follow procedures. The practice was not bending over backwards to help her, rather the reverse; there was a negative attitude at all levels:

- She could not understand the receptionist
- She could not read the literature, even in her own language
- She would need an interpreter, which would mean a longer consultation, and additional cost to the Primary Care Trust (PCT) or the practice itself
- She might have one or more 'difficult' conditions such

as post-traumatic stress disorder (PTSD), tuberculosis (TB), or HIV

defining 'homeless people'

The group includes not only the visible 'street homeless' rough sleepers, but also people living in hostels, bed and breakfast accommodation, and people 'living with friends'. This entails sleeping on floors, and moving from flat to flat as their friends' patience or funds become exhausted. Homeless people have become homeless for a reason; often a relationship breakdown. This could be precipitated by a drug and alcohol addiction or other mental illness, commonly found in this group, both as a result of their homelessness and as a cause of it.[3]

Homeless people are far more likely to suffer from learning disability, making them more vulnerable and less able to seek help assertively.[4] Most of the failed asylum seekers discussed below will also be homeless in this latter sense, and indeed some will be sleeping rough. Homeless people do not usually have a telephone, and they find appointments difficult to keep. Some larger cities have services

run by the PCT dedicated to the needs of 'socially excluded' people.

asylum seekers and refugees

In addition to about 25,000 who now enter the UK each year claiming asylum,[5] there are an estimated 300,000 or more asylum seekers who have not yet been granted permission to stay. Their fate is in the hands of the UKBA, as well as the Asylum and Immigration Tribunal (the court that hears appeals and makes final decisions). After receiving permission to stay in the UK, asylum seekers are known as refugees. They become entitled to the same rights and benefits as UK citizens, and they are able to apply for citizenship themselves.

The mental health needs of refugees and asylum seekers are complex and serious. In particular, PTSD has to be identified or excluded. It is often accompanied by other psychiatric diagnoses, especially major depressive disorder. Good support from a mental health service is important, as there are very specific psychological treatments for this condition.[6] Torture, rape, and injuries such as gunshot wounds carry

emotional as well as physical consequences.

People from sub-Saharan Africa (eg the Democratic Republic of Congo, Zimbabwe, Angola) are more likely to have HIV, for which specialist care is essential. HIV positive patients pose no special threat to primary care, provided that staff members know about the condition and precautions against blood-borne viruses.

TB is a significant disease in vulnerable people. Although easily treated, a high index of suspicion is required, so that all potential cases are referred for screening at the local chest clinic. Asylum seekers are normally screened at the port of entry, and they may be followed up at their dispersal area by public health nurses. Other health issues of this group include poor nutrition and the physical consequences of torture, such as broken bones and gunshot wounds.

limited English proficiency

Both asylum seekers and refugees are likely to have limited English proficiency (LEP), such that they need an interpreter in order to access healthcare. It is a requirement of all NHS providers to offer an interpreter when needed. Although this is a specific right for patients, the corresponding duty on NHS organisations is rather vague; I usually cite the Race Relations Acts and the Disability Discrimination Acts.

Organisations have different ways of meeting this obligation. Some, specialising in the care of asylum seekers and refugees, have a dedicated group of interpreters on call. Others will be able to call on a locally organised interpretation service, while for most it will be a commercial telephone interpreter service. These are of course always available, and while they may be 'second best' to a live and trained interpreter, they are far better than nothing, and would be quite appropriate for our scenario.

Practices in areas where refugees and asylum seekers live should ensure that their staff have some training in the needs of people with LEP. Clinical personnel need training in working with interpreters, as the consultation is quite different when a third person is involved. Many medical schools are beginning to include this in their consultation skills teaching programmes. If yours does not, why not make a request through your staff-student liaison process?

failed asylum seekers

What about 'failed' asylum seekers? People who have exhausted the appeal process in their quest for asylum will have received a letter from the Home Office informing them that they are no longer entitled to

housing support or even NHS care apart from in an emergency. However, the ruling of the High Court in April 2008 [2] overturned this unfortunate Department of Health directive. The 'Still Human Still Here' campaign [7] is seeking to change the law to extend support to such people.

For the present, general practitioners have considerable discretion in how they choose to apply the rules, and they are able to ensure this group is treated with dignity and compassion. There are both public health and humanitarian arguments for providing proper healthcare for destitute asylum seekers. Of course, the government is responsible for managing limited resources, but there is no evidence that the NHS is being exploited, rather the reverse. The financial cost of extending NHS care to this group is a tiny fraction of the NHS budget.

a Christian perspective

Given the legal framework I have outlined, you might ask, why should there be a particularly 'Christian' take on this? Despite the law, there is a huge variation in the way health professionals approach these vulnerable groups. Jesus is described as having 'compassion' [8] – a word with deeply visceral overtones, coming from the Greek word *splanchnizomai*, 'to be moved as to one's inwards (*splanchna*), to be moved with compassion, to yearn with compassion'. [9] Hence in older versions of the Bible, 'bowels of mercy'. Can we share this degree of commitment?

Does our colour blind interpretation of the Bible fail to see the Mediterranean Jesus, the black Simon of Cyrene, the black Ethiopian cabinet minister, and the many different races comprising the early church? [10,11] Have you ever turned a blind eye to discrimination? By doing nothing, you are complicit! Most medical schools have an organisation supporting refugees – perhaps you might join it. Christians can be 'salt' and 'light' beyond the comfort of the Christian Union or CMF group! Maybe there is a church-based 'drop-in' for destitute asylum seekers – your help might be much appreciated. Maybe your own church needs to be informed of the facts. [12] Many asylum seekers are Christians – some have been persecuted for their faith. Welcome them. Others come from an Islamic culture, but are very open to our friendship. Do not ignore them.

Likewise, reflect on your attitude towards those patients in the admission ward with deep vein thrombosis and ulcers from injecting drug misuse, or alcoholic hepatitis and cirrhosis. Unless you subscribe to the 'they get what they deserve' theory, maybe they are rather the modern equivalent of the many 'lepers' whom Jesus met, and touched. [8]

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SSM: healthcare for the homeless

Abi Perini**, **Stephanie Wells** and **Sarah Nathaniel
were challenged to be compassionate

Homelessness is unavoidable. It is found in every city centre, high street and hospital. As medical students, we consider the role of medicine in this 'social' issue. As Christians, we know that Jesus would be among these people, tending to their needs.[1]

We investigated the services available for the homeless in Cardiff during our third year special study module (SSM). To gain an understanding of their problems, we visited a number of healthcare providers and social projects. Our preclinical lectures gave us a theoretical understanding of health inequalities, but these concepts became devastatingly real as our SSM progressed. Even though the NHS ethos is healthcare at the 'point of need', the homeless must negotiate numerous obstacles to access this care.

compassionate witness?

Healthcare professionals are amongst the most accessible forms of help for the homeless. However, an overwhelming majority of the homeless people we met reported their encounters with health services as 'negative'; many felt judged and dismissed. We were challenged to consider if we, Christian medical students, fell into this category. In the person of Jesus, we see the reality of God's love for the poor, the fatherless and the widowed.[2] 'Whatever you do for the least of these, you do for me',[3] he said. The places where we work and worship should be approachable points of non-judgmental assistance.

We all started this SSM with some experience of working with the homeless, through our churches' soup kitchens. Despite this, none of us really felt comfortable approaching a homeless person on the street or in hospital. This was primarily because we were afraid of not knowing what to say or how to relate to them, and of being unable to help. Most of all we felt the guilt of so often just walking straight past them.

beyond stereotypes

The opportunity to build friendships with homeless people was the highlight of our project. One man made a lasting impression on us. He had recently been released from prison and was struggling with feelings of depression after separating from his wife. We got to meet her, and by the end of the project we saw progress in both their lives as they tried to get a flat of their own together.

The more time we spent getting to know homeless people personally, the more our compassion for them grew. We witnessed humanity in its most broken forms and we saw firsthand the vicious cycles of psychological, medical and social problems. Recurrent themes in their lives included relationship breakdowns, problems after leaving foster care, unexpected redundancy and substance misuse.

We spent time with the specialist homeless GP and nurse, as well as other members of the multidisciplinary team. It was encouraging to see how God had placed people with such passion and gifts within these specialist services in Cardiff. It was also a privilege to observe their wisdom, expertise

and resolve. Rather than a larger number of tailored services, we think there is a greater need for communication between existing services and an awareness of the needs of homeless people. We now feel able to approach a homeless patient on clinical placements with greater confidence and we can recommend appropriate services.

organising the project

All this happened because we took the opportunity to 'design a project of personal interest' for our nine week SSM. We found suitable contacts after months of research; we then determined the aims and objectives and began work, with supervision from a medical school tutor. We designed one questionnaire for homeless people and another for GPs in Cardiff, to ascertain their knowledge and opinion of healthcare service provision for the homeless. We also compared the average length of GP consultations for housed patients compared to homeless patients. Assessment of the SSM was through individual written reports.

You could organise a similar SSM at your medical school too. Our advice would be to look into what healthcare services are available for the homeless in your area. This will help you to identify specific problems that the homeless population and healthcare professionals may be facing, which are possible areas of research. Secondly, find local healthcare professionals with a special interest in homelessness, as they may be able to help.

God of the broken

Through spending time with marginalised people in our society, we learnt more about God's loving character. In Mark's Gospel,[4] Jesus met Bartimaeus, a blind man begging by the roadside. Despite the crowd's scorn, Jesus had compassion on him. This story challenged and inspired us throughout our project. The depth of human desperation in some of the stories we heard was a reminder that we must draw on God's strength rather than our own.

As ambassadors of Christ, we are called to seek justice actively for the poor and broken around us.[5] Bringing the work of this project before God gave us a new perspective on our responsibility as Christians and medical students to be salt and light in this world.[6]

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serving the homeless with Barnabus

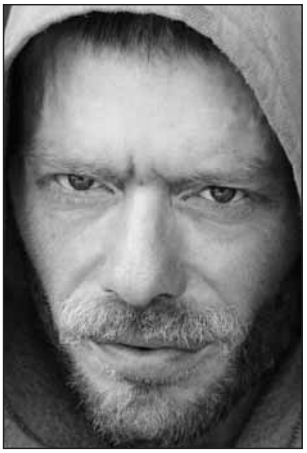
***Andy Meeson** goes out with the medical van*

Barnabus[1] is a Christian charity in Manchester that aims to share the gospel of our Lord Jesus Christ with homeless people, prostitutes and prisoners. During the day, its headquarters, 'The Beacon', provides breakfast, washing facilities, Bible studies, friendship and advice. Evenings see volunteers descend on the streets from minibuses, offering companionship, food, drink, and medical advice or treatment.

Two years ago, I started volunteering once a week. I turned up on my first night expecting to be nice and chatty, and perhaps give out drinks. To my surprise I was asked, 'are you the doctor?' After explaining that I was only a student, I was reassured that was 'good enough' and I was shown to the medical van along with two nurses. After a time of prayer, God had provided them with people to run a medical van, and I turned out to be one of them!

medical needs abound

I have seen a multitude of medical needs in the people we serve. The usual complaints are



foot lesions, mainly from walking the streets all day in poorly fitting shoes, through Manchester's infamous wet weather. Other common presentations are injuries caused by drug or alcohol abuse, such as abscesses at injection sites, broken needles in veins, or head wounds from blackouts and seizures. We also see complaints ranging from chest pain to depressive symptoms – much like a GP surgery or hospital accident and emergency (A&E) department. Ultimately, the treatment we can offer is limited (we cannot prescribe, for example), so our role is mainly advisory.

Very few GPs in Manchester accept patients without an address (I currently know of only one). The local A&E department, I am told, often treats the homeless with irritation and cynicism. So we are frequently their first port of call, along with NHS primary care drop-in centres.

Primary care access is not the only issue the homeless face; a big problem, in my opinion, is the homeless person with a chronic disease. They will often miss appointments because they have no fixed address to receive letters. A particular man with type one diabetes comes to mind; he presented with a large foot ulcer having not taken insulin for years.

One thing I am certain of is that the people I come into contact with at Barnabus do not receive the same level of healthcare as I would. Illness prevention is neglected in this group; instead crisis management and hospital admissions are all too often the mainstay of medical care.

see their spiritual need

The most important thing that I have learned is that these people need to be told about Jesus Christ. We can look after them;

we can feed and clothe them; we can offer friendship; and indeed we should. However, unless we tell them why we are doing this, unless we tell them about the hope we have in Jesus, then we do not love these people as we should. In fact, would we not just be providing momentary relief in a life headed towards an eternity in hell?

Manchester's streets, humanly speaking, are a pretty hopeless place. People are sleeping rough, trapped in vicious addictions to drugs and alcohol, while vulnerable women sell themselves for sex. Some experience this horror for a few weeks, others a few months and some for many years.

The only true hope for these marginalised people is our merciful God and Saviour. He enables us truthfully and wholeheartedly to encourage someone battling with alcohol addiction to have hope, that all is not lost. Because we know that God is powerful and good – he is sovereign over all and with him all things are possible. [2]

I see and hear of God saving prostitutes, pimps, addicts and the homeless; I am repeatedly reminded of God's amazing grace. He graciously humbles me and convicts me of my sin. For we are all sinners, rebels deserving an eternity in hell, who God graciously enables to turn and trust Jesus with empty hands, to be justified through him. [3,4] Praise be to God!

In truth, the mission of Barnabus is hard work – not a long list of conversions. Many people are not interested in the gospel; it seems foolish, or they are more interested in the free food. They are often aggressive and intimidating; although we are looked after by our friends on the street, there have been hostile and even violent incidents. Evangelising often feels awkward or forced so it is easier just to patch them up and let them go. On some nights, Barnabus seems so weak and its work like a drop in the ocean. But God continues to work through us to bring glory to his name, and so we echo Paul's words:

But he said to me, 'My grace is sufficient for you, for my power is made perfect in weakness.' Therefore I will boast all the more gladly about my weaknesses, so that Christ's power may rest on me. [5]

***Andy Meeson** is a clinical student at Manchester medical school*

take action!

Why not ask your local church about opportunities to serve the homeless? You could even encourage your CMF group to volunteer together! Here are a few websites to get you started:

- **Crisis** - *www.crisis.org.uk*
Charity for homeless people; it delivers services and campaigns for change.
- **Shelter** - *www.shelter.org.uk*
Charity providing advice and advocacy for homeless people.
- **Centrepoint** - *www.centrepoint.org.uk*
Charity supporting homeless young people.
- **Homeless UK** - *www.homelessuk.org*
Information on services, publications and training to deal with homelessness.

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5. 2 Cor 12:9,10

Christian prayer for healing

***Andrew Fergusson** considers recent events at Lakeland*

Most of us heard about the supernatural phenomena claimed at Lakeland, Florida earlier this year at events organised by Fresh Fire Ministries, and led by Todd Bentley, the flamboyant, tattooed Canadian evangelist. It was said people were healed of all sorts of diseases and disabilities, and it was even being suggested that people were being raised from the dead. Was this a wonderful revival? Or was it a mixture of the good, the bad and the ugly?

Those questions may partly be answered now because Todd Bentley has stepped down from ministry after an 'unhealthy relationship',[1] and things seem to have gone quiet, but this article will review the Lakeland phenomenon before moving to a wider consideration of prayer for healing.

early comments from the Evangelical Alliance

CMF is a member body of the UK Evangelical Alliance and was consulted about an appropriate response to the early reports from Lakeland. We endorse what General Director Joel Edwards wrote in an open letter on 10 June:[2]

> *I suspect that many of you have watched with interest the recent developments in Lakeland, Florida. Unusual things have been taking place in Todd Bentley's church, and they now seem to be spreading to other parts of the world, including the UK.*
>
> *I've spoken to a number of our members who are overjoyed at what they perceive to be the latest outpouring of God's spirit. Others, though, have expressed their concern at what is happening and particularly the kind of appeals that have been made on TV and the internet.*
>
> *Inevitably, all of this reminds me of the struggles we all had at the Alliance at the time of Toronto. And I simply don't yet know how I feel about all that is going on in Florida. There are aspects that make me rejoice, and others that make me uneasy. However, at the time of Toronto, I drew up the following list of principles that it seems to me have enduring relevance. I share them again with you now so that together we can remain united around our one common cause: the gospel of Jesus Christ.*
>
> 1. *Evangelicals should make every effort to measure all spiritual phenomena by biblical criteria. In every case, the devotional hallmarks of holiness, prayer and witness provide reliable indicators of authentic moves of God.*
> 2. *We also acknowledge that the current phenomenon is not new. During the 18th, 19th*

and early 20th centuries revivals associated with respected figures such as Jonathan Edwards, Wesley, Whitefield and the Jeffreys were also characterised by unusual events which attracted controversy and blessings.

3. *We rejoice with those who testify to a deeper level of commitment and joy as a result of their experience but would equally urge them to avoid excessive behaviour which may discredit the gospel or distance those who genuinely seek an encounter with God.*
4. *Whilst we would caution against indiscriminate enthusiasm, we would equally urge evangelicals to avoid preclusive or condemnatory behaviour which dismisses all unusual events out of hand.*
5. *Finally, we would advocate the Gamaliel principle; if the phenomenon is genuinely of God it will certainly bear lasting fruit.*

another gospel?

Edwards shows twin concerns for truth and for unity. Internationally respected evangelical leader RT Kendall was prepared to risk the latter in his concern for the primacy of truth, as this extract from an article (written before Bentley's departure) shows:[3]

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

But a funny thing kept gripping me. It would take even more *courage to say that the Lakeland phenomenon is not of God. Did I have the courage to say this? After all, I was reluctantly coming to the conclusion that it was not of God, but would I say it?*

Yes. It comes to one thing at the end of the day: is the Bible true or not?

The article continued with a critique of what was not happening at the meetings, as well as a critique of what was, and it all led Kendall to conclude 'I can only call this "another gospel" as in Galatians 1'.

The retrospectoscope is a very useful instrument – it is always easier to make diagnoses with hindsight! But credit to these two leaders for their wise foresight and for the courage of their convictions.

Christian prayer for healing

As we – probably – put Lakeland behind us, we should still conclude that Christians, including and perhaps especially Christians in medicine, should pray for healing. The rest of this article will analyse that whole issue, with much summarised from my CMF book *Hard Questions about Health and Healing.*

healing miracles in the Bible – a medical perspective

Decades ago, Dr Peter May analysed the characteristics of Christ's miracles of healing and of the others seen in the Bible and concluded:[4]

- The conditions were obvious examples of gross physical disease

- They were at that time incurable and most remain so today
- Jesus almost never used physical means
- The cures were immediate
- Restoration was complete and therefore obvious
- There were no recorded relapses
- Miracles regularly elicited faith

These seven characteristics give us a New Testament gold standard for defining healing miracles. Contemporary claims for miraculous healing can be evaluated against this gold standard.

do healing miracles happen today?

Later in the book,[5] I describe an objective approach for Christian doctors to use in evaluating claims for miraculous healing. First line questions include:

- What was the medical version of the story?
- What was the precise nature of the diagnosis?
- At what time did recovery take place?
- Were any treatments being given at the same time?

Depending on the answers to these, a second level of questions may be needed. For example, concerning the diagnosis:

- On what basis was the diagnosis made?
- How reliable were the tests performed?
- How reliable were the observers conducting the tests?
- Have experts checked the results?
- Could there be other explanations for the results?

During controversies about healing miracles in the early 1990s, I was one of three CMF members (each then at different positions on the 'charismatic' spectrum) who reviewed current claims, and concluded '...between us, we did not find a single case that unequivocally satisfied our strict criteria for a...miracle of healing'.[6]

But each of us had exciting personal stories of answers to prayer for healing (and the least 'charismatic' of us had the best stories!). We christened them 'Tales of the Unexpected' after a TV programme popular at the time, and they led us to conclude that, yes, Christians should pray for healing.

Before I turn to the question of how we do that, it will be helpful to list some of the categories that account for the different interpretations that both medical and non-medical Christians may hold:[7]

- Was the diagnosis wrong?
- Was there spontaneous remission?
- Could the diagnosis have been hysteria or psychosomatic illness?
- Was there just a genuine misunderstanding?
- Is it a case of exaggeration, half truth, or frank lie?

how should Christians pray for healing?

I stated above that although we longed to see a genuine New Testament, gold standard example of a healing miracle we had not done so. For me at least, five years later that remains true. But my response is not to assume therefore that God doesn't do miracles today. One of the dangers there is creating a self-fulfilling prophecy: God does not do healing miracles; therefore I will not pray for them; therefore exciting answers to prayer for healing (or even miracles) are less likely to happen; therefore my doubt is reinforced; therefore I will not pray...!

Rather, I am stimulated to pray more. I believe that prayer for healing is no different from other prayers. However, we should be particularly sensitive about how we provide it. The Bible gives us vital help in James 5:13-16:

Is any one of you in trouble? He should pray. Is anyone happy? Let him sing songs of praise. Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective.

There is no space to do other than summarise the principles this passage reveals. Christian healing: [8]

- Is available for all
- Should be patient centred
- Should be practised responsibly
- Involves prayer
- May involve symbols
- Is associated with faith
- Is associated with forgiveness of sin

Application of these principles in church contexts will obviously depend on the traditions and practice there. I believe they can also be applied, occasionally and very carefully and sensitively, in the health professional context, but with these vital emphases: [9]

- The doctor must clearly change role
- The patient must give consent
- That consent must truly be fully informed
- The doctor should reassure that the prayer is not solely because of despair
- Touch is unnecessary and inappropriate
- The doctor should return to role before the consultation ends

the Gamaliel principle

Following that brief consideration of aspects of Christian prayer for healing, let me return to a media enquiry about whether we believed people were being raised from the dead at Lakeland. My response was: 'Yes, God can do anything – but show us the evidence'.

To the Evangelical Alliance, we and others advocated the Gamaliel principle mentioned above. In Acts 5 we read that because of healing miracles performed daily through Peter and the apostles, they were brought before the Sanhedrin, the Jewish ruling council. One of the Pharisees, Gamaliel, 'who was honoured by all the people', gave us this immortal principle, which helps us to value evidence while believing in a God who does miracles:

Therefore, in the present case I advise you: Leave these men alone! Let them go! For if their purpose or activity is of human origin, it will fail. But if it is from God, you will not be able to stop these men; you will only find yourselves fighting against God. [10]

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climate change and health

***John Lockwood** presents a scientific and biblical overview*

From a biblical perspective, creation care is an integral part of the good news of redemption and new creation in Jesus Christ through the Holy Spirit. One of the lessons Job had to learn was that the created order testifies to the vast wisdom of God and therefore is a motive for praising God. Psalm 19:1 states 'The heavens declare the glory of God; the skies proclaim the work of his hands'.

In the early days of experimental science in the 16th and 17th centuries many people, including distinguished scientists, saw their pursuit of scientific knowledge as being for the glory of God. A widely held idea was that God's revelation comes in the form of what could be described as two books: God's works (science) and God's word (the Bible). Thus God's creation can be expected to yield some information about the nature of God, and having looked at creation's God, we then look at the created universe with new eyes.

There is now a wide consensus among the world's scientific community that human activities are having an effect on the climate. Global warming and the resulting impacts are among the most serious environmental problems facing the world community. This article starts by explaining the science behind greenhouse gas induced global warming. It then considers why Christians should be concerned about the human impact on God's creation, followed by a review of the main possible effects on human health.

the natural greenhouse effect

The gases nitrogen and oxygen, which make up the bulk of the

atmosphere, neither absorb nor emit thermal long-wave radiation. Consider an atmosphere consisting *only* of these two gases. As the sun's short-wave solar radiation passes through this atmosphere, about 6% is scattered back to space by atmospheric molecules and about 10% on average is reflected back to space from the land and ocean surfaces. The remaining 84% remains to heat the surface.

To balance this incoming solar radiant energy, the earth itself must radiate on average the same amount of energy back to space in the form of thermal radiation. Otherwise the earth would show very marked long term heating or cooling. To balance the absorbed solar energy by outgoing thermal radiation, the average temperature of the Earth's surface should be -6°C. This is much colder than is actually observed at 15°C.

This difference can be explained by the fact that, in addition to nitrogen and oxygen, the earth's atmosphere also comprises clouds, water vapour, ozone, and carbon dioxide. These are the principal absorbers of infrared radiation emitted by the earth's surface. Only about 9% of the thermal radiation from the ground surface escapes directly to space. The rest is absorbed by the atmosphere, which in turn reradiates the absorbed infrared radiation, partly to space and partly back to the surface.

This blanketing effect is known as the natural greenhouse effect and the absorbing gases are known as greenhouse gases. It is called 'natural' to distinguish it from the enhanced greenhouse effect due to gases added to the atmosphere by human activities such as the burning of fossil fuels and deforestation. It needs to be stressed that the natural greenhouse effect (a major regulator of surface temperature) is a normal part of the climate of the Earth and that it has existed for nearly the whole of the atmosphere's history.

human induced CO_2 emissions

Concern about the greenhouse effect arises over two issues: how the natural greenhouse effect may vary with time, and how human activities might enhance the natural effect. Since the industrial revolution, human activities have increased atmospheric trace gases such as carbon dioxide. Before the start of the industrial era, around 1750, atmospheric carbon dioxide concentration had been 280 parts per million (ppm) for several thousand years. It has risen continuously since then, reaching 379ppm in 2005. The annual carbon dioxide growth rate was larger during the last ten years (1.9ppm/yr from 1995-2005) than it has been since the beginning of continuous direct atmospheric measurements (1.4ppm/yr from 1960-2005).

When glacial ice forms, small bubbles of air are trapped within, creating a continuous record of atmospheric composition. By drilling through the Antarctic ice sheet, it is possible to reconstruct atmospheric composition over the last 600,000 years. The present atmospheric carbon dioxide concentration has not been exceeded during the past 600,000 years, and possibly the past 20 million years.

Several lines of evidence confirm that the recent and continuing increase of atmospheric carbon dioxide content is caused by human carbon dioxide emissions, and

in particular fossil fuel burning. These human-induced carbon dioxide emissions enhance the already existing greenhouse effect, causing global warming and fundamental changes in climate.

rising temperatures

Largely as a result of increasing atmospheric greenhouse gas concentrations, global mean temperatures have increased by 0.7˚C since around 1900. Over the past 30 years, global temperatures have risen rapidly and continuously (at around 0.2˚C per decade) to the warmest level reached in the current interglacial period, which began around 12,000 years ago.

Most climate model calculations show a doubling of pre-industrial levels of greenhouse gases is very likely to commit the earth to a rise of between 2˚C and 5˚C in global mean temperatures. This level of greenhouse gases will probably be reached between 2030 and 2060.

Long-range climate forecasts lack detail because of the non-linear chaotic nature of climate systems. Warming is projected to be greatest over land and at most high northern latitudes, with Arctic late-summer ice disappearing almost entirely by the latter part of the 21st century.

why the controversy?

Climate change studies in the late 20th century were often highly controversial, partly because some oil and other commercial companies, to protect their perceived interests, funded campaigns against the results of climate research. Climate research in the 21st century has made considerable advances.

The Intergovernmental Panel on Climate Change (IPCC) comments that warming of the global climate system is unequivocal, in their latest assessment report. This is now evident from observations of increases in global average air and ocean temperatures,[1] widespread melting of snow and ice, and rising global average sea level. The report further comments that continued greenhouse gas emissions at or above current rates would cause further warming and induce many changes in the global climate system during the 21st century that would very likely be larger than those observed during the 20th century.

Clearly carbon dioxide emissions have to be reduced, but 'by how much?' is a recent source of controversy. A 50% reduction of global emissions below 1990 levels by 2050, widely considered to be the

most stringent achievable target, will not avoid major global impacts. It is therefore being suggested that limiting impacts to acceptable levels by mid-century and beyond would require an 80% cut in global emissions by 2050. The UK has recently committed itself to an 80% cut in greenhouse gas emissions by 2050. Such a reduction would require fundamental changes in lifestyles, which many communities and countries would find difficult.

a biblical perspective

There are a number of reasons why Christians should be interested in the environment and in its care. Traditionally these may be described as follows.

1. the earth belongs to God
God created the earth. We encounter this in the very first words in the Bible, but it also pervades the whole of Scripture. As far as the biblical writers are concerned, this is undisputed. God's creation of the world is never the conclusion of an argument, but usually the starting point of other arguments. For example, God speaks through the psalmist of not needing our sacrifices, 'for every animal of the forest is mine, and the cattle on a thousand hills. I know every bird in the mountains, and the creatures of the field are mine.' [2] In John 1:3 we read that 'Through him all things were made; without him nothing was made that has been made.' Paul, in Colossians 1:16, emphasises the full extent of what God has created.

2. God sustains the earth
It is not a foreign concept to Christians that God sustains his people in their daily walk with him. There is also a clear sense in the Bible that God's constant involvement is not just limited to people, but it encompasses everything. For example, Paul writes, 'He (Christ) is before all things, and in him all things hold together.' [3]

3. God created the earth good
The account of the creation in Genesis 1 has as a refrain, 'And God saw that it was good'. The natural environment is not benign because one result of the 'fall' is that the earth is also cursed. [4] Therefore the whole of creation, not just mankind, is in need of liberation and re-creation. [5] We now see a fallen creation; nevertheless the earth is still capable of declaring the glory of God. Part of the meaning of the goodness of creation in the Bible is that creation witnesses to the God who made it, reflecting something of his character. [6]

4. humanity created as stewards
In Genesis we are told 'The Lord God took the man and put him in the Garden of Eden to work it and take care of it.' [7] From Genesis onwards, men and women have been called to be God's workers in the world, to look after it as he would, and to preserve it. Jesus expresses the essence of the kingdom of God in two commandments: '...the Lord our God, the Lord is one. Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength.' [8] and 'Love your neighbour as yourself.' [9]

Each of these commandments has implications with regard to

our concern for the environment. To love God must surely mean also to value his creation as he values it. To love your neighbour must surely also mean not to spoil their environment by polluting it, or pushing them into poverty so that they cannot maintain it. The World Health Organisation

(WHO) estimates the global cost of climate change to be 'up to 5% of the gross domestic product by the end of this century'.[10] They further comment that 'climate change threatens to undermine progress toward the Millennium Development Goals: poverty cannot be eliminated while environmental degradation exacerbates malnutrition, disease and injury'.

impacts on health

An increased frequency of hot extremes, heat waves, and heavy precipitation is likely. Scientists are confident that, by the middle of this century, many semi-arid areas (eg Mediterranean basin, western United States, southern Africa and northeast Brazil) will suffer a decrease in water resources due to climate change.

1. heat stress

The IPCC considers it very likely that warm spells and heat waves will increase in frequency over most land areas and lead to increased risk of heat-related mortality, especially for the elderly, chronically sick, very young and socially isolated.[1] The WHO estimates for European Union (EU) countries that mortality increases by '1-4% for each one-degree rise of temperature above a cut-off point'.[11] Over 70,000 excess deaths were reported from twelve European countries following the heat wave in summer 2003. In the EU, 86,000 extra deaths are projected every year, with a global mean temperature increase of 3˚C, in 2071-2100.

2. malnutrition

Food security is another area of major concern because of decreasing precipitation and increased frequency of severe drought. Food productivity is projected to decrease in the Mediterranean area, south eastern Europe and central Asia. Crop yields could decrease by up to 30% in central Asia by the middle of the 21st century leading to a worsening of malnutrition, especially in the rural poor.

3. disease transmission

Already occurring shifts in the distribution and behaviour of insect and bird species are signs that biological systems are responding to climate change. This is leading to significant changes in infectious disease transmission by vectors such as mosquitoes and ticks.

Climate change has a number of health impacts, apart from the three discussed above. The US Centers for Disease Control and Prevention has produced a useful summary table (table 1). It links weather events to health effects and to populations most affected – illustrating the WHO warning that 'health impacts will be disproportionately greater in vulnerable populations.'[12]

what can doctors do?

1. educate

The first step is to educate ourselves about what science and the Bible say about climate

table 1: health impacts of climate change [13]

weather event	health effects	populations most affected
heat waves	heat stress	extremes of age, athletes, people with respiratory disease
extreme weather events (rain, hurricanes, tornadoes, flooding)	injuries, drowning	coastal, low-lying land dwellers, low socio-economic strata (SES)
droughts, floods, increased mean temperature	vector-, food- and water-borne diseases	multiple populations at risk
sea-level rise	injuries, drowning, water and soil salinisation, ecosystem and economic disruption	coastal, low SES
drought, ecosystem migration	food and water shortages, malnutrition	low SES, elderly, children
extreme weather events, drought	mass population movement, international conflict	general population
increases in ground-level ozone, airborne allergens, and other pollutants	respiratory disease exacerbations (COPD, asthma, allergic rhinitis, bronchitis)	elderly, children, those with respiratory disease
climate change generally; extreme events	mental health	young, displaced, agricultural sector, low SES

change. We can then inform our colleagues, churches, and wider society about the health impacts. [14] Our advice to patients also matters; a good diet (less meat, less processed food, local food) and walking or cycling to work not only improve health, but reduce carbon emissions as well. [15]

2. moderate

Small changes in lifestyle by many people can add up to a major contribution. So we need to consider our own carbon footprints. Firstly, review your travel arrangements; for example, are all those flights really necessary? Secondly, assess your energy usage; does your home need more insulation? Thirdly, think about the food you eat. Has it been air-lifted across the world? Can you drink tap water instead of bottled water? A professor of public health argues that our role in addressing climate change is comparable to that in combatting smoking; we should be committed to both, setting a personal example. [16]

3. advocate

Many of us will have opportunities to influence the organisations we work for to reduce their carbon footprints. Those who are enthused can join in advocating for local, national and global frameworks to constrain carbon dioxide emissions. [17] For example, you could get involved with the Climate and Health Council. [18] Another starting point is to get your local church to act together by forming an Eco-congregation. The

Eco-congregation movement providers a creation care kit for churches with a simple environmental audit, free resources to encourage action, and an award scheme.

uncomfortable questions

It is easy to look back at Christian slaveholders in the 18th and 19th centuries and ask, 'how could they not see that slavery was incompatible with the gospel?' What did they, and the Christian people who supported them, think they were doing? Will our grandchildren look back at us, as they wrestle with ecological issues, and ask why we could not see the Christian responsibility for stewardship of the earth?

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useful resources

Christian environmental organisations:

- Eco-congregations - *www.ecocongregation.org/englandwales*
- A Rocha - Christians in conservation - *www.arocha.org.uk*
- Christian Ecology Link - *www.christian-ecology.org.uk*
- John Ray Initiative - an educational charity to bring together scientific and Christian understandings of the environment - *www.jri.org.uk*

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fighting for doctors' rights?

***Derek Munday** suggests a biblical approach*

What? No more free accommodation and no pay increase to cover the extra cost!

Just when I thought life was becoming easier without the demands of out of hours work on top of a very pressured and long working day, the government piles on additional QOF[1] *demands!*

These could easily be the comments of a Foundation 1 doctor and a GP. Hidden within such statements is the assumption that it is my 'right' that working conditions, pay and prospects should always improve. It is very easy to let indignation and feelings of being used and abused determine behaviour. But, can the current culture of 'rights' ever sit comfortably with a Christian, who by definition has given up their rights in submission to the lordship of Jesus Christ?

Before we can begin to grapple with the position a Christian in today's world should take, we are on much firmer ground if we are prepared to spend time understanding the age in which we live, learning from history and challenging the robustness of our theology. It is outside the scope of this article to engage in an in-depth analysis of our society; however, there are certain pointers that may be helpful.

learning from history

Christians were influential in the establishment of trades unions in the 19th century as a response to the exploitation of the poor. However, by the first half of the 20th century there was a growing conviction amongst evangelicals, particularly those from non-conformist backgrounds (ie members of churches other than from Catholic or Anglican denominations), that involvement in politics and protest was not something that a real Christian engaged in. Indeed in some evangelical churches, voting in political elections was frowned upon.

I vividly remember an elderly man in the church I attended boasting that he had never voted in his life. For him this was a mark of his separation from the world, his love for God and his commitment to Jesus. As a teenager, this did not seem right to me. I remember having huge discussions about politics, rights and trades unions – which were always regarded as ungodly, if not downright sinful organisations.

Such a position, from today's perspective, seems extreme and probably the province of those on the margins of the evangelical church. However, many who were sympathetic to such views had a deep love for God. Among them were professionals, some of whom were involved in the influences that brought about the founding of CMF. One

consequence that still lives with us is that in 1967, when the Abortion Act was passed, hardly an evangelical voice was raised in protest. That would not happen today.

We live in an age that views things very differently. But are we right? 50 years ago such an article as this would never have been considered. The evangelical position that I have described was, to some extent, a reaction to the 'Social Gospel' that had developed at the end of the 19th century, influenced by liberal theology and the rejection of the evangelical belief in the Bible as literally true and containing all that was needed for salvation. Polarisation ensued. Things were either black or white. In many ways those days were more simplistic but also more dedicated, self sacrificing and self denying than our own.

In the eyes of many there was a clear separation between issues to do with the world and issues to do with church. For many, the latter consisted of preaching the gospel. Anything else was only valid if it enabled such preaching or evangelism. Nothing was good for its own sake. Indeed, in the more reformed (ie Calvinistic) part of the church, a sort of 'worm' theology had developed – all that was not directly seen to be from God, or the preaching of the gospel, was to be regarded as of no value. The best I could do was 'like filthy rags'[2], in comparison to what God could do.

a sense of vocation

50 years ago the world was a more ordered place. There was a sense of service and altruism. The word 'vocation' was in common use, certainly for those entering the Christian ministry, or becoming missionaries and committing themselves to a life of service, and in some cases intense poverty. To some extent it is still understood today that those entering such a lifestyle and ministry will only do so out of a sense of calling. But in the past, those entering the professions of medicine, nursing and teaching, would also have been expected to have a similar vocation, especially, but not exclusively, in Christian circles.

Medicine being a vocation, rather than a job, led to a very different mindset. Being a doctor defined me. It was not what I did, but what I was. It was a great privilege. My whole

life was to be spent in caring for others, rather than seeking for the best ends for myself.

The great danger, of course, would be just to assume that this was in every way correct, because it sounds so full of high principle. But there were downsides. Like Christian ministers, many Christian doctors' families suffered. Children could feel that they came a poor second to their father's care of everyone else in the community. There was little challenge to a system that often needed to be challenged. Often Christians stood aloof from the messy world of politics and debate. There were some, however, who combined a costly vocational call, with a willingness to challenge the system and bring about positive change. These, if their lives also

reflected the love and grace of God, were men and women of great influence. The late Dame Cicely Saunders, one of the founders of the hospice movement, was a good example.

from vocation to job

In the mid 1970s junior doctors began to challenge the safety of long hours and some very real situations where juniors were, if not abused, certainly used by their consultant bosses against whom they had no means of defence. This led to the beginning of the movement away from 'profession' to 'job.' Overtime was paid for the first time. A one in three rota (ie working 9am to 5pm every weekday plus every third night and every third weekend) was introduced as the standard to which every hospital should aim for junior doctors. Junior doctors' pay increased.

Nevertheless there was a downside. Free accommodation and food ended. In hospitals all over the country, the junior doctors' mess was closed. This had been the meeting place and centre of a supportive community of colleagues. It usually consisted of a dining room where food was always available free (frequently even during the night), with a kitchen, a television lounge and often a library and a bar. Hospital management willingly took back the accommodation, often turning it into administrative offices. The cost of insisting on 'rights' was the loss of privileges. The culture had moved from community to workplace, from vocation to job, from the cost of vocation to the cost of rights.

Was this the correct way to go? I do not know. There can be no right or wrong in these circumstances. This, after all is not a moral judgment, but rather a choice of culture, vision and work philosophy.

Today, the Christian junior doctor faces similar if somewhat different choices. It is probably true to say that, as in the mid 1970s, insisting on rights will mean losing privileges. There is always a trade off. How do we decide what to do? The easiest answer is to find some legalistic formula by which we can work out what God wants us to do. Yet God does not look for people who follow formulas. He looks for those who seek for relationship with himself. Jesus spent much more time in the middle of crisis and difficulty, with those who were regarded as sinners by the religious people of the day, than he spent in the synagogues of those who made a separation of the sacred and secular and therefore regarded themselves as set apart and spiritually superior. Jesus looked for relationship with men and women, not sterile religious observance and legalistic formulas.

the importance of right theology

Evangelical theology can be very reductionist. Part of the problem for many of us brought up in the latter half of the 20th century, was that evangelical belief had been reduced to a sort of 'lifeboat' theology. It suggested that: 'this life is only

a testing ground for heaven. We need to be saved, thus getting into the lifeboat, so that we may end up in heaven. Our only other role is to pull people into the lifeboat with us so that they also may be saved. All else that does not serve this purpose is of no value.'

While the need for men and women to find God, and to find salvation in him cannot be given too high an importance, the problem with this approach is that evangelism becomes the narrow objective of our lives. Everything that I read in the Bible, however, seems to suggest that true evangelism is the result of the entirety of our lives. It is not so much an external activity that we engage in but the consequent actions of a life lived in dynamic relationship, experimental faith and obedience to the Father. Evangelism is the inevitable result of a life lived to the full in relationship with God, in his world; recapturing the heart that he expressed when seeing the world before the fall, 'God saw that it was good.'[3]

Evangelism is the outflow of a life filled with the Holy Spirit, fully engaged in God's world, as well as being a formal activity. But the formal activity is based on the natural outflow of a life lived in this way, never the other way around. In other words – we should live as Jesus lived.

what would Jesus do?

Firstly, he would not have followed a formula. He would have spent time with his heavenly Father, seeking his will and wisdom. Secondly, he would have been where the people were, no matter whether the religious people of the day considered them to be sinners, outcasts or even hated Romans. Thirdly, he would always be listening to what he believed the Holy Spirit to be saying, and then, as a man, needing to take the step of faith to obey what he believed he was hearing.

In the same way, there is no formula about how we should behave towards, or negotiate for, what we perceive to be rights and justice. We, like Jesus, need to seek the perspective and wisdom of our heavenly Father. We then need to walk in obedience and above all humility. Unlike Jesus, we are sinful and we can get things wrong. The man or woman who has the confidence to stand and say, 'this is what I believe,' while having the security in God also to acknowledge to themselves and others that they could be wrong, is powerful indeed.

Such quiet confidence – rooted in the knowledge that God loves us more than we can ever understand, that he will gently correct us and restore us, and that he cares more about the issue than we do – leads to a place of rest and security. But it does require us to walk in God's grace rather than legalistic observance, to walk by faith rather than formula, and cultivate humility rather than pride. Far from stamping us into uniform conformity, God will call us different ones to radically different activity over the same issue. Some may be called to an intense secret life of prayer, some to great exposure and public profile. The key thing is to know his day-by-day leading whatever we are called to do.

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fearfully and wonderfully made:

compliancy

The compliancy of skin enables it to adapt to its environment. It has the capacity 'to flow around whatever surface it contacts'. Dr Brand, after spending 'hundreds of hours researching the anatomy of living skin', explains the compliancy of fat globules beneath the skin of the hand.

The fat globules which are unable to preserve their own shape are surrounded by interwoven collagen fibrils. Where stress occurs in the palm of the hand, for example grasping a hammer, fat cells alter their shape in response to the pressure. They become tightly gathered and enveloped by the firm collagen fibrils. The resulting tissue, constantly shifting, becomes compliant and takes on the shape of the handle of the hammer.

This biological property of compliancy is mirrored spiritually; the author uses the analogy that a Christian represents a grasping hand. Do we become square to those things that are square and round to those things that are round? Through our compliant tissue, an object is not required to fit the shape of our hand, as our hand adapts. The apostle Paul writes, '...I have become all things to all men so that by all possible means I might save some'. (1 Cor 9:22b)

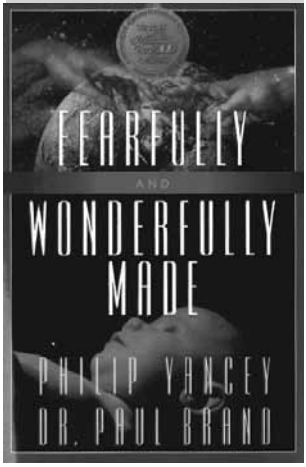
We can often adopt a 'one size fits all' method in evangelism, when in fact each person is unique and at a different stage of his or her spiritual journey. Some seek detailed answers to the issue of suffering for instance, whereas others are encouraged by our simple testimonies. Perhaps we can wisely learn to adapt our ways of evangelising to be as compliant as the hand.

I was initially concerned that striving to be a 'compliant Christian' could put us at risk of compromising our standards. But, after prayer, I feel convicted that we cannot confuse compliancy with compromise. Through the Scriptures we see how Paul accommodated Jews and Gentiles within the limits of God's Word and his Christian conscience; he would not transgress the standards of God:

To those under the law I became like one under the law (though I myself am not under the law), so as to win those under the law. To those not having the law I became like one not having the law (though I am not free from God's law but am under Christ's law), so as to win those not having the law. (1 Cor 9:20b,21)

May we be led by the Holy Spirit in showing sensitivity to the needs of individuals in evangelism, such that they can reach an understanding of the gospel and come to know Christ.

This article is inspired by a chapter from Yancey P, Brand P. *Fearfully and Wonderfully Made*. Grand Rapids: Zondervan, 1987. The authors expand on the New Testament analogy of the Body of Christ, linking it to the human body.



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how to read the Bible for all its worth

***Siôn Glaze** teaches us to read the Epistles*

the epistles: learning to think contextually

This series is summarised from Fee G, Stuart D. *How to Read the Bible for all its Worth* (3rd ed). Grand Rapids: Zondervan, 2003.

Taking a patient's history can be daunting. You think you know how to get all the information and how to ask the awkward questions, but the nerves set in when the patient is in front of you. And you realise how much you missed out when you speak to your consultant afterwards! We can do exactly the same with the epistles. We read them confidently and think we understand the entire message, but we rarely do.

The epistles are all the books of the New Testament minus the four Gospels, Acts and Revelation. They are split into 'real letters' and 'epistles'. 'Real letters' are those that were written specifically for the recipient (eg Hebrews). Conversely, the 'epistles' were intended for the general public (eg James). However, the distinction is not always clear, and in this article, 'epistles' will refer to both. The epistles were written in the first century and they were all occasional ('arising out of and intended for a specific occasion'),[1] so context is key.

form an impression

When you meet a patient you instantly form an impression of him. For example, does he look ill? This is even before you find out about his symptoms. Do the same with the epistles. Reading through your chosen epistle in one sitting is important to see the big picture. Try making notes on the following:

1. Who are the recipients?
2. Attitudes of the author
3. Hints about the occasional nature of the letter (eg specific events)
4. Logical divisions between sections

Taking 1 Corinthians as an example, here are a few points you could pick out:

1. Most of them were Gentiles (12:2)
2. Paul is rebuking them (5:2)
3. Paul has been informed by Chloe's household about quarrels happening (1:10-12)
4. Some sections are more obvious, eg sexual immorality (6:12-20). Look for clues, such as the repeated phrase 'now about' (7:25, 8:1)

presenting complaints

The next step is to consider each of your patient's symptoms in turn. You need to find out as much as you can; simply knowing that he has pain is not enough! Similarly, the epistles were written for a reason. They often addressed specific issues important to the recipients, like the symptoms of a patient.

Pick one of the divisions you identified: read it then re-read it in a different translation if possible. Make notes, paying attention to key words and phrases. Themes emerging from the section on

sexual immorality mentioned above (1 Cor 6:12-20) include: your body is for more than just sex, it is a part of Christ's body.

drug, family, and social history

These aspects of a medical history place everything they have told you into context. We also need to form an 'informed reconstruction' [2] of the cultural context of the epistles.

Finding out about medication the patient is currently taking will help you pick up on medical conditions that have been missed. Drug side effects may play a role in the presenting complaint. In the epistles, what false doctrines can you see being fed to the Christians? How are they in conflict with the teachings of Christ and what effects are they having on the local church? In 1 Corinthians 6:12, for example, some were advocating that there were no sexual boundaries.

A family history gives invaluable information about potential genetic linkages. Likewise, what is the heritage of the recipients of the epistle? Were they formerly Jews or Gentiles? How might this affect their interpretation of the gospel?

A social history provides a more holistic perspective of the impact of the symptoms on the patient's day-to-day life. How are we to make sense of the 'symptoms' in the epistles unless we understand the day-to-day lives of the people in the churches described? Encouraging monogamy in a sexually immoral church is very different in a society that sees nothing wrong with promiscuity compared to a society where monogamy is celebrated. A Bible dictionary or the introduction in a commentary will help you put the epistle into context.

treatment plan

After taking their 'patients' histories', the authors of the epistles understood their 'patients' diseases'. Inspired by the Holy Spirit, they were able to give treatment. The question is why they prescribed what they did. Consider each *paragraph* of a section in turn to appreciate the *literary context*. Thinking in *paragraphs* is fundamental 'to understanding the argument in the various epistles' [3]. For each paragraph summarise two things as concisely as you can:

1. What is being said
2. Why you think the author has said this, at this point in time

You should now have a clearer understanding of the epistle's intended message. For example, in 1 Corinthians 6:12-17, Paul states that sex is more than just a physical act for pleasure, and that we must use our bodies appropriately. Paul says this to rebuke those who were saying random sex was permissible.

conclusion

We must not neglect asking the Holy Spirit for guidance when reading the Bible. But having a formula at hand, as you read one of the epistles, will help you really to get to grips with its messages. This formula reveals 'God's Word to *them*' (exegesis) - those who originally read the epistles. The next step is to understand 'God's Word to *us*' [4] (hermeneutics). That is what we will consider in the next instalment of the series.

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letters...

Editor,

Throughout my first year at medical school, I was worrying whether God actually wanted me to do medicine. So I found Sam Leinster's article on 'Planning your Career' a great comfort and full of practical advice.

My mind was filled with doubts. What if I don't get a job at the end of this? Why does everyone else seem to know what they want to do? What if I make the wrong decision about my career? What if I have already made the wrong decision? The article reminded me that God has promised to guide me (Ps 37:23) and that God mostly shows us our path one step at a time (Ps 119:105), not in a massive lightning bolt of revelation.

It also reminded me of the importance of prayer. I've prayed hundreds of times, 'Your will be done', but I never actually realised that this means I should be praying for God to make his plans, rather than mine, happen.

The article encouraged me to take time to consider my career, not just to fret. Also, if things don't turn out the way I think they should, God may just be poking me in a different direction than the one I originally wanted – but true success is fulfilling God's purpose, whatever that turns out to be.

Liz McClenaghan
Brighton and Sussex Medical School

Editor,

'Evidence Based Faith', made me question the roles of *evidence* and *reason* in faith. The Bible says, 'Now faith is being sure of what we hope for and certain of what we do not see.' (Heb 11:1) Faith is invisible, so surely its essence is lost the moment *evidence* is used to justify it?

I am not saying that faith and *reason* are mutually exclusive. Indeed, both have been given by God, and acts of reason have elements of faith as they are always based on assumptions. But if faith was rational, Abraham would not have tried to sacrifice his son Isaac. (Gn 22) If faith could be explained, Nicodemus would have easily understood what it meant to be 'born again' (Jn 3:7).

God wants us to trust in him and not lean on our own understanding (Pr 3:5). Without a simple childlike faith, trust with no preconditions, it is impossible to please God (Heb 11:6).

Norris Igbineweka
King's College London

Editor's response,

Throughout the Bible, faith is rooted in evidence and reason:

He who had received the promises was about to sacrifice his one and only son, even though God had said to him, 'It is through Isaac that your offspring will be reckoned.' Abraham reasoned that God could raise the dead, and figuratively speaking, he did receive Isaac back from death. (Heb 11:17b-19)

Abraham trusted God on the *evidence* of what God had already done; Isaac was an unbelievable gift given how old Abraham and Sarah were. In taking this step of faith, 'Abraham *reasoned*' from what he already knew of God, and this was the basis of his act of faith.

Hugh Ip
Nucleus *editor*

student services

These include literature, conferences, elective advice,international links and local group support.

Reps can supply joining forms, literature, extra copies of *Nucleus* and information about conferences and activities. Further information is on the CMF website: *www.cmf.org.uk* or from *students@cmf.org.uk*

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