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for today's Christian doctor

triple helix

'compassionate' killing?

medical (un)employment, drugs and alcohol, maternal health, Haiti, handling abortion requests, Nazareth, reviews

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contents

God and politics

How will you vote?

'We don't do God', said spin doctor Alistair Campbell. 'Keep religion out of politics' proclaimed Australian opposition leader Mark Latham.[1] A Google search on 'Keep God out' brings up 99,600,000 references with California, Canada, Haiti, Irish law, public affairs, government, our democracy, stem cell research and football all prominent. As the General Election approaches we will hear similar sentiments – not least from those who feel they have something to lose from 'the Christian vote'. And there will no doubt be warnings not to 'go the American way' by allowing moral issues to become election issues.

But in fact morality is at the very heart of politics – ideological convictions ultimately drive most politicians and inform public policy. Ideological convictions are in turn informed by personal values and a person's worldview. God is of course already intimately involved in politics. God establishes governing authorities, and holds them ultimately accountable.[2] Our political leaders therefore need our prayers[3] but God has also given us a part to play in who actually exercises civil authority. Each of us, before God and in good conscience, must make our own decisions about voting; but we need to ensure we exercise our votes wisely, thoughtfully and in an informed way.

In Spring 2005 *CMF News*[4] I raised ten questions – apart from health, education, crime and the economy – that Christian doctors might ask candidates at the last general election, and with a few (but not many) modifications I shamelessly do so again.

1. Euthanasia. *How will you ensure that euthanasia is not legalised in this country?* Margo MacDonald MSP's End of Life Assistance (Scotland) Bill is entering the committee stage and a new bill is expected in Westminster just after the election.

2. Abortion. *What will you do to stem the tide of abortions?* With seven million 'legal' abortions since 1967 and 200,000 per year, it is tantamount to abortion on demand. Where do your local candidates stand on 'upper limits', extension to Northern Ireland, abortion up to birth for disability, and government policy to offer all parents the eugenic choice to eliminate children with genetic disease before birth?

3. Embryo-destructive research. *Will you seek to repeal existing laws and prevent further liberalisation?* The government decision in the 2008 HFE Act to permit more pre-implantation diagnosis, parentless embryos and wider boundaries for embryo research was unnecessary, dangerous and morally wrong. Animal-human hybrids have already become a farcical footnote in history, while ethical alternatives such as cord blood remain chronically underfunded.

4. Sexual health. *What is your policy to arrest the spread of STIs?* With a national epidemic of STIs, unplanned pregnancy, tubal infertility and cervical cancer, we still relentlessly pursue failed 'harm reduction' policies like condoms, morning-after pills and more STI clinics, excluding measures such as abstinence based sex education and promoting marriage.

5. Poverty and Health. *How will you ensure justice in healthcare for the developing world?* Britain still gives only a fraction of the internationally agreed minimum of 0.7% of GDP in overseas aid; plunders trained health professionals from the developing world; and engages in unjust economic trade practices through subsidies, tariffs and encouraging indebtedness.

6. Freedom of worship. *How will you ensure that Christians are able to practise, share and defend their faith without being prosecuted?* So-called 'equality and diversity' legislation and policy have led to major threats to the freedom to pray, evangelise, exercise Christian conscience, and even express a Christian opinion in hospitals, businesses and local government.

7. Marriage and family. *What will you do to affirm, protect and support the traditional family?* Marriage and the family are fundamental for a stable society; but their status and stability are being eroded by easy divorce and by removing support for the traditional family unit relative to other 'models'.

8. Addiction. *How will you act to reduce alcohol, nicotine, drug and gambling addiction?* Present policy is aimed more at harm reduction than at restricting access (through price control) and effecting behaviour change.

9. Obesity and Inactivity. *What will you do to encourage the general population to adopt a healthy diet and get regular exercise?*

10. Marginalised groups. *How will you ensure that vulnerable groups like the elderly, the mentally ill, ethnic minorities and asylum seekers receive an adequate basic level of healthcare and are not marginalised in healthcare allocation?*

I warmly recommend helpful resources on the websites of Evangelical Alliance,[5] CCFON,[6] CARE,[7] and the Christian Institute.[8] The last contains a comprehensive past record of current MPs' voting records on key issues. Let's put God back on the political agenda.

***Peter Saunders** is CMF Chief Executive*

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news reviews

Spiritual care standards in the NHS

England and Northern Ireland lag behind

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

This January a consultation closed about standards and competencies for spiritual care delivery in the NHS in Wales. Final standards and guidelines should be out soon.

Several Christian organisations (including Healthcare Christian Fellowship, Christian Nurses and Midwives[1] and Evangelical Alliance) made submissions, and most agreed the only real deficit was the failure to recognise that doctors, nurses and other staff all have key roles to play in delivering spiritual care. It is not just about chaplains. We wait to see how final strategy documents will address this.

Wales is the second UK country to set such standards. Scotland went further in 2001, requiring every health board to have a clearly stated spiritual care strategy.[2] England and Northern Ireland lag far behind, yet the WHO has made it clear that health includes a spiritual dimension. When the National Secular Society called last year for the removal of chaplains from NHS payrolls (apparently confused over the differences between spiritual care, religious care and evangelism),[3] it was clear from the reaction of health service managers, doctors, and other clinicians that the spiritual input of chaplains is of benefit to patients (and staff).[4] However, the question is, what kind of spiritual input?

Spiritual care is not always related to faith or religion, although in practice it often is. It can involve a sharing of one's own faith, but is not about evangelism *per se*. However, research overwhelmingly suggests that a person delivering spiritual care needs a well developed spirituality of their own,[5] so Christian doctors and other health professionals are well placed, if not always well skilled, to deliver such care. But in reality many Christian health professionals are not well prepared, or lack confidence, to care for patients' spiritual needs.[6]

While the NHS in England dithers, and health professionals withdraw from spiritual care, fearing the consequences of a misplaced word or offer of spiritual support (see the Caroline Petrie case[7]), we should be reclaiming this ground. CMF already runs courses such as *Saline Solution* to help equip Christians in the NHS to be spiritual carers, but we also need to champion the issue in our trusts and PCTs, Royal Colleges, and the Department of Health, so that all recognise the vital need for chaplaincy services and the role that all health professionals, not just chaplains, have to play in spiritual care.

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Funding health and social care

Who pays – and how?

Review by **Andrew Fergusson**
CMF Head of Communications

The rising costs of health and social care are an ever present but rarely acknowledged background to the end-of-life debate raging at the moment, and with the General Election expected on 6 May, the debate about social care funding has become particularly heated.

Eighteen charities including Carers UK, Age Concern and Help the Aged, and the Alzheimer's Society wrote to *The Times* on 13 February[1] calling for an end to 'party-political squabbling' and seeking a consensus on reform of social care that 'delivers long-term solutions that will not be reversed by changes in government or in the economic climate'. At a major meeting on 19 February attended by charities, providers, council chiefs, and politicians (but boycotted by the Conservative Party) the government was advised to back a compulsory fee to pay for social care.[2] The Tories had dubbed this a 'death tax' and produced a controversial poster of a tombstone engraved 'R.I.P. OFF' with the slogan 'Now Gordon wants £20,000 when you die'.

The problem is not new. In 1999 a Royal Commission recommended that personal care and nursing care be provided free at the point of need,[3] but Scotland (implementing this under devolved powers) found costs unexpectedly doubled between 2003-4 and 2007-8.[4] Whatever party manifestos finally say, and whatever the outcome of the General Election, there is certainly going to be 'no quick fix'.

Meanwhile the British Medical Association has begun an aggressive political campaign about the funding and management of health costs which has the overwhelming support of doctors. Their slogan 'Look after our NHS – publicly funded, publicly provided' introduces opposition to NHS market reforms and asks not just where does the money come from, but who spends it?[5]

CMF members will make their own choices in voting, but will also have to work with the consequences of decisions to be taken. We will be guided by scriptures like 'Honour your father and your mother, so that you may live long in the land the Lord your God is giving you'[6] and 'Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress…'[7]

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Umbilical cord blood stem cells

We told you so

Review by **Peter Saunders**
CMF Chief Executive

In January 2008 CMF welcomed a new bill which encouraged the donation at childbirth of umbilical cord blood and its storage for public use,[1] and called on the government to invest more actively in developing the NHS cord stem cell bank.

MP David Burrowes' Umbilical Cord Blood (Donation) Bill[2] aimed to increase awareness of umbilical cord blood's value in treating diseases and to promote further research for new treatment methods using cord blood stem cells. The bill required doctors to inform all parents of the benefits of collection and storage, and sought to promote collection from specific shortage groups, such as mixed race families and families with a history of cord blood treatable diseases.

Sadly, the bill was not granted parliamentary time to progress, the government instead pursuing its agenda of cytoplasmic animal-human hybrid (cybrid) research through the Human Fertilisation and Embryology Bill – a bill that is now law. Very shortly after this bill was passed, new research suggested this avenue of research was unlikely ever to be successful. At the time CMF predicted animal-human hybrid research would become a 'farcical footnote in history'.[3]

This January scientists reported exciting new developments suggesting that cord blood may well hold the answer for people with leukaemia requiring bone marrow transplants, and quite possibly for those suffering from other similar diseases.[4] The latest advance greatly multiplies the tiny number of cells from the cord ready for a transplant.

The same day the BBC carried the story of Natalie Salama-Levy who was unable to donate cord blood from her baby, due at London's Royal Free Hospital, because the hospital lacked the facilities to collect and store it.[5] Ironically her husband chairs 'The Cord Blood Charity' and was inspired to become involved following the death of a close friend from leukaemia. In 2008 only three NHS hospitals were collecting cord blood, and the situation has not improved much. Cord blood has already cured around 10,000 people around the world, but despite this our own UK cord blood banking facilities are woefully behind the times. We should be making this simple and ethically uncontroversial technology much more readily accessible.

The number of live births (currently around 700,000 per year in England and Wales alone) has been increasing every year since 2001. If the government had been more active in encouraging cord blood storage in the last five years, rather than over-hyping hopes about hybrid embryonic stem cells, we could potentially have had millions of samples of stem cells banked for treatment by now. Instead they intend to invest only £10 million to increase the size of the bank to 20,000 stored units by 2013 – see my blog.[6]

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The Robin Hood tax

Practical and just

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

A high profile campaign was launched in February to levy a 0.05% tax on all major bank transactions (currency trading, share dealing, derivatives, etc). This would raise tens or even hundreds of billions towards international development, supporting poorer nations in reducing carbon emissions, and sustaining UK public services in health, education and social care.[1]

Endorsed by the inevitable celebrities, the 'Robin Hood Tax' campaign drew equally inevitable derision from bloggers and commentators,[2] many seeming to think, mistakenly, it was a tax on ordinary banking and currency exchange.[3] Maybe calling it a 'Robin Hood' tax played to popular sentiments on both sides of the ideological divide, and the attempt by some bankers to hijack a web poll only added fuel to the fire![4]

But almost all the economic counter-arguments (that it would increase market volatility, push costs on to the consumer, not raise as much money as suggested, and only work if every major economy instituted it) have fallen somewhat flat,[5] with Nobel Laureate economist Joseph Stiglitz coming out squarely in favour.[6] Meanwhile most major economies (including the EU and the US) seem to be considering something like this,[7] and even senior economists and bankers are suggesting this, or something like it, is an idea whose time has come[8] provided we get it right.[9]

This *Triple Helix* concludes the series on the three health-related Millennium Development Goals. While throwing money at maternal health or HIV/AIDS won't solve all the problems, targeted financial aid can and does help. And as we look at the long term problems of caring for a growing elderly population here in the UK and funding an increasingly high-tech NHS, a new source of revenue, from the very banks and trading floors that created our current economic woes, has a strong sense not only of practicality, but also of justice. This is why CMF is supporting this campaign.

The scriptures remind us that those who have wealth and power are held accountable to God for how they use it, and are enjoined to help the poor and the vulnerable.[10]

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Peter Saunders on worrying developments in law

Photo: PA

Assisted suicide: 'COMPASSIONATE' KILLING?

key points

Cases in the media spotlight and the publication by the Director of Public Prosecutions of new prosecution guidelines have intensified the debate about assisted suicide.

While much improved, the definitive guidelines remain fundamentally flawed. By seeming to endorse assistance that is 'wholly motivated by compassion', they have confused *intention* with *motivation*. British law is based on the biblical prohibition of the intentional killing of the legally innocent.

This legal sanction in the DPP guidance may fix the idea in the public mind that there is such a thing as justifiable 'compassionate' killing. Imminent cases and forthcoming legislation will test this.

Assisted suicide is once again in the media spotlight thanks to the high profile prosecutions of Kay Gilderdale and Frances Inglis, continuing controversy around the activities of Philip Nitschke (*Exit*) and Ludwig Minelli (*Dignitas*), and celebrity endorsement by authors Terry Pratchett and Martin Amis. So much so that both MPs and Peers have recently made allegations of BBC bias on the issue.[1,2] But among all these, the key event recently has been the publication of new prosecution guidelines by the Director of Public Prosecutions (DPP).

The Law Lords, ruling in July 2009 on the case of MS sufferer Debbie Purdy, required the DPP for England and Wales, Keir Starmer, to produce an 'offence specific policy' making public the factors he would take into account when deciding whether or not to prosecute for assisted suicide. He produced his interim guidance on 23 September and this was out for public consultation until 16 December. A parallel consultation took place in Northern Ireland.

The DPP's draft (interim) guidance listed 16 factors that made prosecution more likely and 13 that made it less likely. It was widely criticised as 'discriminatory' in making prosecutions less likely when the 'victim' was sick, disabled or had a history of past suicide attempts, and 'naïve' in making prosecutions less likely for 'loved ones' (close relatives or friends) acting as 'assisters'. A significant proportion of abuse of elderly and disabled people occurs in the context of so-called 'loving families'! CMF with others[3] lobbied hard to have these provisions amended and many individual members made personal submissions.

Definitive guidance much improved

The DPP published his definitive guidance on 25 February[4] and we were pleasantly surprised to see how much improved it was. Almost 5,000 submissions[5] had been received from individuals and organisations and in response to these the DPP had made several key changes. The updated guidelines first emphasise that assisting with suicide remains a criminal offence, and that only Parliament can create exceptions to it. Over 1,200 submissions had requested removal of the factors on 'sick or disabled' and 'loved ones' and over 1,000 had requested removal of 'past suicide attempts'. The DPP has therefore removed all 'victim'-related factors from the 'less likely to prosecute' list, leaving just six relating to the 'suspect' alone.

In addition new factors have been added, most notably one making prosecution more likely if 'the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care'. Other factors in the definitive guidance effectively rule out internet promotion of suicide and Swiss-style suicide 'clinics'.

When the new guidelines were published the pro-euthanasia lobby group Dignity in Dying posted a notice[6] that it did not 'provide any information on how to end life or on how to arrange an assisted death', and the Medical Defence Union underlined its previous advice to members that 'doctors approached by patients for advice about suicide should not engage in discussion which assists the patient to that end'.[7]

Still fundamentally flawed

However despite these improvements, the guidelines remain fundamentally flawed, both in principle and in their detail. The Law Lords' judgment which led to them has been criticised by a leading lawyer as being 'unprecedented and unsound, if not unconstitutional'.[8] The Lord Chief Justice had wisely observed, in the Court of Appeal decision on Purdy, that granting her application would in effect create exceptions to the crime. Creating exceptions was something only Parliament could do, and it had chosen specifically not to do so twice in the last four years. The Law Lords ruling, by contrast, seemed to 'think it a proper function of the judiciary to help someone evade prosecution for the future commission of a serious crime'.

The ruling looked even stranger when seen against Parliament's recent move in the Coroners and Justice Act 2009 to expand the crime of assisting suicide to include 'encouragement' or 'assistance' by way of media or internet. Commentators have even referred to the guidance as providing a 'tick box get out of jail free card' for would-be assisters or even, in the case of crime-writer PD James, a 'murderer's charter'.[9]

Specifically, the mitigating factor 'wholly motivated by compassion' attracted most concern. This was defined in part to exclude actions where 'the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim', but still left many questions.

How was compassion to be defined? Given that motives are often mixed, how would the DPP interpret the word 'wholly', and was there any legal precedent? Given that the key witness, the 'victim', was dead, how would the DPP determine whether the act was 'wholly compassionate'? To what extent could one reliably trust the testimony of the 'suspect' about what really happened and what motivated him, given that the answers to these questions might make the difference between no prosecution on the one hand or a conviction for assisted suicide (up to 14 years' imprisonment) or mercy killing (mandatory life sentence) on the other? How is the DPP to determine from the evidence available in most cases that the action to 'help' was not at least in part motivated by a desire to be rid of an economic, emotional or care burden, or whether the 'suspect' was being subtly coerced or emotionally blackmailed by the 'victim' ('if you love me you will help me end it all')?

'Intention' not 'motivation'

Both the Suicide Act 1961 (which decriminalised attempting suicide itself but kept assisting suicide as a crime) and the Murder Act 1965 were based on the principle that the key issue legally was not 'motivation' but rather 'intention'. This concept – that it is wrong intentionally to end the life of any innocent human being regardless of one's motivation – has its origin in the Bible and is the basis of the sixth commandment: 'You shall not murder'.[10] Suicide, biblically speaking, is 'self-murder'. This in turn is consistent with the Bible's teaching that our lives do not belong to ourselves but to God.[11] It is clear from the biblical passages that expound the sixth commandment that it is the 'intentional killing of an innocent human being' that is being prohibited.[12]

As commentator Kevin Yuill has recently argued, 'The motivation for decriminalising suicide in England and Wales in the 1961 Suicide Act, as its authors clearly pointed out, was not toleration of suicide but a desire to be understanding, helpful and sympathetic towards the *failed* suicide and also the families of successful suicides… It is the disapproval of suicide – and, more importantly, its concurrent assumption that human life is valuable – which is now threatened.'

Quite apart from the clear scriptural perspective, suicide has been viewed by most societies as a deeply anti-social act that destroys possibilities, not just for the suicide victim, but for others too.

'Compassionate' killing?

However, the carefully orchestrated, powerfully funded campaign we have seen from the pro-euthanasia lobby – fuelled by celebrity endorsement and media hype around hard cases – has given credence to the idea in the public mind that there is such a thing as justifiable compassionate killing, and this has now been given legal sanction in the DPP guidance, along with the concept that there is such a thing as 'a life not worth living'. Suicide has shifted in the public consciousness from being a preventable tragedy (hence national suicide prevention strategies and suicide watches) to a choice that in some circumstances society is obliged to endorse and facilitate.

On 10 February, the Scottish Parliament established the End of Life Assistance (Scotland) Bill Committee with the remit to consider the general principles of Margo MacDonald MSP's bill which attempts to legalise both assisted suicide and voluntary euthanasia in Scotland for terminally ill, chronically ill and disabled people. The Committee launched its public call for evidence on the bill on 3 March and is expected to take oral evidence in May and June and publish its report during the summer, with a Stage 1 debate in September/October.[13]

I write this a few days prior to an adjournment debate in the House of Commons on 10 March on 'assisted suicide and the law' called by former Health Secretary Patricia Hewitt, now a patron of Dignity in Dying. This will further raise the temperature as we move into a new parliament after the election, when a private member's bill attempting to legalise assisted suicide is expected.

In coming weeks we will also see a barrage of cases which are going to test the new DPP guidelines, including those of two doctors (Michael Irwin[14] and Libby Wilson[15]); two husbands who allegedly 'helped' their wives kill themselves (Michael Bateman[16] and William Stanton[17]); and one elderly BBC journalist who confessed on national television to a 'mercy killing' (Ray Gosling[18]).

The pressure to change the law will be ongoing and relentless. We must continue to resist it.

***Peter Saunders** is CMF Chief Executive*

Photos: PA

Terry Pratchett

Kay Gilderdale

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Victoria Kim and **Liz Croton** describe their recent experiences of unemployment

(Un)employment – the long and the short

key points

Unemployment now faces junior doctors because of increasing competition for training posts. Doctors trained outside the EU require a permit to work in the UK, and fewer jobs are available for newly qualified GPs. Two CMF members share their recent experiences.

Victoria Kim came from Uzbekistan to develop her skills in cardiology but for more than two years could find no employment. God's word helped her during 'times of utter despair' and she learnt where her identity really lay. She is now a respiratory registrar.

Elizabeth Croton is a GP in Birmingham. For four months between contracts she kept afloat on locums, but shares honestly about valuable lessons of submission and obedience to God learnt through painful times.

Back in 2005, the British Medical Association warned about the threat of unemployment facing junior doctors due to increasing competition for training posts.[1] Added to this came the news in 2006 that doctors trained outside the EU would require a work permit to work in the UK, thus severely limiting their opportunities.[2] Newly qualified GPs have also come into the spotlight with fewer jobs available for them after qualification.[3] All these developments make unemployment among doctors a real concern.

As Christian doctors, our hope lies in the Lord, but how does that translate when the rubber hits the road? Two doctors share their experiences of unemployment.

'What do you do?'

Victoria Kim *is a specialist registrar working in the UK*

I was born and grew up in Uzbekistan (then Uzbek Soviet Republic), of Korean ethnicity. I became a Christian because I always believed there was more to life than 'this big Universe'. I wanted to study medicine and so I applied to the First State Tashkent Medical Institute in Uzbekistan. My friends thought this was an insane decision as it was known to be difficult to get into. I was accepted and made a promise to God that I would continue to study his Word. At the time I belonged to an excellent Baptist church in Tashkent with superb teaching.

After graduation, I applied for my residency. I was interested in research and dreamed of training in interventional cardiology. I felt that a placement in the UK could give me the experience I needed. I prayed that God would provide for me financially – which he did through a friend's loan – and started preparing for the PLAB exam to enable me to practise in the UK. By God's mercy I passed it on the first attempt. It was then I faced unemployment. I saw many of my friends struggling to secure a job and I struggled to believe that God was in control. I had always thought that if you worked and studied hard you would find employment but this theory was proved wrong when I received no reply from the dozens of applications I submitted throughout the UK.

While in this trial, God provided me with a local Christian couple who became my 'English parents'. They provided me with advice, support and prayer. He also provided me with Christian friends and timely clinical attachments. As a clinical attaché I was able to gain experience on a voluntary basis as an introduction to the NHS. Although I was not earning, I never went hungry as God provided again through people, and I always had a warm house to go to and clothes to wear.

At times of utter despair, I relied on his word. I meditated regularly on verses such as:

But seek first his kingdom and his righteousness, and all these things will be given to you as well (Matthew 6:33).

Have I not commanded you? Be strong and courageous. Do not be terrified; do not be discouraged, for the LORD your God will be with you wherever you go (Joshua 1:9).

My other problem was my identity. I was a Russian-speaking Korean Uzbek living in the UK! I realised that much of my identity had been tied up in what I was doing. I had been a medical student and then a cardiology resident and now I was doing nothing. I became sharply aware that I had no answer to the question that everybody asks on introductions – namely 'What do you do?' I was unemployed from December 2004 until February 2007. During that time I prepared for exams, continued in my clinical attachments, and worked as an honorary clinical fellow.

You might wonder what happened next. I persevered and secured a place as a part-time maternity locum. I then worked my way through various SHO positions before stepping up as an acting respiratory specialist registrar. With God's help, I completed my MRCP exam and am now working as a respiratory registrar. Slowly but surely, God made a way for me at his pace. Through my experiences, I learnt that God is good all the time and working for the good of those who love him (Romans 8:28). My identity lies within him rather than in my status as a doctor, and through his grace I can now identify with those who too are going through unemployment.

Our identity is in Christ, not our degrees

Elizabeth Croton *is a Birmingham-trained GP who became a Christian in 1997. During 2008 she experienced a period of unemployment after being made redundant from a salaried GP position*

As I approached the end of my registrar year, I started to become increasingly anxious about finding a job. I had been writing for the GP newspapers for a number of years and was involved in one of their internet forums – 'GP35' – which endeavoured to showcase the opinions of GPs under the age of 35 on their magazine website. The rumour mill was flooded with stories of newly qualified GPs being out of work and having to survive on the 'hand to mouth' existence of locum work. This didn't bother me initially, but then stories began to abound about the locum market being flooded and there being little opportunity for career progression.

I decided to send a copy of my CV to every practice in the PCT explaining that I was looking for work. By 'pure chance' I received a call from a practice about a salaried position they were about to advertise. They needed somebody with some surgical experience and felt that I would be ideal. I went to the interview and was offered the job. Initially it was a six-month contract but I was told in all likelihood it would be a permanent post.

I must stress that all this job-seeking was done largely without God's guidance. Yes, I read the Bible and prayed regularly but I felt that I didn't have time to 'wait for the Lord' (Psalm 27:14). The job was stimulating but I knew practice budgets were becoming tighter and staff were being laid off. I had been there four months when I discovered that another salaried GP appointed before me was not having her contract renewed, for 'financial reasons'. Shortly afterwards I was told the same. I had just over a month to find myself another job.

This was a real blow to my confidence and I became increasingly anxious regarding my future. I was worried that future employers would view my redundancy in a negative light and raise questions about my clinical competence. Like Victoria, I meditated on the Bible and tried to convince myself that God was working for my good through all this (Romans 8:28). I also dreaded people asking me about how my career was going. My identity had been centred on my status for so long and now this was stripped away from me.

I was forced to turn to the Lord and cling to him instead:

But now, Lord, what do I look for? My hope is in you (Psalm 39:7).

I became extremely envious of those GPs who had secure jobs because I felt they were better than me. I had always been ambitious but now that ambition was becoming jealousy, and if I am honest with myself I wished at times the same thing would happen to them so they would know how I felt – another example of 'selfish ambition' leading to sin (Galatians 5:19-21). I also began to worry about money – not because I was in debt but because I wanted the security of knowing I had a regular income. I didn't trust that the Lord would provide for me.

I managed through locum work to keep afloat for the next four months. The Lord had taught me a valuable lesson regarding submission and obedience and I tried to walk closely with him through praying and reading his Word. Again 'by chance' I was approached by a practice who had received my CV and I now work on a permanent basis for them. I realise I am lucky – the Lord did provide but this is not the main moral of the story for me. As Christian doctors, our identity is in Christ, not our degrees and for me it took the loss of my regular work to realise this. I won't ever forget this lesson though.

My identity lies within him rather than in my status as a doctor

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Derrett Watts challenges our attitudes to substance misusers

DRUGS + ALCOHOL: *Why* should we care?

key points

From a seminar he gave to doctors and students from across Europe-Eurasia at the 2008 ICMDA conference, the author examines substance misuse from both medical and Christian perspectives, concentrating on our atitudes to the stigmatised.

Alcohol and drug misuse are common and have enormously destructive effects on physical, mental and social health. All doctors should care, particularly because treatment works.

Recognising that stigma must be overcome, the author draws a broad parallel with biblical leprosy and Christ's response, and encourages Christian doctors to treat effectively and to restore dignity.

1. Why *as doctors* we should care about substance misuse

It is common

At medical school it perhaps seemed that esoteric syndromes were the key areas to study (linked to their significance in examinations). Substance misuse was barely mentioned yet in the working lives of many doctors across a wide range of disciplines, substance misuse in general, and alcohol misuse specifically, has a prominent place.

Substance misuse is common. 38% of men and 16% of women have alcohol use disorder (drinking above the recommended levels), while 6% of men and 2% of women have alcohol dependence (meeting ICD-10 criteria for dependence).[1] Recent concern has focused on increased rates of drinking in women (closing the gender gap for excessive and harmful drinking), and changes in alcohol use in those under the age of 16, who were drinking twice the amounts in 2006 compared to 1990.[2] Over a third of the population have taken an illicit drug in their lifetime, with higher rates of drug use in younger people:[3]

Reported drug use in last year	16-59 years old	16-24 years old
Illicit drug	12%	28%
Cannabis use	11%	26%
Class A use	3%	8%

It has widespread effects on health

Alcohol misuse is linked to 70% of A&E attendances between midnight and 5am, to 125,000 facial injuries per year, to 60-70% of domestic assaults, and to 23% of child neglect cases.[4] In 2007, for the first time, a health performance target was linked to alcohol, aiming to reduce the number of alcohol-harm related hospital admissions.[5]

Across all ages the top three conditions related to alcohol are hypertensive disease (133,307 admissions annually), mental and behavioural disorders due to use of alcohol (94,382 pa) and cardiac arrythmias (76,540 pa). Other conditions featured prominently in different age groups (eg assaults, falls, epilepsy, and spontaneous abortion).[6] 39,180 people are admitted each year with alcoholic liver disease. Liver disease now ranks fifth for causes of death in the UK, and is rising, while the four causes of death above it have rates that are falling.

Similarly, illicit drug use has diverse and serious effects on health. Opiate misuse may be associated with weight loss; deep vein thrombosis; pulmonary emboli; infections and abscesses at injection sites; other infections such as hepatitis, HIV and endocarditis; and carries the risk of overdose, which may be accidental or deliberate, and may be fatal.

There is also significant co-morbidity with mental health disorders; with increased rates of conditions including depression, anxiety and phobic disorders. The substance use may prove a barrier to individuals accessing treatment – or treatment being offered. Additionally, individuals with substance misuse may have had difficult upbringings (eg abusive childhoods, unstable family structure, poor schooling) and may continue to experience social disadvantage (eg debt, lack of jobs, poor housing, involvement with the criminal justice system). Substance misuse is thus truly 'holistic'.

Treatment works!

In our world of evidence-based medicine it is important to note that interventions in this field do work. An American study[7] involving 1,726 patients (over 95% of whom had alcohol dependence) found three different types of psychological treatments – cognitive behavioural therapy, motivational enhancement therapy, and 12-step facilitation (which is integral to the approach of Alcoholics and Narcotics Anonymous) – all led to improvements. Over the whole group the drinking days fell from an initial average of 25 days per month to six, while the number of drinks per day fell from an average of 15 to three. A similar UK study showed that psychosocial therapies used for alcohol treatment saved about five times as much in expenditure on health, social, and criminal justice services as they cost.[8]

Other studies have demonstrated the beneficial role of medications such as acamprosate, naltrexone, and disulfiram in maintaining abstinence from alcohol. For opiate dependence a recent health technology assessment concluded that both methadone and buprenorphine were more clinically effective and cost effective than no drug therapy.[9] Treatment saves lives, reduces crime, and gives opportunity for a degree of stability to develop and so other difficulties (physical, psychological or social) can be addressed. For some this may lead on to a period of rehabilitation, and some programmes have a clear Christian ethos.

2. Why *as Christian doctors* we should care about substance misuse

Stigma affects treatment outcome

One of the greatest compounding difficulties is that of stigma, which can lead to reduced access to education, housing, employment and health care. A sample of 234 GPs in Norfolk showed that 66% believed drug addicts to be deceitful, unreliable and unwilling to co-operate with treatment. The same percentage felt drug addicts deserved all the help they could get, indicating that a third did not![10] A Manchester study of 341 GPs showed 11% to believe that all opiate users should be removed from practice lists.[11]

The patient's perceptions of health professionals were revealed in a further primary care study of 116 patients having treatment for addiction. GPs tended to score highest for professionalism (accessibility, confidentiality, and to a lesser extent, knowledge). Personal characteristics such as ease of conversation, understanding and criticism took the middle ground, while the lowest rankings were for sympathy and usefulness.[12] This finding contrasts with evidence that having an empathic relationship with a professional is a key factor in whether that treatment is successful.[13]

Biblical leprosy and substance misuse: a parallel

And the leper in whom the plague is, his clothes shall be rent, and his head bare, and he shall put a covering upon his upper lip, and shall cry, Unclean, unclean. All the days wherein the plague shall be in him he shall be defiled; he is unclean: he shall dwell alone; without the camp shall his habitation be (Leviticus 13:45-46, AV).

The biblical word 'leprosy' applies to a number of diseases affecting the skin, and the parallel with substance misuse is in the area of stigma. In this passage we see the lepers have had their dignity removed (clothes torn, head shaven); have faced public shame ('Unclean, unclean'); and have become outcasts from society ('he shall dwell alone'). What would follow would be a disruption in family relationships, loss of jobs, and doubtless intense personal distress. In our privileged position as medical practitioners, how should we respond?

Christ wants Christian doctors to be different

Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind (Romans 12:2).

Our minds are to be different, but to to accomplish this we need to undergo a transformation – a metamorphosis! This is the same word as used for the transfiguration of Christ in eg, Matthew 17. It is a difference so significant it should be evident to all who see it. The evidence will be seen in the attitude we show to others; not so much in great deeds but in the way we respect others and do not think of ourselves as being 'better'. We are different, not because of any good in us but 'in view of God's mercy' (Romans 12:1), 'to test and approve God's will' (verse 2) and 'in accordance with the measure of faith God has given you' (verse 3).

How can we demonstrate this difference? How would Jesus respond to people who use drugs? How did Jesus respond to lepers?

A man with leprosy came to him and begged him on his knees, 'If you are willing, you can make me clean'. Filled with compassion, Jesus reached out his hand and touched the man. 'I am willing', he said, 'Be clean!' Immediately the leprosy left him and he was cured (Mark 1:40-42).

Jesus was approachable (the man 'came to him'), caring ('filled with compassion'), responsive ('I am willing') and effective in using the ability he had ('Jesus touched… he was cured'). Surely these are the same characteristics we are called to use with all patients, including those with substance misuse? Perhaps the ultimate challenge to our attitude to substance misusers comes from the lips of Jesus himself:

For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me…I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me (Matthew 25:35-36,40).

Derrett Watts *is a consultant addiction psychiatrist in Stoke-on-Trent*

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It is in God's people that **Vicky Lavy** finds hope for Haiti

Where is God in HAITI?

key points

The author touches on the theology of suffering and of natural disasters, but notes that much human suffering and poverty are the result of man's greed and failure to care for the vulnerable.

The high-density, badly-constructed housing in which the disadvantaged were living and the poor infrastructure which made assistance so difficult partly explain why the earthquake caused such massive loss of life.

CMF member Chris Lewis works with Save the Children and helped coordinate the continuing aid response, prioritising primary health care. Answering her question 'Where is God in our broken world?' the author concludes he is in his people.

It's so unfair. My children live in a comfortable house, eat three meals a day and have a friendly GP down the road – though they rarely need him. Today, thousands of children in Haiti are living in shelters made of cardboard and cloth, eat once a day if they are lucky, have no access to healthcare, and are dying from preventable diseases. The earthquake which hit Haiti in January killed 230,000, injured 300,000 and left 1,200,000 homeless. Why did a devastating earthquake happen in a country already ravaged by poverty, instability, dictatorships and environmental degradation? Why did God allow it? Why?

Throughout the ages man has wrestled with the problem of suffering – the only answer Job got to his questions was that God is beyond our understanding.[1] We may never get a full answer to 'Why?' this side of eternity. However, we do know that man's sin did not only spoil his relationship with God, but brought disharmony and decay to creation as well.[2] We also know that much human suffering and poverty are the result of man's greed and failure to care for the vulnerable. In Haiti, 1% of the population own half the country's wealth.[3] The high-density, badly-constructed housing in which the disadvantaged were living and the poor infrastructure which made assistance so difficult were some of the reasons why the earthquake caused such massive loss of life.[4]

However, if we ask a different question, 'Does God care?' we do find an answer – in a manger and on a cross. God did not stand aloof, watching a broken world groaning under the effects of man's sin.[2] He came into the world as one of us and by his suffering and death has broken the power of the Fall and begun the process of redeeming and restoring creation. We hang on to the fact that one day 'there will be no more death or mourning or crying or pain'.[5]

But what of now? Where is God while we wait for that day? Where is God in the chaos and tragedy in Haiti? I believe he is right there, in his people – the body of Christ. He is in the local church and in the Christians who have gone to help.

Haiti facts and figures

- Poorest country in the Western hemisphere
- 70% Haitians live on less than a dollar a day
- 60% have no access to healthcare
- 1 in 6 children die before their fifth birthday
- 230,000 people have died in the earthquake
- 300,000 were injured
- 1,200,000 are left homeless

Chris Lewis' story

CMF member Chris Lewis is the Emergency Health Advisor for Save the Children Fund UK. I interviewed him in Haiti – by email – to find out what is happening there and what he is doing to help.

Chris - what are you doing in Haiti?

I am here to establish Save the Children's emergency response health programme for Haiti,

and then hand it over to other members of the team to continue. We have had over 50 international staff and many more national staff working as part of the emergency response in a number of sectors including health, nutrition, sanitation, education, shelter, protection and food security. Within the health sector, following the initial focus on trauma after the earthquake, the Ministry of Health and the World Health Organisation (WHO) are now prioritising primary health care.

Most people are living in makeshift camps with no health facilities, so Save the Children is running 20 mobile health teams who are providing essential services in 40 camps, seeing over 3,000 patients a day. The most frequent problems are acute respiratory infection, diarrhoea and malaria – the three main causes of under-5 mortality globally. Other activities include immunisations and management of acute malnutrition. As time progresses the interventions will become more comprehensive and integrate reproductive health, community case management and HIV activities.

What does your average day look like?

The day begins with organising the health teams, making sure they have enough medicines, food, vehicles, tables, chairs, etc for the day and getting them to the appropriate camps to set up mobile clinics. After this 'detail' work, I will spend the middle of the day juggling the 'big picture' work: planning strategies with Save the Children/WHO/Ministry of Health, working on recruitment, supplies, budgets and proposals. At 3 o'clock it's time to find an available vehicle, battle through the Port-au-Prince traffic for an hour, and join the mêlée in the health coordination meetings at the UN base, when representatives of the numerous aid agencies meet to plan how to work together effectively.

Coordination has been one of the challenges of this earthquake response, with the large number of short-term small organisations arriving into Haiti, including many without experience of working in this context. There are 360 different agencies registered with the health sector! Coordination and planning are incredibly difficult when individuals are not used to working in emergencies, and when some organisations come in for three weeks and leave without handing over activities.

When the UN meeting is over, I drive back to the office as the sun goes down and the curfew begins. I get back to my desk to try and get on top of everything before the end of the day, finishing work hopefully before midnight.

How did you first get involved in this kind of work?

I got the 'bug' when I was travelling around East Africa in 1996 and spent some time in the Rwandan refugee camps. As students my wife Karinya and I felt called to work in this area, but wanted to finish our junior doctor training before working overseas. After a couple of years as a GP, I studied the Diploma in Tropical Medicine, Karinya studied a Master's in Community Eye Health – and we set off. We worked in Southern Sudan for three years, initially with Medair. We lived 'in the bush' in a small tent in Jonglei, supervising primary health care, a TB programme and being part of the team responding to disease outbreaks – cholera, meningitis, hepatitis E, etc. We then moved to Juba, where Karinya worked for CBM as an ophthalmologist and I worked as Health Coordinator first for Tearfund, and then for WHO/Ministry of Health. We came back last year to start a family – our son is now five months old – and I began work with Save the Children.

People often ask me how they can get into humanitarian work. When the job description often reads 'Two years of humanitarian experience is required for this role' how can you get experience when you can't get the initial job? If you are interested in this line of work, do some travelling and volunteering in developing countries to be sure that this is the environment that you want to work in. Some organisations such as Medair will take people without humanitarian work experience as volunteers for the first year, following a selection process. The Diploma in Tropical Medicine or a Master's in Public Health are useful qualifications.

Out there in the midst of the devastation, do you ever ask why God allows these things to happen?

The impact of this tragedy is enormous – one in every fifteen people that were in the earthquake died. Everyone has lost someone. When I think of the effect on the individuals in Haiti, it is impossible not to feel the emotion and sense of injustice. When we wrestle with the question 'Why does God allow suffering?' we can read books, look at the background, and come up with theological reasoning which, though still difficult, makes sense. However, it is much more difficult when confronted head on with the reality of a 'natural' disaster. While driving through the wreckage and hearing the individual stories of tragedy, I have struggled with this reality. In this acute period, I have had to put it to one side for the moment in order to do my job. When I get home and when I am ready, I will pray, reopen the books and the discussions, and I am sure that the question 'Why does God allow suffering?' will be a lot more real and difficult. Despite this, it is inspiring to see the faith of the Haitian people as I hear worship songs drifting across the ruins.

Conclusion

Where is God in our broken world? He is in his people. He is in those who continue to praise him in the midst of suffering, he is in those who pray, those who give and those who go. We can each play a part, as members of the body of Christ.

Vicky Lavy *is CMF Head of International Ministries*

Photos: Chris Lewis

Everyone has lost someone... it is impossible not to feel the emotion and sense of injustice.

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Andrew Fergusson reviews GP members' attitudes to abortion requests

ABORTION REQUESTS: should we 'refer'?

key points

Christian GPs find handling abortion requests troublesome. CMF's recent publications on the subject are reviewed.

Jim Newmark began a new discussion about refusal to make a written referral to hospital: there are inevitable consequences to other doctors, whether Christian or not, now caught up in the issue.

Mark Houghton usually writes a referral letter but uses it to point out the probable illegality if an abortion were to be carried out. Rhona Knight seeks a shared understanding and negotiated management plan, in which evidence-based and values-based medicine both play an intrinsic part. Greg Gardner reviews law, the practice of providers, and the medical evidence and concludes it is entirely reasonable to decline a woman's request for referral.

Over the years *Triple Helix* has considered the vexed question for GPs of handling abortion requests. In 2003 Liz Walker and Huw Morgan discussed[1] the following real life case:

'Jenny is 15 and thinks she may be pregnant. After talking and examining her you establish that she is around 20 weeks pregnant. She says she does not want to have the baby. She is scared to tell her parents and asks if you would tell her mother if she got her along to see you under false pretences.'

In 2008 Rachael Pickering who had edited that discussion used the Juniors' Forum to review professional aspects,[2] and the same edition contained an extensive and reassuring legal review.[3] The introduction to a 2009 *CMF File*[4] used the example of abortion to illustrate the right of conscientious objection:

'The right of conscientious objection is enshrined in medical law. For example the 1967 Abortion Act states that *…no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection.*'

Each abortion consultation is stressful, and the troubled consciences of members continue to provoke them. This new year, another GP raised a further issue:

Jim Newmark (salaried, Bradford)

'I have been a Christian doctor for very nearly a third of a century. You would have thought I would have this issue just about sorted, but I do not. I remain confused. And just a touch irritated. This has nothing to do with those from whom conscientious objection has 'recently come under attack', nor with my secular acquaintances, friends, and patients. My take is from the perspective of a jobbing front-line Christian GP who personally has never (yet) signed a blue form, but does not object to making a written referral to the hospital.

I am puzzled by the objection to making a written referral to the hospital for a woman to undergo a termination of pregnancy. This is held to be reasonable in the light of the provision of the conscience clause…'

He went on to make the point that those who refuse to make a written referral ignore 'the inevitable consequences to other doctors, whether they are Christian or not, who are now consequently, and inevitably, caught up in the issue. Like the unborn child, they are ignored, a by-product of events out of their control…I think what has happened in Christian circles is that people have paid too much attention to the theoretical objections as a proxy for their "personal integrity", and have lost sight of the magnitude of the consequences… in the real world to others. And I have a sneaking suspicion that there is at least some element of one-upmanship in the sense that "by invoking my right of conscientious objection I am a better Christian than you".'

He summed up '…a doctor cannot un-know what he/she knows. In virtually all these situations in real, as opposed to theoretical, general practice, the doctor *is* a participant, albeit unwilling – end of story. I think that, too often, Christians use the conscientious objection clause without really thinking about what it means either for themselves or for others.'

The correspondence that followed stimulated a lively discussion at the Editorial Board, and it was agreed to canvass the views of some other GP members.

Mark Houghton (part time, Sheffield)

'I offer patients four things:

- Respect – for the mother, baby, father and family
- Review of knowledge to fill in the gaps about the fetus, social services, and so on
- Regard for the law which does not permit abortion on demand
- Referral as a last resort

The woman may arrive scared, angry, hurt and confused. I explore opportunities to find joy, because she is carrying a new person. A colleague of mine said to a woman: "You might be carrying the next Beethoven". Years afterwards she would bring the boy in, smiling, "Here is Beethoven"! Always seek trusted local counsellors and ultrasound scan.

In this area of terrible hurt and injustice we Christians need to decide our group strategy. We should leave patients free to choose their own path, fully informed of the threats to their life, health, conscience, fertility, and from the law. Jesus never stood in anyone's way but he did invoke the law.

We can choose non-cooperation and non-referral to stress a corrupt system into change – or we can combine to invoke the law. The UK Abortion Act is weak but exists to protect the woman and baby.

As a last resort the law offers hope for my little patient. And it may save her mother from death because abortion is more dangerous than a delivery.[5] If she is determined on abortion I write a detailed, referenced letter concluding "I find no grounds in law for this termination request. If it happens I would consider it illegal. The peer-reviewed evidence is below." Lawyers are eager to test this. If we all invoked the law and the medical evidence then change would be rapid.

Rhona Knight (portfolio, Leicester)

'My current approach to such consultations is to do what I aim to do in all consultations. I will take a history, clarifying the presenting problem and identifying the patient's ideas, concerns, thoughts, fears, and expectations and why they have them. I will explore external pressures compromising free choice. Having reached a shared understanding, I then hope to negotiate a management plan, in which evidence-based medicine and values-based medicine both play an intrinsic part.

I find myself at odds with the latest BMA position that 'Doctors who have a conscientious objection to abortion…should make their views clear at the start of any consultation...should tell patients they had a right to see another doctor and, if appropriate, arrange for another doctor to take over the patient's care'.[6] I am more inclined towards the GMC guidance[7] which, in acknowledging the potential of the physician's expression of personal beliefs to exploit the vulnerable patient, still gives the doctor permission to stay true to their moral beliefs.

The negotiated way forward, like each consultation, is unique. It may include time for reflection, or accessing other pregnancy support organisations, or bringing the patient back to see a colleague who would be happy to refer for abortion if this is what the patient chooses. In this overall approach, I hope I am making the care of the patients my first concern, demonstrating love for neighbour, born and unborn, while also working as part of a wider team who may have differing ethical beliefs.'

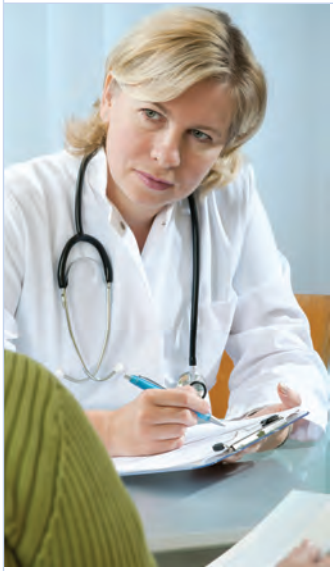
Greg Gardner (part time, Birmingham)

'The NHS commissions abortion services from two major and a number of smaller providers as well as its own hospital trusts. The two largest private providers are BPAS and Marie Stopes International which between them have a gross annual income of around £125 million.[8] Although having 'charitable status' their profitability is huge, extending to their desire to fund advertising for their services on prime time TV. It is extremely rare for a woman to be refused an abortion by an abortion provider. Referral for a "second opinion" is in reality nothing of the sort. It is referral into a system which fast tracks pregnant women to one outcome only. Failure to screen women adequately for risk factors prior to abortion is negligent and failure to tell a woman if she does have risk factors for post-abortion injury is also negligent. Women need access to evidence and information – and time to think. Adherence to a proper standard of informed consent would go a long way to counter the paternalism and financial self-interest of the abortion industry.

There is no such thing as a legal right to abortion. The Abortion Act (1967 amended 1990) merely decriminalises abortion if certain criteria are satisfied. Among these are that the risk to the mother's physical or mental health would be greater if she continued with the pregnancy than if she had an abortion. Although a risk assessment has to be made in each case, there is enough evidence already of hidden and delayed maternal morbidity and mortality[9,10,11,12] and this undermines the legal basis of virtually every abortion done in the UK.

How ethical is it for GPs to refer women into the abortion pathway? It depends on what your view is of complicity. At the very least it could be construed as endangering someone's life since this referral route almost always results in the death of the unborn child. Given that information conveyed to women prior to abortion is usually inadequate; given that most abortions done under clause C in the UK are illegal; given that putting a pregnant woman on to a referral pathway to an abortion provider endangers the life of the child; and given that there are issues surrounding complicity, it is entirely reasonable to decline a woman's request for referral to an abortion provider.

Andrew Fergusson *is CMF Head of Communications*



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Christine Edwards reviews the failure to improve maternal health

Photo: Wellcome

MDG 5 – saving the lives of mothers

key points

Millennium Development Goal 5 seeks by 2015 to have reduced maternal mortality by 75% from 1990 levels and to achieve universal access to reproductive health. It is probably the most off-target of all the MDGs.

Mortality and morbidity are quantified, and 'three delays' postulated to explain maternal mortality: in deciding to seek health care, in reaching the facility, and in receiving care once at the facility.

Faith based organisations do better than government hospitals, and the success of an integrated functioning health system in the LAMB project in Bangladesh is described.

MDG 5

Millennium Development Goal 5 aims to improve maternal health, and has two targets:

- to reduce maternal mortality by 75% between 1990 and 2015
- to achieve universal access to reproductive health by 2015

The two key indicators for monitoring the progress towards the first target are the maternal mortality ratio (MMR) and the proportion of births attended by skilled health personnel.

The second is monitored by the contraceptive prevalence rate, the adolescent birth rate, antenatal care coverage, and the unmet need for family planning.

Recent reports [1,2] explain the difficulty of obtaining current data, but all but 12 of the 68 nations working towards these goals still have 'high or very high' MMRs, and in some cases these may actually be rising. [3] The consensus is that MDG 5 is the most off-target of all the MDGs.

Four explanations are proposed, although the situation is too complex for any one to be the entire answer:

- Economics
- Political instability
- International donors and governments preferentially fund other health and development priorities
- Poor governance and corruption

A jumbo jet crashes, killing all on board. International headlines, major investigations, review of protocols, etc. Yet every day the equivalent of three 747 jets of women die as a result of pregnancy and childbirth, more than 500,000 women a year, and it rarely hits the headlines.

An estimated 300 million more live with complications related to childbirth including chronic infection, infertility, prolapse, and the shame and isolation caused by vesicovaginal fistulae. The vast majority are in low-resourced countries. The lifetime risk of dying of pregnancy-related causes is 1 in 3,800 in the UK against 1 in 6 in Afghanistan. Along with the mothers the babies die too, either during birth or due to a subsequent lack of breast milk and care. Four million babies a year die in the first month of life, yet 70% of avoidable neonatal deaths could be averted through access to adequate maternal health services.

Why are these women dying?

The straightforward medical answers are haemorrhage, pre-eclampsia/eclampsia, infection (including HIV), obstructed labour, and unsafe abortion. Nearly 20 million unsafe abortions are undertaken each year, resulting in 70,000 maternal deaths, [4] though this important, if contentious, issue is beyond the scope of this article.

Nevertheless, we do know how to reduce this awful toll. The maternal mortality ratio (MMR) for England and Wales in 1934 was 441 per 100,000 live births. [5] It went down to 87 in 1950, 39 in 1960, and is just 7 today. [6] The regional MMRs for South Asia and sub-Saharan Africa are 560 and 940 respectively. [7]

The main reasons for the reductions in the UK MMR over the last 75 years were universal midwifery care, antibiotics, safe caesarean sections, and blood transfusion. We know the medical reasons for maternal mortality, and in the majority of cases we know how to prevent and treat them to save lives.

Yet despite this understanding, and while some progress has been made in reducing maternal mortality in the poorest nations, many low income countries are still struggling to achieve MDG 5. So why are these mothers dying unnecessarily?

Three delays

Deborah Maine proposed the 'three delays model' which leads to maternal mortality:[8]

Delay 1: delaying the decision to seek care

This is multifactorial and in many ways the most challenging to address. It includes:

- beliefs concerning health – eg eclampsia being regarded as demon possession and therefore needing spiritual rather than medical attention
- beliefs concerning pregnancy – eg the pregnant woman being vulnerable to evil spirits, thus restricting travel out of the home
- traditions and socio-cultural constraints. In many countries most deliveries occur at home, mostly without trained birth assistance. 75% of deaths occur within 24 hours of delivery
- lack of confidence in the maternal healthcare systems
- in some resource-poor settings women are last to receive the limited family resources, so expenditure on maternal healthcare is not prioritised

Delay 2: delay in reaching the healthcare facility

This includes financial, transport and terrain constraints; eg in Ethiopia 75% of people live two days' walk from the nearest road which may then be many miles away from a functioning healthcare facility.

Delay 3: delay in receiving care once at the facility

All too often health centres are so poorly resourced that the woman is subjected to further delay in care because of a lack of supplies and trained staff. This of course reinforces the lack of confidence in the healthcare system.

Only about half of the 123 million women who give birth each year receive the antenatal, delivery and newborn care they need.[9] An additional 215 million who wish to avoid pregnancy do not have access to modern, reliable methods of family planning.

What is needed?

Pregnancy is not a disease and 80% of pregnancies and deliveries are normal. However, all pregnant women are at risk of developing complications, most of which can neither be predicted nor prevented. When a complication develops the woman – and her baby – need prompt access to appropriate emergency obstetric care. Making this accessible to all is the challenge confronting MDG 5. There is a growing consensus that access is needed to an integrated functioning health system which provides for women's care as and when needed.[10]

Gill and Carlough[11] reviewed the literature on mission hospitals and other faith based organisations (FBOs) and concluded that the care provided is often better than in government hospitals. There are many reasons for this, including more resources, commitment to and provision of training, and flexibility in procuring medicines and equipment. They recommend increased collaboration between governments and FBOs, and international funding to encourage effective partnerships.

Case study – LAMB integrated rural health and development project, north west Bangladesh.

Established in the 1970s, LAMB[12] currently works with approximately 700,000 people, among whom it has developed an integrated maternal health system to provide appropriate, accessible and affordable health services for the poor, through a 'household to hospital' continuum of care.

The heart of LAMB's ethos is that men and women are created equally 'in the image of God',[13] and therefore maternal and child healthcare is an issue of justice. These values are explored in women's groups, and in all educational encounters with the community.

The primary health care workers are village volunteers, selected by their own community, and each responsible for 100 households. They link women with antenatal care, birth planning, postnatal care and family planning. Birth planning is an essential component and is part of addressing the 'first delay'.

The next cadre of healthcare providers are the community Skilled Birth Assistants (SBAs) who are trained in antenatal and postnatal care, safe delivery, recognising danger signs and providing obstetric first aid and neonatal care.

The communities run their own Healthcare Centres and in 17 areas these also incorporate Safe Delivery Units staffed by SBAs.

The 'third delay' is addressed through a 150 bed general hospital which provides 24/7 comprehensive emergency obstetric care.

There has been a 26% reduction in maternal mortality in LAMB-served areas,[14] and MMR is 133 per 100,000 live births, against a national ratio of 320.

Conclusion

Much remains to be done, both in Bangladesh and globally, if the MDG to reduce maternal mortality by 75% by 2015 is to be achieved. Efforts need to be targeted across the board – from building relationships of trust and accountability locally, through to stimulating political will to bring about change. M Fathalla, past president of the International Federation of Obstetrics and Gynaecology, has stated 'Women are not dying of untreatable diseases; they are dying because societies have yet to make the decision that their lives are worth saving'.[15] Jesus treated women with dignity and respect, in a time and culture that did not. As his followers, we need to be passionately engaged, stimulating the debate at all levels.

Christine Edwards *is a UK trained obstetrician/gynaecologist, currently Clinical Fellow at Gloucestershire Royal Hospital. Until recently she worked in Bangladesh for 17 years as Medical Director at LAMB Hospital. She has an ongoing involvement in International Safe Motherhood.*

Photo: PA

So why are these mothers dying unnecessarily?

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Katy Barker and **Genie Lee** on the developing world frontline

Should I STAY or should I GO?

Burden of disease

Should I stay or should I go? A question that may sound familiar to many junior doctors, and one that may be lurking at the back of your mind. No, I'm not referring to the song by The Clash; I mean that big question you ask yourself about practising medicine overseas…I know I've asked it. I know I still do.

Many different reasons stop us from going, but rather than addressing these individually, I'm going to look at the reasons to go.

Why go?

The short answer is simple: God loves the poor and the oppressed.[1] His concern for them is evident throughout the Bible. There are many references regarding the poor, both to people crying out to God to defend their cause,[2] and what our actions should be in response to need.[3,4,5,6,7] The Bible is clear there are blessings and treasures in heaven for those who do respond[8,9,10] for 'he who is kind to the poor lends to the Lord, and he will reward him for what he has done',[11] but there will be consequences for those who do not.[12] God's heart is for the poor, for the orphans, for the widows – ours should be too.

What I don't want to do, however, is discourage people from getting involved with work in our country; there are needy people here and there is some great work already being done.

But with respect to the question 'why go?', take a fresh look at our world and visit *worldmapper*.[13] The maps change the dimensions of the continents to represent the global distribution of a topic. Although Africa and India swell to immense proportions with regard to burden of disease, Africa becomes threadlike with the distribution of doctors while the UK enlarges to obese proportions.

The poorest in the world have the greatest health needs, but the fewest doctors. So instead of 'why go?', ask yourself 'why stay?' And remember '…whatever you did for one of the least of these brothers of mine, you did for me'.[14]

Be inspired!

Medical mission comes in all different shapes and sizes, for varying time periods. We can take ideas from what others have done. **Genie Lee** shares her experiences:

Since I've graduated I have been hugely blessed being able to go on short-term medical mission trips. This is despite many trainers, mostly from secular organisations, expressing disbelief at the possibility of such trips, and questioning how useful a junior can be in the mission field. The trips have ranged from three days to two weeks, mostly as study leave, occasionally as annual leave, but more often as 'professional leave'. My consultants were so proud of what their juniors were doing they contributed 'for humanity' by facilitating my going. So far the Lord has led me to Nepal and Sri Lanka on my elective with Leprosy, Tibet and Uganda with Care and Share Foundation, India with SIM, and to the Czech Republic and Armenia with

Distribution of doctors

PRIME. The work has ranged from obstetrics in a busy rural Indian hospital to health needs assessment in Tibet. I have enjoyed working with different organisations and seeing how things can be done. I have discovered my niche is in medical education, which I have done in my last four trips.

There have been many memorable experiences for me both as a Christian and as a medic. These are often times when I draw closer to God, away from my iPod, emails and various commitments back home. I have witnessed how you can sing 'Blessed be your name' in the midst of an African famine when many of the congregation do not know where the next meal will come from, yet are still able to glorify his name, and clutched a child with polio in Tibet. These are experiences I will always cherish.

I would highly recommend all juniors to undertake some form of short-term trip. Not only do you witness what God is doing in his kingdom, keeping a perspective on medicine in the world outside the manic NHS, but you gain valuable clinical and teaching experience you would not otherwise receive in the comfort of UK practice. It has also facilitated leadership training and healthcare management as I experienced alternative healthcare management in other countries first hand. The UK training programme actively encourages such experiences and, overall, my supervisors have been wholeheartedly supportive. So, what are you waiting for?

The end of Foundation Training marks what I am waiting for. At the end of FY2 I'm taking a year out to practise medicine in the developing world. What are you waiting for? Get reading, get praying, get talking: be inspired!

(I am grateful to Genie Lee and to Vicky Lavy for inspiring and challenging talks about medical mission overseas at the CMF roadshow. A useful resource is *I Could Do That!* reviewed on page 21)

Katy Barker *is an FY2 in Leeds and Series Editor of Juniors' Forum.*
Eugenia Lee *is a GP with special interest in public health in SE London.*

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6. Luke 12:33
7. Acts 4:32-35
8. Isaiah 58:10
9. Matthew 19:21
10. Luke 14:12-14
11. Proverbs 19:17
12. Ezekiel 16:49-51
13. *www.worldmapper.org*
14. Matthew 25:40

eutychus

Skin cells to brain cells?

With dementia and degenerative neurological diseases driving demand for euthanasia and assisted suicide, encouraging research has shown that 20% of skin cells from mice tails could be reprogrammed into neural cells. Lead researcher Marius Wernig described their surprising success as 'one of those high-risk, high-reward projects'. If this research could be repeated in humans, there are claims it could lead to treatments for conditions like Alzheimer dementia and for Parkinson's disease. (David Derbyshire, *Daily Mail* 28 January 2010. *tinyurl.com/y9wyfm5*)

Embryos destroyed for 'minor' disorders

If such research saves embryos, the Human Fertilisation Embryology Authority has triggered a new row about 'designer babies' by permitting destruction during PGD without further HFEA consent of embryos with 116 inherited conditions. Some of these present late in life after decades have been enjoyed, others are not life-threatening or can readily be treated. Pete Sampras has a version of the thalassemia trait yet has won 14 Grand Slams, and historic Marfan's sufferers are thought to include Rachmaninoff, Charles de Gaulle, and Abraham Lincoln. (Lois Rogers, *Sunday Times* 24 January 2010. *tinyurl.com/ydxnklj*)

Protecting children

CMF member Janice Allister who chairs the RCGP's Primary Care Child Safeguarding Forum has announced the updated *Safeguarding Children and Young People Toolkit*. This arose from a joint RCGP/NSPCC collection of educational tools disseminated to all GPs, stimulated partly by Lord Laming's report into the Victoria Climbié tragedy. Elsewhere, the Royal Colleges of Paediatrics and Child Health, Psychiatrists, and GPs have jointly protested about detaining children and young people pending deportation of their families after failed asylum appeals. (Both in *RCGP News*, February 2010: 4)

How much does alcohol cost?

Depends how you look at it. It costs the NHS £2.7 billion a year treating alcohol related conditions, and the overall cost to society is about £20 billion pa. In Scotland alone, adults drink the equivalent of 537 pints of beer, or 130 bottles of wine, or 46 bottles of vodka a year. This is partly because alcohol is so cheap and so available – licensing laws have been liberalised, bars offer promotions, and supermarkets sell alcohol for as little as 11p a unit. CMF has campaigned for licensing restrictions and a minimum price. (*BMJ* 2010;340:c372)

'The cruellest of cuts'?

No, not an article about forthcoming reductions in frontline NHS spending but a scholarly review of circumcision as a religious obligation. Reporting the practice within Judaism (quoting parts of Genesis 17:10-14) and (at greater length) within Islam, the authors also review claims that male circumcision could reduce sexual transmission of HIV from women to men by 60%, such that WHO has described the efficacy of circumcision as 'proven beyond reasonable doubt'. (*BJGP* January 2010:59-61)

Burn out hits all doctors

Dana Hanson, a Canadian dermatologist and the President of the World Medical Association, told the recent Global Forum of Health Leaders' conference that 45% of physicians worldwide are in an advanced state of burn out, with the figure even higher in developing countries. Women doctors have an increased risk of suicide and a significant proportion of all doctors have symptoms of anxiety and depression. 'Physicians should not have to choose between saving themselves and serving their patients', the president said. (*BMJ* Careers, 21 November 2009: GP160)

Working time directive

With reports emerging of conflicts for doctors wishing to work beyond their shift hours, we should note this salutary lesson from the decisions of a live-in care home manager. Rita Longbottom, a pensioner in Southport with dementia, locked herself out of her care home flat, but the manager refused to use her master key to let her back in. She said her shift had ended and she did not wish to violate the EU working time directive. A neighbour alerted a call centre in Bradford which sent a locksmith from Bolton. Reports of how long Rita was locked out range from two to six hours. (*Quadrant*, November 2009: 2)

Ethical advertising for homoeopathy?

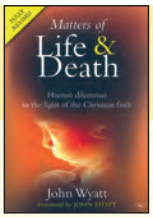
Edzard Ernst, professor of complementary medicine in Exeter, has claimed that the Society of Homoeopaths breaches its own code of ethics by posting 'speculative' statements on its website. The Society's code sets out rules it expects members to abide by, such as not being 'false, fraudulent, misleading, deceptive, extravagant or sensational' but Ernst lists a dozen specific claims on the Society's site for which there is no good clinical evidence. (*BMJ* 2009;339:b4605) Readers who prefer provocative videos to academic articles might like to visit *richarddawkins.net/articles/4057*

Look after our NHS

Talking about being provocative, the British Medical Association has spent a lot of members' money on its campaign 'Look after our NHS – publicly funded, publicly provided'. This has included sending out posters and an impressive 32-page booklet: *Warning! NHS market reforms are damaging our health service* which helpfully reviews history and gives a good evidence base for the BMA's 'Eight Principles for a public NHS'. (*www.lookafterournhs.org.uk*)

Free at the point of delivery

With the General Election looming, Eutychus is getting tired of everybody's slogans and soundbites, so enjoyed the different take of the BMA's *Hypocritus*: 'These days, methinks that the phrase 'free at the point of delivery' might be better suited as an advertising logo for a less-efficient security company that transports prisoners from court to jail'. (*BMA News*, February 13 2010: 11)



Matters of Life & Death

Human dilemmas in the light of the Christian faith

John Wyatt

IVP/CMF 2009
£12.99 Pb 303pp ISBN 978 1 84474 367 4

This substantially updated second edition examines ethical dilemmas at the beginning and end of life. Written by a Christian professor of ethics and perinatology, the philosophical, theological, legal and medical aspects of these issues are discussed in a real-world setting.

The book starts with reviews of well-known UK medical cases that have presented ethical challenges. The first chapter examines the contemporary worldview of humanness, society and medicine. The next presents biblical perspectives on humanness, suffering and redemption. Subsequent chapters scrutinise reproductive technology, biotechnology and stem cells, and include new sections on regenerative medicine and saviour siblings.

A historical perspective on abortion is presented, then the Christian understanding of personhood. Wyatt demonstrates how he brings Christ's love into his work in 'The dying baby'. Assisted dying and attempts to change UK legislation are then analysed. The book finishes with a challenge to the Christian doctor to be distinctive, and to be inspired by the biblical understanding of humanity's future.

This book excellently combines well-referenced philosophical and medical discussion with clear biblical exegesis. Wyatt's personal faith shines through and his clinical experience makes this book essential reading.

Claire Stark Toller *is an SpR in Palliative Medicine in Oxford*

Travelling Light

Daily Bible meditations for student electives

Various authors

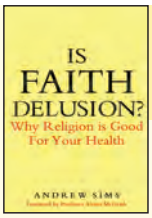
CMF 2009
£4.95 Pb 139pp slim ISBN - N/A

Travelling Light is a daily Bible meditation containing a mixture of thoughts, readings and stories from doctors, nurses and students who have spent time abroad. It is split into weekly chunks under headings including 'Hope', 'Reliance on God', 'Dealing with death, suffering and inadequacy' and 'Rising above the day to day'.

This book is a real companion for those spending time abroad and confronted with abject poverty, new cultures, different types of healthcare, and perhaps a face of Christ that is less than familiar. The Bible readings challenge yet comfort, and encourage deeper trust in God. There is a great sense of solidarity in the pages, not only from people in the Bible who have gone before but also from the contributors.

My advice is this: buy the book but resist the temptation to read it before you go on your elective or mission trip. You will then discover a fresh perspective from your heavenly family at a time when you may well feel in need of people who understand the joys and the difficulties of working for Christ abroad.

Katie Dexter *is an intercalating medical student from Leeds*



Is Faith Delusion?

Andrew Sims

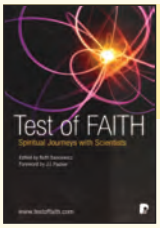
Continuum 2009
£14.99 Pb 237pp ISBN 978 1 84706 340 3

Andrew Sims, CMF member and former President of the Royal College of Psychiatrists and professor at Leeds, considers the question: is faith delusion? He presents the evidence concerning religion and mental health and explains why it is not. Ranging widely, he includes a chapter on the history of psychiatry that recalls Freud's statement that belief in God is delusional.

He finds the great majority of studies show a positive association between faith and mental health. Religious belief conveys a health advantage for conditions including depression, anxiety, psychosis and substance misuse. Spiritual healing through prayer is considered and its efficacy found to be weakly positive, although more rigorous research is needed. The relation between religion and personality is covered in depth.

Andrew Sims speaks with integrity from his professional and personal experience. He says attitudes have changed such that it is acceptable to allow patients to discuss how their beliefs relate to their mental illness. He provides evidence for why this should be encouraged. This authoritative book is a valuable resource for all who work in mental health and seek to justify the importance of spiritual care therein, and for others who wish to learn about belief and wellbeing.

Clare Cooper *is Associate Director of PRIME (Partnership in International Medical Education)*



Test of Faith

Spiritual Journeys with Scientists

Ruth Bancewicz

Paternoster Press 2009
£7.99 Pb 192pp ISBN 978 1 84227 661 7

I was not expecting this to be the read it was, despite being a scientist of sorts – well, aren't all medics? I am easily confused by complex scientific concepts and I expected to be confused. However, this is not so much a book of science as a book of stories of scientists and how they became able to reconcile science and faith. At the end of each chapter there is a meditation from the scientist featured.

This book is easy to read, although relatively easy to put down as each chapter is complete in its own right. There is an accompanying DVD, to be used with a study guide and leader's guide for small groups. This focuses more on the issues at the interface between faith and science, providing a format for discussion.

This book does not explain or apply science but shows its impact in real life. If you want to work through how science and faith fit together, this may not be the place to look. If you want to see how people live with science, faith and integrity, then it's a good place to go.

Charlotte Hattersley *is a GP in East Yorkshire and works for CMF with younger graduates*

I could do that!
15 short accounts of working overseas
Andrew Fergusson and Steve Fouch (Eds)

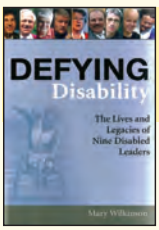
CMF 2009
£6.95 Pb 79pp ISBN 978 0 90674 739 1

These compelling stories, modestly written, demonstrate how Christian doctors, nurses and midwives have followed God's prompting and made important contributions to the health of the communities they have gone to serve. Probably none of them had any idea where their obedience would lead, but the stories describe their progress and achievements step by step. These are ordinary people doing extraordinary things. The role of mentors in offering support and encouragement was central in many cases.

For those with a vision for mission, this is a heart-warming read. Anyone testing whether he or she should go into a mission setting, whether overseas or in their own country, will find this book challenging and encouraging. It could be the confirmation they need.

This book is not only for healthcare professionals. It would help those in a church setting to consider whether a candidate wanting to do this work will be able to cope with it. Friends and family of someone going out to the mission field would gain an insight into the opportunities and experiences of those who have already trodden this path and proved God's faithfulness.

Liz Capper *chairs Christian Nurses & Midwives*



Defying Disability
The Lives and Legacies of Nine Disabled Leaders
Mary Wilkinson

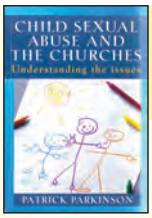
Jessica Kingsley 2009
£17.99 Pb 224pp ISBN 978 1 84310 415 5

This book examines nine high-profile disabled people and how their achievements influenced British disability politics over the last 40 years. It provides remarkable insight into those disabled lifelong with a range of conditions. As a disabled doctor, I anticipated a source of inspiration, yet struggled with this book and only diagnosed why near the end.

The book profiles well-known personalities including Jack Ashley, who defied deafness to become an MP, and Tom Shakespeare, the achondroplastic academic. Shakespeare made a film about his daughter, who of course inherited his genes, only to hear a colleague say 'How could Tom have gone and had a child knowing there was a strong possibility she would be disabled?' A recurrent fear underlies: 'How disposable are we, the disabled?' Unsurprisingly, most are against eugenics and euthanasia.

The struggle for acceptance runs through the book. While I admire the determination of these nine people, it left me sad that wheelchair Olympian Dame Tanni Grey-Thompson concluded that to be accepted, 'performance was what counted'. How much stronger would these remarkable people be if they found that Christ's estimate of everyone, 'disabled' as we all are, is that each of us is priceless?

Mark Houghton *is a part-time GP in Sheffield*



Child Sexual Abuse and the Churches
Understanding the issues
Patrick Parkinson

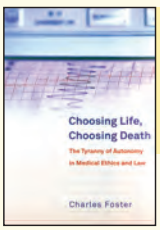
Aquila Press 2003
£8.99 Pb 321pp ISBN 978 1 87696 056 6

This author pulls no punches in tackling tortuous and challenging issues in this updated edition of his 1997 book. An Australian law professor specialising in child protection, he shows remarkable insight into these intensely painful areas of human experience, from the perspectives of child victims, adult survivors, family members, church leaders and indeed perpetrators.

He does not shy away from exploring some of the most difficult questions facing churches and individual Christians. These include providing sensitive and appropriate accompaniment for abuse survivors, and the necessity of facing up to current abuse occurring in church families and within church activities. He also examines the time and place for forgiveness, grace and repentance.

Many Christian doctors are sought out by patients, family, friends and churches on such issues, and this book provides a resource for informing, supporting and perhaps educating those who look to us for wise counsel and support. 'Child protection awareness' may be familiar to professionals but is rarely ventured into voluntarily. I will certainly be sharing my copy with those able and willing to read it.

Ruth Cureton *is a GP in Surrey and Trustee of the Trauma and Abuse Group.* www.tag-uk.net



Choosing Life, Choosing Death
The Tyranny of Autonomy in Medical Ethics and Law
Charles Foster

Hart Publishing 2009
£22.50 Pb 189pp ISBN 978 1 84113 929 6

Charles Foster concedes: 'In many ways this book is utterly trite. It states something that is obvious – that medical law and ethics, dealing with the whole of the immensely variegated human condition, needs to listen to other principles as well as autonomy.' Yet this book is an important challenge to the dominance of autonomy in medical ethics and law.

Having summarised autonomy's dominance, he goes on to consider the place of autonomy in laws relating to abortion, consent to treatment, the end of life, and other issues. One conclusion is that, while judicial decisions appear to defer to autonomy, the courts do employ other principles. The problem, however, is that the other principles (such as beneficence and justice) are often employed implicitly, giving the impression that autonomy is the only principle.

Recognising these other principles in medical law and ethics explicitly is important because it is necessary for 'intellectual democracy' and thus 'intellectual integrity'. This book will therefore be a useful and thought-provoking resource for those studying or teaching medical law and ethics.

Mark Campbell *trained in medicine, retrained in law, and is currently a visiting tutor in the School of Law, King's College London*

Vincent Acheson explains how a Christian hospital 'lives reconciliation'

Can anything good come out of NAZARETH?[1]

Photo: Nazareth Trust

A Muslim nurse joining Christmas celebrations

In March 1993 David Lipskind, a Jewish Israeli Army reservist, was attacked at a bus stop in Nazareth by two Arabs wielding knives. Stabbed repeatedly, he staggered across the road and called out 'Brother – brother – help – I'm wounded!' His cry was heard by Tewfik Sheikh Sliman, a Nazarene taxi driver and Muslim Arab. Tewfik bundled David into his Mercedes and raced to the Emergency Room at the Nazareth Hospital.

The two clinicians principally responsible for saving David's life were an Arab Christian anaesthetist and a Muslim urologist. Both remain on staff to this day. David was dying – his abdomen full of blood due to a kidney puncture. While Dr Henry Hadad, the anaesthetist, clamped both the abdominal aorta and the inferior vena cava, Dr Basil Fahoum performed what a Jewish colleague later described as 'the fastest nephrectomy I have ever seen – no more than two or three minutes'. David became sufficiently stable to be transferred to a larger hospital in Haifa, where the staff later commented they were not confident they could have saved him.

Had David died, Nazareth would have been transformed from a quiet place where Christians, Muslims and Jews have always co-existed into a focus of inter-communal tension and fear. As it was, evil was turned to blessing as the staff of this Christian hospital, at the heart of the largest Arab town in the Jewish state, showed that hatred and violence need not win.

Two months after David was discharged, Tewfik's father threw a party to celebrate his return to health. Dr Fahoum and Tewfik were honoured by the governments of both Israel and Jordan by being invited to attend the signing of the Peace Treaty between the two countries in 1994.

Nazareth Hospital EMMS / School of Nursing

In 1861 a visionary Christian doctor called Kaloost Vartan arrived in Nazareth and set up a 4-bed clinic. This became an expatriate medical mission belonging to the Edinburgh Medical Missionary Society and is now a modern general hospital, staffed by Israeli citizens. The EMMS was wound up in 2001, but remains registered in Scotland as an independent charity known as 'the Nazareth Trust'. Today our 25 acre site is home to a hospital, an excellent School of Nursing, and the 'Nazareth Village'. The hospital has 147 beds, a catchment of around 250,000 and 50,000 A&E visits per year (many more per inpatient bed than any other hospital in Israel).

The School is about to start delivering Nursing BA degrees. Local families are happy to have their daughters enrol as students because they see the caring pastoral ethos. Thus 70% of the student body are young Muslim women, who are taught the medical ethics which will underpin their careers from a specifically Christian perspective.

Living reconciliation

How does a medical mission remain relevant in the 21st century? Every case is unique. Answers will depend on the context of the ministry as well as the services it provides. Any ministry which retains relevance will have an essential feature which sets it apart from humanitarian endeavours.

Our campus overlooks the town, and many years ago acquired the name 'the holy hill'. Under Ottoman, British and now Israeli rule, we have welcomed and treated all, irrespective of background, and have gained the trust, affection and respect of all groups. Today, Jew, Muslim, Druze and Christian are all represented among both staff and patients. Thus – working as we always have 'in the name of Jesus' – we live out a testimony of peace, collaboration, co-existence and mutual respect which has much to offer the Holy Land. Put shortly, 'we live reconciliation'.

'Living reconciliation' is hard to analyse, but easy to describe. It is the Muslim nurse screening Ethiopian Jewish immigrants for tuberculosis, the Chaplain befriending an elderly Bedouin patient, Muslim nurses and families joining with Christians carolling on Christmas Eve in the paediatric ward. In June 2009, the ultra-Orthodox-Jewish Israeli Health Minister, the (Arab) Anglican Bishop of Jerusalem, and our Muslim operating room manager were joined by the US and British Ambassadors at the cutting of the ribbon when we opened a new surgical complex.

Going forward

We want to remain valid, relevant and vibrant to the end of our second century in Nazareth, and beyond. We need to remain true to our distinctive heritage and to develop. We want to ensure Christ remains at the centre of each strand of our service; to make best use of our land and resources as we 'Heal, Teach and Serve'; and to 'build bridges' between Christians in the Holy Land and Christians elsewhere, to bless those outside Israel and to support our work.

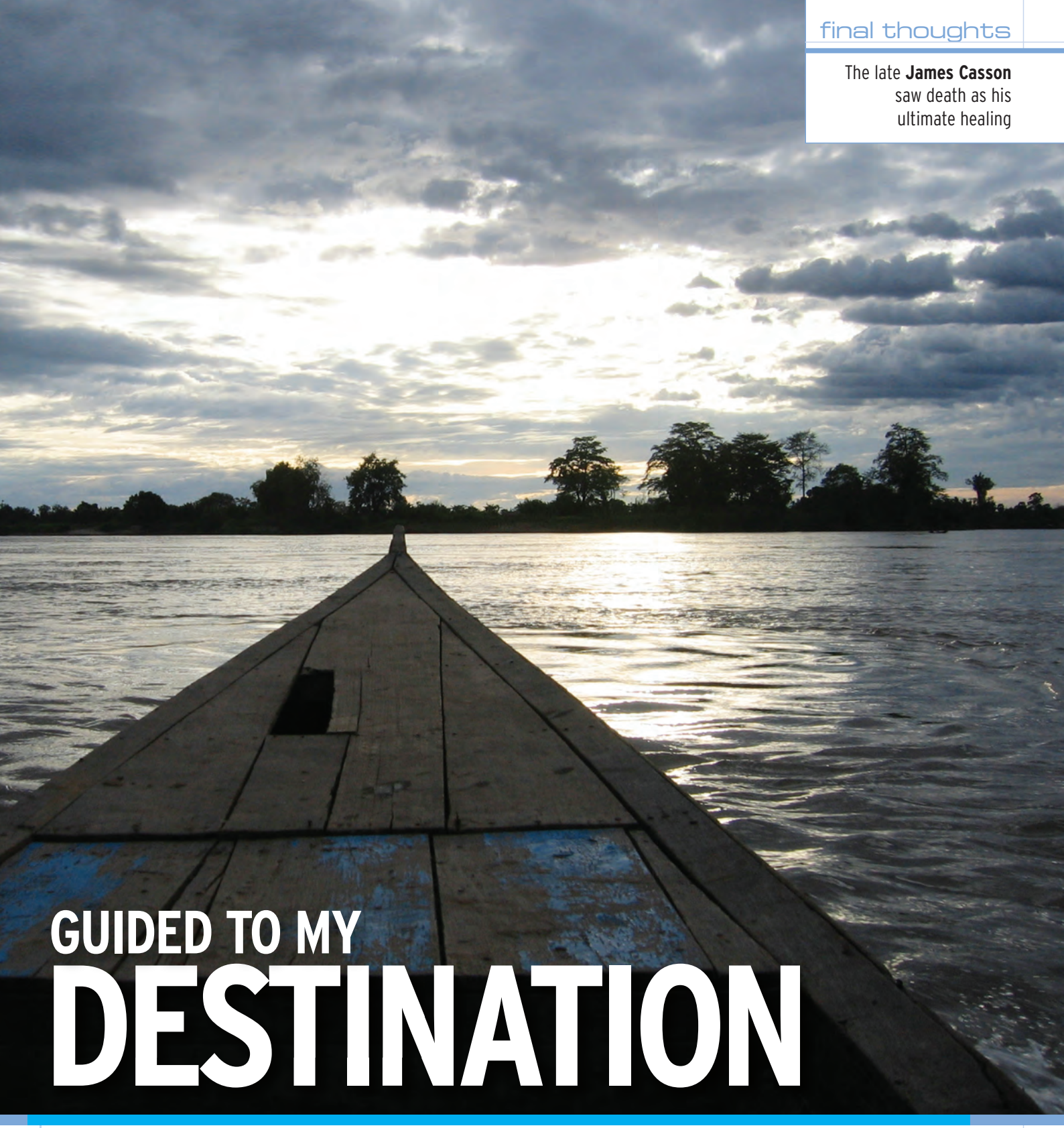
2,000 years ago Nazareth was home to God made flesh – Jesus Christ. Today we work in his name to demonstrate his unconditional love in ways which seek to make a uniquely Christian difference to his home town.

Vincent Acheson *is Head of Programmes for the Nazareth Trust, responsible for re-establishing links between Nazareth and Christians in the UK. See* nazarethtrust.org

reference

1. John 1:46 (NKJV)

The late **James Casson** saw death as his ultimate healing



GUIDED TO MY DESTINATION

In all the frenzied media debate about euthanasia and assisted suicide, the question of what lies beyond death is almost never raised. Thirty years ago, CMF's best selling book was published posthumously.[1] Its concluding passage is immensely relevant.

A young family doctor, James Casson died of a malignancy in 1980 after a long illness. He recorded many of the lessons he learned during that difficult process and describes the outcomes of various prayers for healing. He was not cured and struggled with this, and with his feelings about how to pray and be prayed for. He ends:

However, the conflict of whether 'I was doing everything correctly' did trouble me. Release came with the realisation that the whole issue was out of my hands. One morning I had a clear picture that I was in a boat. Before, when asking for healing, it was as though I was in a punt where one stands at one end pushing on the punt pole and steering with more or less expertise.

Afterwards, I was in a rowing boat, my back to the direction I was going, but travelling in a much more leisurely fashion. The great joy was that the Lord was at the tiller, his face gently smiling and his eyes twinkling as he quietly guided me to my destination.

Was I healed? Yes I believe I was.

reference

1. Casson JH. *Dying - the greatest adventure of my life*. Republished with Casson P. My Cancer. CMF, London 1999. *www.cmf.org.uk/bookstore/?context=book&id=51*

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