

for today's Christian doctor

triple helix



CMF at 60

assisted suicide, adoption, busyness, whole person medicine, MDG 6, abortion, harm reduction, reviews, the wider horizon

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Assisted suicide: amendment defeated

What is not broken does not need fixing



On 7 July the House of Lords rejected by 194 to 141 a change in the law on assisted suicide.¹ Lord Falconer's amendment 173 to the Coroners and Justice Bill² would have exempted from investigation and prosecution those who help terminally ill people to travel abroad to seek assisted suicide where legal – in effect, Switzerland.

The amendment was the culmination of a carefully orchestrated campaign by Dignity in Dying (formerly the Voluntary Euthanasia Society), built around perceived public sympathy for high profile cases of people taking relatives to end their lives at Ludwig Minelli's 'Dignitas' facility in Zurich. Ironically the clause they were attempting to amend had been designed for another purpose altogether, to prevent internet promotion of suicide.³

The amendment's resounding defeat by 53 votes (larger than the 48 in May 2006 for Lord Joffe's 'Assisted Dying' bill), followed strong opposition from senior legal figures,⁴ senior doctors,⁵ disabled people's leaders⁶ and faith leaders⁷ and a robust debate in the Lords itself where the serious objections were eloquently laid out. Once again in this matter, by God's grace, sanity prevailed.

Six days earlier the British Medical Association, at its annual representative meeting, had rejected a two part motion (370) on assisted suicide. The first part, calling for the BMA to support legislation to 'ensure that those accompanying the patient at an assisted death, but not actively participating, will not be subject to criminal prosecution' was defeated by 52.6% to 44.4%. The second part, supporting a legal change to 'allow the choice of an assisted death by patients who are terminally ill and who have mental capacity' was lost decisively on a show of hands.⁸

Baroness Iora Finlay, Professor of Palliative Medicine in Cardiff, and Suffolk junior doctor Helen Grote spoke strongly against the motion, emphasising issues of public safety. BMA Council Chair Hamish Meldrum and Ethics Chair Tony Calland, although emphasising this was a conscience vote, drew attention to the imminent Lord's debate and the profession's historical opposition to assisted suicide.

In the same week, senior lawyers, among them former Chancellor Lord Mackay, had labelled Falconer's amendment 'ill-defined, unsound and unnecessary'. In a comprehensive clinical briefing, senior doctors led by Ian Gilmore, President of the

Royal College of Physicians, had criticised its vague wording and branded it 'wide open to manipulation and abuse'. Over 30 leaders of the disabled people's movement in the UK and USA, led by disabled peer Baroness Campbell, had warned it would 'undoubtedly place disabled people under pressure to end their lives early to relieve the burden on relatives, carers or the state'. 'We are scared now', they said; 'we will be terrified if assisted suicide becomes state-sanctioned'.

A cursory examination of Falconer's amendment confirms why there was so much concern. 'Terminally ill' was not defined and could have applied to people with a wide range of chronic progressive illnesses, some with life expectancy stretching to decades. The 'assessing doctors' were not required to know, to see, nor to examine the person in question nor even to review the case notes; nor was it necessary they possess the requisite training, experience and skill necessary to make sound judgments about prognosis and capacity.

Ethics aside, on pragmatic grounds alone a majority of Peers could see that especially at a time of economic recession with imminent health cuts, with growing numbers of elderly people, and with increasing levels of elder abuse, the last thing needed was to put elderly, sick or disabled people under pressure to end their lives through a change in the law. Many of them already believe they are a financial or emotional burden.

The current law's blanket prohibition of all assisted suicide is both clear and right and has stood the test of time. The penalties it holds in reserve give it both a stern face to deter would-be abusers and a kind heart to enable judges to exercise compassion in hard cases. The Falconer amendment would have created legal confusion by loosening a law the government intends to tighten, to stop internet suicides. What is not broken does not need fixing.

The next day newspapers reported a case where it was alleged a woman had tried to murder her husband who has motor neurone disease, after learning insurers would pay a six figure sum if he died.⁹ It was a chilling reminder that not all family members necessarily have the best interests of their 'loved ones' at heart, and why the law must stay as it is.

Peter Saunders is CMF General Secretary

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Swine flu

The global pandemic highlights the gap between rich and poor

Review by **Helen Barratt**

SpR in public health, working with swine flu

Reports of illness caused by the novel virus, influenza A/H1N1v, known as swine flu, first emerged in Mexico in April. On 11 June, the World Health Organisation (WHO) raised the worldwide pandemic alert to Phase 6, indicating that a global pandemic is underway. This reflects the fact there are now ongoing community level outbreaks, with person to person spread, in multiple countries. On 15 June, 76 countries had reported 35,928 cases and this may be a considerable underestimate.¹ The highest number of cases has been reported in the USA, followed by Mexico, Canada, Australia and Chile.

Globally, 163 deaths have been attributed to the illness.

At the time of writing, over 2,500 cases have been reported in the UK, with the West Midlands, Scotland and London being particularly badly affected. Much remains to be unravelled about the virus and its epidemiology, but the highest number of cases has been among males

aged 10-19. 39 people have been admitted to hospital, while one patient in Scotland is believed to have died as a consequence.

The UK was thought to be one of the countries best prepared to cope with a pandemic, although the source was not avian influenza from South East Asia, as many had been anticipating. The Health Protection Agency (HPA) in England, and equivalent bodies in Scotland, Wales and Northern Ireland, have taken a proactive approach to containing the virus. To date over 60 schools have been closed at some point due to confirmation of one or more cases in pupils or staff members.

There is much we still don't know about the behaviour of the virus, but there are concerns that countries in the northern hemisphere will see a second, potentially more devastating 'wave' of influenza activity during the normal autumnal flu season this year, as occurred during previous global pandemics. Even if symptoms remain mild, a flu-like illness affecting a large proportion of the working population could have a

detrimental economic impact in already troubled times. The consequences for healthcare delivery, of both staff illness and a potential sudden surge of patients, also warrant consideration.

Looking beyond our borders, the rapid inter-continental spread reflects globalisation and a culture of easy international travel. But the global spread of swine flu further highlights the yawning gap between rich and poor.² While Western countries invest considerable amounts in containment and mitigation policies, many developing countries will struggle to implement any such strategies in the face of limited healthcare resources.

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Abortion advertising on TV?

A BMA debate

Review by **Mark Pickering**

GP and CMF regional secretary in York

Back in March I went to a local BMA meeting to submit some motions for the ARM (annual representatives' meeting) on 29 June-2 July. At the time there was media coverage of a potential relaxation of advertising rules that could see abortion providers advertising on TV. So I wrote a motion against it, which was accepted, and forgot about it, until an *Observer* journalist called me during afternoon surgery a couple of weeks before the ARM. Then a few days later the *Mail on Sunday* wanted some quotes, then Radio 4 Woman's Hour. Only the *Mail* actually ran anything, and that with an unhelpful headline,¹ but it was generating interest!

The motion was based on the Broadcast Committee of Advertising Practice consultation, considering revisions to the code, which was out to public consultation until 19 June. It proposed relaxing the rules on 'post-conception advice services', which would include both abortion providers and crisis pregnancy counselling centres. It also

proposed forcing such services to be explicit about whether or not they referred directly for abortion.²

The motion was debated at the ARM on 1 July, just before a motion on assisted death. It was clearly going to be controversial. I put the case that the BMA should oppose the move, as it would be:

- *Unnecessary* – as information on abortion is readily available, and any woman who wants an abortion can find one already;
- *Discriminatory* – as only the big, government-funded abortion providers like BPAS and Marie Stopes would be able to afford TV advertising, and this would effectively exclude not-for-profit crisis pregnancy counselling centres;
- *Giving the wrong message* – as raising the profile of abortion services would further permeate the message that unwanted pregnancy is not such a big problem, because there's always a safety net.

Furthermore, I called for existing sex and

relationships education to be values-based, to counter the values-free messages coming from an oversexualised media. Sadly the motion fell. But it gave me some great conversations, including one with one of the speakers against the motion.

It left me with renewed optimism in the opportunities for effecting change through local BMA divisions, along with some valuable lessons about tightening up the wording for future attempts!

In the meantime, let's pray that the ongoing deliberations on advertising rules won't result in abortion TV ads – we expect the decision in the autumn.

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Spirituality in the NHS

Still belongs at the frontline of healthcare

Review by **Steve Fouch**

CMF Head of Allied Professions Ministries

The case of Caroline Petrie, a community nurse suspended for asking a patient if she wanted prayer, hit the headlines in January and created a national and international storm.¹ It prompted Bernadette Birtwhistle and others to table motions at the BMA ARM recognising the importance of spiritual care,² and that doctors and other health professionals should not face censure for offering prayer and other spiritual support. While the meeting supported the former it rejected the latter, although as ARM Chair Peter Bennie reminded the meeting, even if they did not pass a motion, it did not mean that the opposite held. We hold that spiritual matters still belong at the frontline of healthcare.³

This January, the Department of Health quietly issued equality and diversity guidelines for NHS trusts on religion and belief.⁴ While containing much of use, they are also extremely vague and open to interpretation on issues to do with expressing faith in the workplace.⁵ At the same time the Employment Equality (Religion or

Belief) Regulations (2003)⁶ make it unlawful to discriminate against people on the grounds of their faith. The legislation and the guidelines differ, and are open to wide and often contradictory interpretations, so creating ambiguity and confusion for NHS staff and management.

There is a major gap in health policy on spiritual care, in England in particular. While the Scottish Executive has required all Health Boards to develop policy since 2002,⁷ and similar guidelines have been developed by the Welsh Assembly, there is nothing comparable in England. Some centres, such as Southampton,⁸ have developed spiritual care policies and staff training programmes, but the overall picture is poor. A recent *Nursing Times* survey showed that although most nurses saw spiritual care as an appropriate role, most felt there were inadequate guidelines and a lack of training and support.⁹

Caroline Petrie's case was not unique. She and others we know of admit that professional bodies and trade unions are just as unclear about the rights and wrongs of these situations. CMF, Christian Nurses and

Midwives¹⁰ and the Christian Legal Centre¹¹ are supporting those who have been affected. Caroline sees her case as catalysing the debate on the wider issues of the place of Christian faith, prayer and spiritual care in the NHS.¹² It is important we do not ignore this challenge, but see it as an opportunity to speak up for Christ in the NHS.¹³

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Organ Donor Campaign

Mobilising faith communities

Review by **Andrew Fergusson**

CMF Head of Communications

In polls, 90% of the public say they support organ donation, but far fewer are actually on the NHS Organ Donor Register – by this July the number was only 27% of those eligible (although up from 20% in the last year).¹ The Organ Donation Task Force concluded in 2008 against a national policy of presumed consent, that people should have to 'opt out' rather than 'opt in', thus agreeing with the recommendation CMF made as we endorsed organ donation when it is an altruistic free gift in a context of fully informed consent.²

The Department of Health has redoubled efforts to increase donation rates, and there are to be 197 new clinical leads and 197 new 'lay champions', one for every acute trust, as well as 63 new transplant co-ordinators. (It is this approach utilising better communication and co-ordination on the ground, rather than their presumed consent policy, which probably accounts for the higher transplant rates in Spain.)

'Black and minority ethnic' (BME) communities in the UK have a higher prevalence of the diseases requiring transplantation, but also a much lower proportion of their members on the register, meaning that appropriate tissue matches are less likely. The Organ Donor Campaign (ODC) has come into existence largely to fill this BME gap.³ It seeks to reach BME groups through their respective faith communities, and began at the grassroots in the north west, after several highly motivated young people separately lost close friends who died while on a transplant waiting list, and was launched with a fanfare in Parliament in January.

CMF has been in contact since the beginning, and is advising about reaching the Christian community. At a meeting in Manchester this July, CMF along with senior denominational figures took part in a workshop to explore these issues. Other faith-specific workshops will involve the five other major religions in the UK. Working

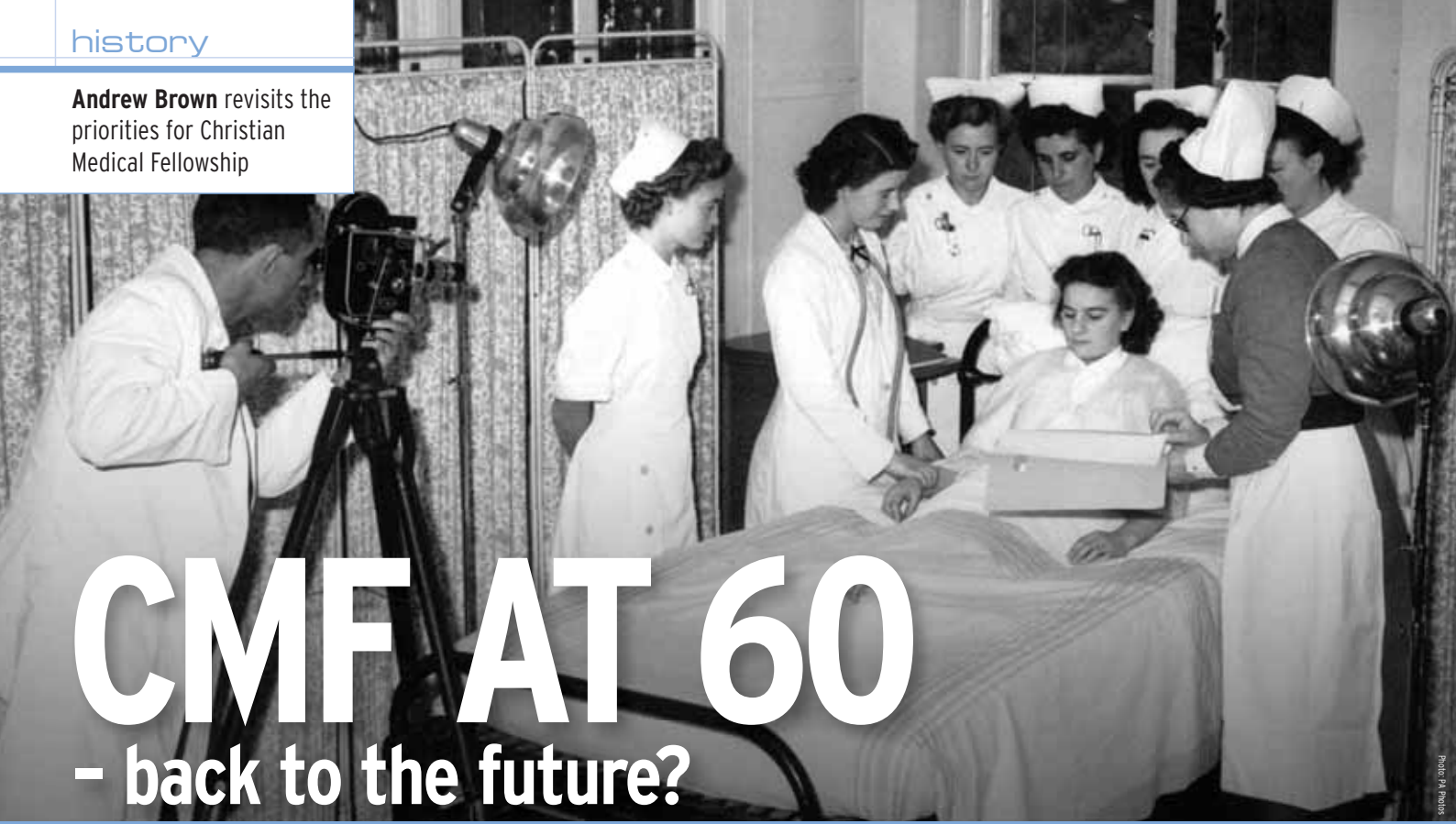
with the Department of Health, the ODC have already trained 60 Manchester students to go out across the north west to raise awareness (without any hard sell) of the gap between supporting the concept of donation and actually going onto the register. Their slogan is 'Have you talked about it?'

The Manchester students mainly come from Hindu and Muslim backgrounds, and their campaign further challenges Christians to consider for themselves whether they should register. CMF acknowledges some ethical controversies but believes Christians should support organ donation.⁴

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Andrew Brown revisits the priorities for Christian Medical Fellowship



CMF AT 60

- back to the future?

key points

Recognising the risk that retrospective views are inevitably rose tinted, the author recounts the history of CMF's foundation in 1949 and shares some personal reflections on Dr Douglas Johnson.

He reviews the subsequent period of momentous change for the profession and society at large, and notes the current target-driven, over-regulated health service with its reduction in the influence and power of doctors.

If the founding fathers could consider continuing Christian witness in these complex times, they would still stress the priorities of prayer, a boldness to speak up for Jesus Christ, and consistent Christian living as the most powerful weapons in our armoury.

The older I get the more vivid is my recollection of things that never happened.

(Mark Twain)

The problem with looking back in time is that it is almost as inexact a science as predicting the future. Even if accurate records are available, it is an enviable skill to be able to place events in their proper perspective as far as their true relevance and importance are concerned.

For many of us nearer the end of our careers it is generally when looking at old photographs, or viewing old films and television programmes, that we are confronted with the enormity of the changes in political, professional and social life that have taken place over a working lifetime. This evidence, combined with the natural conservatism that usually comes with age, risks a 'rose tinted' retrospective view as we fondly look back to a 'golden age' of the medicine of our younger days. We wistfully remember (probably correctly as it happens) the vitality of Christian life and witness that we recall as students. The risk of such a sentimental view is particularly strong when we reach a milestone as notable as a 60th anniversary!

Founding father - the role of Douglas Johnson

My own contact with CMF came shortly after I entered medical school in 1969 with a career aim of training in maxillofacial surgery, having already completed a dental degree. As a not so young medical student, I was approached to see if I would take over as the 'CMF Students' Representative'. Thus I was introduced to the man who was probably more responsible than any other for promoting the

vision of a Christian witness in the profession, and who ensured that the Fellowship prospered during the 25 years he served as its first General Secretary. Despite his natural reticence and antipathy to taking the limelight, Dr Douglas Johnson (known to all simply as 'DJ') was a seminal figure in the world of student witness in the universities and colleges during the first half of the 20th century.

A graduate in arts, theology and medicine, he had been General Secretary of the Inter-Varsity Fellowship since its inception in 1928 (renamed the Universities and Colleges Christian Fellowship in 1975). In response to a stimulus from W M 'Bill' Capper (later Professor of Surgery in Bristol and a joint Editor of 'Bailey and Love') he established a medical section of the graduates' division of the IVF in 1947. Shortly after this the leaders of the Medical Prayer Union, which had a long and honourable history since its foundation in 1874, suggested that merging the two groups would be sensible in view of shared aims and purposes. Thus the CMF was born in 1949, less than a year after the founding of the NHS, with an initial membership of 6-800. The MPU ('it did exactly what it said on the tin' - a continuing challenge to our own lack of prayer!) simply asked that CMF continue their regular breakfast meetings at the annual BMA conference. This evangelistic opportunity continues to this day, usually with the BMA President in the Chair, and there have been many distinguished speakers.^{1,2}

There were, of course, many other significant contributors, but since his name and considerable influence will be unknown to many, it is only fitting to pay tribute to the very important role that DJ played behind the scenes in so many areas. Bishop John Taylor ended his *Times* obituary: 'Little known in mainstream Christian circles and virtually

unknown outside of them, Johnson did much to shape the church of the 20th Century’.

Coping with change

How has CMF developed since? Most change is incremental of course and we inevitably adapt to it as it happens. This is as true for institutions as for individuals. The challenge for Christian organisations and for us as individual Christians is to remain loyal to our calling and purpose in the face of change.

This does not mean we should fossilise into an irrelevant *status quo*, but equally it does not mean we should just ‘go with the flow’ and mould and compromise our faith to fit the prevailing worldview. The challenge for the Christian is always to be a ‘radical conservative’ – remaining true to Christ’s teaching and a biblical worldview while engaging with and challenging the secular worldview that increasingly prevails, not least in modern medicine.³

During the past 60 years CMF has had to grapple with these issues and many more during a period of momentous change for the profession and society at large. It has even been suggested that the rapid therapeutic advances in many areas that took place during the four decades after the Second World War represent a highpoint of medical scientific progress which will possibly never again be repeated in such scale and significance over such a short period.⁴ Not surprisingly, with such amazing progress have come increasing ethical dilemmas. With it too has come a questioning of the profession and a readiness to apportion blame. It seems that the more that doctors can accomplish, the less forgiving are patients and society when things go wrong.

Ethical conflicts

In the immediate post-war years, and even to some extent during my own training in the 1970s, medicine was generally formal, hierarchical, conservative in outlook, somewhat snobbishly superior, and often patronising to patients and public alike. However, there was an unspoken consensus that a Judaeo-Christian basis for medical ethics was the safest foundation and many routine aspects of current practice, such as abortion and embryo research, would generally have been thought completely unacceptable.

Battle weary Christian doctors today may feel that too many ethical conflicts have already been lost and flinch at the even greater challenges that loom. We are constantly reminded that ‘all that is necessary for the triumph of evil is that good men do nothing’ – although this pessimistic aphorism discounts the possibility of God’s intervening power and the certainty of an ultimate triumph over evil in Jesus Christ.⁵

Priorities revisited

But I suspect it was ever thus. Each generation brings its own problems. Although much has changed since the days of sports jackets and

sensible tweed skirts for medical students (I’ve been looking at those old photos again!) the actual issues facing Christians in the profession today remain in many ways the same.

Yes, the founding fathers of the CMF would not recognise our target-driven, over-regulated health service with its reduction in the influence and power of doctors. Yes, they would have no conception of the interventional power of modern medical techniques. Yes, they would probably be surprised at how quickly atheistic, materialistic secularisation has triumphed in Britain today. But they would still stress the priorities of prayer, a boldness to speak up for Jesus Christ, and consistent Christian living as the most powerful weapons in our armoury. If we fail to make an impact as a Christian organisation or as individual Christians the reason is usually not far away from these neglected priorities.

Back to the future

The interesting question, as always, is to ponder what the senior CMF members of 60 years ago would make of the CMF that has emerged and developed over the last six decades. I think they would be amazed at the growth in staff numbers and the size and budget of the current organisation. They would marvel at the quality and professional look of our publicity and publications, although they would have no idea what a website is! They would no doubt be encouraged by the growth of student activities and the literature and staff which supports them.

I suspect they would be quite surprised at the activism that has resulted in increasing involvement in public policy debates. Most would be supportive and perhaps a few critical of this move (including I suspect DJ himself) – possibly fearing a diminution of gospel effort and a dilution of evangelical distinctiveness. This debate no doubt continues!

However, I wonder if the founders would be concerned at a lack of active involvement in the Fellowship by many who would consider themselves as Christian doctors? The rather selfish individualistic ethos of our current society has crept into the church, and many modern Christians are not ‘joiners’ or willing to commit time and effort to gospel causes as in the past. Perhaps too they may be concerned at the risk of relaxing into a ‘maintenance mode’ with a temptation to confuse busyness and activity with effective Christian witness.

Looking back, we can only be grateful to God for all that has resulted from the founding of the CMF sixty years ago. Looking forward, we must pray and work to maintain the basic priorities set by those who responded to the need for the medical world to be confronted with the claims of Christ.

Andrew Brown is a recently retired maxillofacial surgeon. He was the founding editor of Nucleus and a former editor of Triple Helix



Photo: PA Photos

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Paul and Hilary Johnson have both professional and personal experience of adoption

ADOPTION

– not just a calling for the childless

key points

As paediatric surgeon and child and adolescent psychiatrist, Paul and Hilary Johnson are involved professionally with the adoption of children. They have also adopted two children who are now teenagers.

They believe the wider concept and practice of 'adoption' is at the very heart of the Christian message, and share their personal testimony. Current challenges include international adoption, adoption by single parents and gay couples, and prejudice against Christians.

After words of encouragement and general advice for the 'childfree', they challenge all Christians that it is a central calling for God's people to look after those who have no family of their own.

In the UK, at least 72,000 children and young people are looked after by the state on any given day.¹ Of these, 51,000 (71%) live with temporary foster families (often moving from placement to placement), and in England alone, 6,500 children are living in children's homes which include secure homes and hostels.

Only 4% of children taken into care in England in 2008 were placed for adoption. The average age of those being adopted was 3 years 11 months. Despite over 60% of children in the care of the state being over ten years of age, only 5% of those adopted were within this older age-group. Many children in care face a future of extreme under-achievement, instability, and poverty compared to their socio-economic counterparts.² Only 15% of children in care will achieve more than 5 GCSEs grade A-C, compared to 60% of all children.¹ A report in 2006 by the Centre for Policy Studies highlighted that of 6,000 young people who left care, 75% did so without any qualifications, 50% were unemployed within two years, and 20% were homeless (these figures are slowly improving).³ Of adults in prison, 26% have been in care as children, as opposed to 2% of the non-prison population.⁴

These statistics make desperately sad reading. Although in Christian circles there is much said and written about abortion, there seems to be disproportionately little discussion or action on these 'injustices of childhood' and the need for Christians to address them radically. A number of studies have clearly demonstrated that adoption significantly improves the outcomes for these children in terms of social, emotional, and educational outcomes when compared to both foster care and residential settings.^{5,6}

The aim of this article is to highlight the importance

of 'the calling' of adoption, and to suggest that this needs to be a consideration for all Christian families rather than just the childfree. We write this as a couple who are both involved professionally in the care of adopted children. We also have the personal experience of having adopted two children who are now in their teenage years. We both agree wholeheartedly with the statement of Barnardo's that 'every child has a right to family life'. We also believe passionately that God's people have the resources to help make this ideal a reality.

Biblical precedent for adoption

Although there are clear examples of childhood adoption in the Old Testament (Moses, Esther, and Genubath), the wider concept and practice of 'adoption' is at the very heart of the Christian message. This is seen in three broad ways:

1. God's adoption of us is central to our salvation

In addition to the analogy of 'new birth', we find many references in the New Testament in which our salvation is described as 'God's adoption of us into his family'.^{7,8,9} Indeed, we reflect on this truth in our musical worship each time we sing songs such as:¹⁰

*Father God, I wonder how I managed to exist
Without the knowledge of Your parenthood
and Your loving care
But now I am Your son,
I am adopted in Your family
And I can never be alone
'Cause Father God, You're there beside me*

We are also reminded in Ephesians 1:3-6 that God's adoptive plans for us were integral to his original purposes before the beginning of time.

We read that: '...[God] chose us in him before the creation of the world to be holy and blameless in his sight. In love he predestined us to be adopted as his sons through Jesus Christ in accordance with his pleasure and will – to the praise of his glorious grace.' In other words, this was not just a 'back-up' plan that God developed once he saw that mankind had fallen. It was at the very heart of his creative order. God has adopted us 'in love' so that his grace could be put on display most clearly. John Piper, a leading Bible expositor and strong proponent of Christian adoption, has put it like this: 'Adoption was God's idea...He created the world so that there would be a space, a place, a dynamic, and a people in which he could do this thing called adoption.' A key biblical foundation for the adoption of children therefore is that God's adoption of us is at the heart of our salvation.

2. God's adoption of us has many parallels with our adoption of children

While the heart of adoption is central to our salvation, there are also a number of practical ways in which God's adoption of us mirrors the act of us adopting children. These include the facts that adoption has a personal cost (to adopter and adopted); it often involves rescue from very sad and difficult situations; it involves changing the legal status of the adopted; it makes the adopted into heirs of the person adopting; and it often still involves some suffering in the present with the promise of a fuller glory to come. These parallels (and more) have been helpfully discussed in an article we would recommend entitled 'Adoption: the heart of the gospel'.¹¹

3. Scripture clearly calls God's people to look after the 'orphan'

There are many references in the Bible that remind us of the priority God places on the 'widow and the orphan', and also his ideal design and purpose for the family unit. In James 1:27 we are told that 'religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress...' If our faith is to reflect the heart of God, we need to ensure that we care for those in our society who are 'in distress', with a special emphasis on children who have lost their birth parents. We must remember that the main priority of parenting is raising and looking after children, rather than obtaining pleasure and satisfaction for the parents. Indeed, the biblical perspective of parenting is to enable children to be led into maturity, and – through God's grace and aided by loving, godly, parental example – into a personal relationship with Christ Jesus.

A personal testimony

Like many couples, we spent the first few years of our married life carefully planning when the 'perfect' time would be to have our own children. In our naivety, this timing obviously had to fit carefully with

our different career pathways (one of the biggest distortions of true Christian parenting), and we had also thought we needed to keep a careful eye on the ever ageing ova! We both loved children and our main debate was whether to have three or four.

God's plans were different! In 1995, we discovered we were unlikely to be able to have our own children. This was devastating news. After the initial shock and sense of loss (and we would not underestimate this), we slowly found ourselves being moulded by 'the potter' and being brought into his plans and timings for our lives. We had both had a conviction from the very early days of planning our family that we should adopt a child, although we had always thought this would be in addition to our birth children. Therefore, the transition to adoption for us was not as hard as it might have been.

However, the richness of the journey we had to take to reach the point of eventually adopting a sibling pair was something we can honestly say (in retrospect) we would not have wanted to miss out on. We had to learn first hand what God meant when he said in Isaiah: "For my thoughts are not your thoughts" declares the Lord. "As the heavens are higher than the earth, so are my ways higher than your ways and my thoughts than your thoughts."¹² The whole adoption process made us reliant on God in a way that we weren't before. It opened our eyes to needs in the UK, and further afield, that we would not have encountered purely in our professional roles. Most importantly it taught us that parenting is primarily about the children. The splendour of being adopted into God's family has taken on a new meaning. Yes, adoption has been hard and costly at times; yes, it has required sacrifices. However, it has been a calling we would highly recommend and encourage other couples to consider.

Current challenges and controversies

In a short article, it is impossible to do justice to many of the challenges and controversies in adoption today. However, we feel it important to highlight a few:

International adoption

In the search to adopt babies or small children, many couples are now looking to adopt from overseas. However, this can present new and different challenges. While adopting babies overcomes some of the early behavioural challenges involved in adopting an older child, the potential problems with cultural identity when the child is older must not be underestimated. In addition, there is increasing recognition that it is important in many situations to maintain some contact with the birth family. Clearly this can be difficult if the child has been removed from their country of birth. God's calling to adoption will be different for different couples, and meeting the needs of children from all different backgrounds is all part of God's overall purposes.

Adoption by single parents

Although society would try to persuade us differently,



Photo: M. Phillips

The whole adoption process made us reliant on God in a way that we weren't before



at the centre of the biblical concept of a human family is the stable and loving marriage relationship between male and female. In the UK however, potentially anyone is now eligible to adopt if they are over 21, as long as they can provide a permanent, caring, and stable home. This eligibility is regardless of marital status, sexuality, race, religion, and whether the individual is in work or has a disability. In 2008, 9% of all adoptions were allocated to single parents. Although single parent adoption does not provide the biblical two-parent model of family, it can provide stability for a child who has moved from foster home to foster home, or has been placed in an institutional setting. Further, in cases of severe sexual abuse etc, it may occasionally be the preferred option.

Gay adoption

Since 2005 it has been possible in the UK for gay people to be considered as adopters. Indeed, the legislation now states that gay adopters must be assessed equally with heterosexual couples. While this is clearly at odds with the biblical view of family, it must be remembered that the alternative for many children is institutional care. There is currently no good data confirming outcome differences between adoptions by heterosexual or homosexual couples. Interestingly, our own two adopted children were at odds with each other when asked whether they would have preferred to have been adopted by a gay couple or placed in a care institution.

Prejudice against Christian adoption

Over the last few years, there have been increasing examples of Christians being prejudiced against in terms of adoption and fostering, as a result of their desire to affirm their Christian beliefs in the home. As Christians we need to ensure that the Godly principles of family life are maintained, and that Christian couples are not subject to unacceptable anti-Christian prejudice or bias.

A message for the childless

We are aware that some reading this will be undergoing assisted fertility treatments, or having to come to terms with the major heartache of infertility. These are difficult times. We are very cautious about offering specific advice that can easily be misinterpreted as unhelpful platitudes. However, as people who have experienced this situation first hand, we would simply want to reassure and encourage you that there is 'light at the end of the tunnel'.

The words from Jeremiah 29:11, although originally intended for a nation, were particularly helpful for us as a couple during those initial dark days: "For I know the plans I have for you" declares the Lord, "plans to prosper you and not to harm you, plans to give hope and a future". When you are ready, and have come to terms with your loss, we would really encourage you to find out more about adoption.

Although it is not a replacement for having your own children, it can be a wonderful alternative.

We would also argue that it is more acceptable ethically than some (though certainly not all) of the fertility treatments you might be offered. On the other hand, we are also very aware that for some of you, childlessness (or 'childfreeness' as Hilary prefers to call it), might well be part of a specific calling to enable other avenues of Christian service.

A message for all Christian families

We believe strongly that the calling for adoption is for all Christian people, not just for those couples unable to have their 'own' children. That is not to suggest that all Christians should actually be undertaking adoption. However, it recognises that the calling to care for the parentless is something we should all be engaged in. We must not forget that all children (whether our birth children, or those we have adopted or fostered) belong to God rather than to us, and have been temporarily given to us with the principal aim of demonstrating God's love and to bring him glory.

We can all pray for, and support practically, couples in our fellowships who have adopted children. We can recognise that these children will not always fit the stereotypes of Christian children in middle England, and can remove the burden and stigma for adopting parents by showing unconditional love and Christ-like acceptance to their adopted children regardless of any behavioural difficulties they may have!

We can follow the example of churches such as Bethlehem Baptist Church in Minneapolis in which adoption is increasingly emphasised as something for all Christian families to consider doing. We can support and establish further initiatives such as the MICAH Fund (Minority Infant and Children Adoption Help)¹³ and the LYDIA Fund (Let Youths be Delivered from Institutions by Adoption)¹⁴ that facilitate adoption by Christians. We can encourage all those strongly opposed to abortion equally to champion adoption as the 'pro-life' alternative. Indeed, we would argue that any anti-abortion policy must have within it provisions for the many children who would then be born.

A central calling for God's people

We have tried to highlight the importance of adoption. We believe it is a central calling for God's people to look after those who have no family of their own. It is our prayer this article will have informed many, but will also have encouraged some to pursue this vital ministry personally.

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Making the most of our time

The past year has seen a lot of changes for me. In twelve months there have been: one set of exams, two job applications, three job rotations, more night shifts and on-calls than I wish to count, small groups, CMF, church, sport, one wedding proposal with subsequent planning and marriage, and two house moves. It has most definitely been exciting, but certainly has been busy.

This is not an uncommon list among Christian junior doctors. We spend all day or night busying ourselves at work, but have so many outside commitments that we are just as busy when not at work.

I have had *The Busy Christian's Guide to Busyness*¹ on my bookshelf for a good two years now, but yes, you have guessed it, have not found the time to read it. Or at least, I have felt that I could not prioritise my time to read it. I have been grateful though for the chance to write this article, which has actually made me stop and think through things, and for the opportunity to attend the time management seminar at the junior doctors' conference. (I would highly recommend all junior doctors to fit this weekend into their busy schedules!) I am indebted both to the author of the book, and to Trevor Stammers for some of the following suggestions, which I have found useful over the past few months and hope that you do too.

How busy are you?

Cardiologist Meyer Friedman² described in 1999 a condition he termed 'hurry sickness'. He found that among others, symptoms of this condition included: regularly working half an hour a day longer than your contracted hours, checking work emails at home, not having enough time to pray, driving above the speed limit, and friends and family complaining they do not have enough time with you. Some of these I am sure occur daily for junior doctors.

One of the exercises we did during the seminar was to compose a life matrix. Essentially it is a three-by-three grid into which you put the nine activities that you spend your time doing. Once you have done this, you write what percentage of time you spend doing each one. On adding up those percentages, the majority of us totalled over one hundred percent, and among the common areas missed from the grid were sleeping and eating!

It certainly gave me something to reflect on, and I have found it useful to come back to it as a way of reassessing how I am doing, and what I am spending my time doing that is making me so busy. What has the Bible got to say about time management?

Work and rest

Both work and rest are important in the Bible. Paul writing to the Colossians urges us to work hard in all we do, as though working for the Lord, and not for man.³ Indeed, hard work is commended^{4,5}

and our satisfaction in it is a gift from God.^{6,7} The Bible also commends rest. Rest was the culmination of creation; when God's work was done, he rested.⁸ Jesus also rested, and encouraged his disciples to do so too.⁹ In the same way that God rested, and that Jesus rested, we also are to rest.

The idea is not that one is a means to the other, but that in our daily lives whether at work or at rest, it is all for the glory of God. The invitation is there from Jesus: 'Come to me. Get away with me and you'll recover your life. I'll show you how to take a real rest. Walk with me and work with me – watch how I do it. Learn the unforced rhythms of grace.'¹⁰ We just have to take up that invitation.

Setting our priorities

The Bible is very clear on how we should prioritise our time: we are to 'seek first his kingdom and his righteousness'.¹¹ Where this world has one set of priorities, as Christians we are called to have Kingdom values. We are urged to be wise in how we live, and to make the most of every opportunity.^{12,13} Paul was able to say that he had been faithful to the ministry that God had given him, and this too is the challenge we have.

Putting it into practice

How busy we are will naturally fluctuate throughout our lives, and although in itself busyness may not necessarily be a bad thing, the reasons behind it may be. Establishing the root of our own busyness can be the start to tackling it.

Identifying the areas that I particularly struggle with has been a start to addressing my busyness. I like having things to do, but I am not good at saying 'no', which means I can end up taking too much on, and being stretched. The result of this does not glorify God in either work or rest. God has given each of us skills and talents, and fortunately we are all different – we need to concentrate on the areas where we are gifted, while remaining servant-hearted.

"The "success" of our lives will be measured not in what we have "achieved", but in our faithfulness."¹⁴

Katy Barker (previously Lane) is a busy FY1 in Leeds, but she's working on that!

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David Chaput de Saintonge considers Jesus as a model for whole person medicine

'The great physician'

key points

Recognising the difference between medical knowledge in Jesus' day and ours, the author, a PRIME tutor, suggests Jesus' healing ministry gives clear guidelines for the practice of whole person medicine today.

Jesus touches the untouchable and is touched by people's suffering, releases physically and socially and spiritually, and never condemns. Unafraid to do what is right, he is flexible, sensitive, and persistent. He looks for what is really going on underneath illness, is prepared to get his hands dirty, knows the healing power of words, and teaches students.

Noting Jesus never asks for payment, the author pays tribute to Christian colleagues in Eastern Europe who work for a salary insufficient to live on, because they look to Jesus as their role model.

Jesus is sometimes referred to as 'the great physician', but clearly his medical practice was quite different from ours. He had almost no effective drugs to call upon, surgery was extremely primitive and, in our terms, he was untrained. Clearly none of that would have made any difference to him. But we do not have his power, even though the Bible teaches us we do have access to it. Nevertheless, Jesus' healing ministry gives us some clear guidelines for the practice of whole person medicine today.

Jesus touches even the untouchable

Jesus frequently, but not always, uses touch as a means of healing. Patients with leprosy or extensive skin diseases were untouchable in his time, as were women with menstrual bleeding. Jesus is unconcerned with tradition or even with the laws of hygiene, and does what he knows is best to bring healing to the patient.

The dermatologist who taught me as a student emphasised the importance of touching the patient's damaged skin, even though it might not be strictly necessary for diagnostic purposes. The act of touching is a way of reducing the social and psychological distance between the doctor and the patient. It signifies acceptance and inclusion, and helps build relationships by reducing feelings of rejection and isolation.

Jesus is touched

Jesus is clearly moved by the suffering of others, both patients¹ and relatives. When Jesus saw Mary weeping for her dead brother '...he was deeply moved in spirit and troubled'.² Jesus is fully present when faced with the sufferings of others, and does not attempt to maintain a professional distance.

Jesus releases

Jesus describes the crippled woman he healed on the Sabbath as somebody who was 'bound' by Satan.³ Typically he releases his patients:

- physically from their illness⁴
- socially; eg lepers can now re-enter society
- and spiritually, as his patients accept forgiveness

He works for wholeness in body and mind and spirit. However, this also involves giving people back their free will, which is clearly not without its risks. The paralytic who was healed at the pool of Bethesda is later warned: 'See, you are well again. Stop sinning or something worse may happen to you'.⁵ This suggests that, in spite of his release from a life of sickness, the man continued to make bad choices. Maybe he chose to continue in a sick role. We do not know.

I remember seeing two senior physicians leaving their outpatient clinics just before Christmas. One of

them carried a large pile of patient notes, the other a pile of gifts from grateful patients. The first doctor tended to see patients once or twice only and then discharge them, releasing them back to their homes and the care of their family practitioners when necessary. The other doctor tended to follow patients regularly for some time and of course they were grateful. I've no doubt that some needed to be followed carefully in hospital, but I suspect that others attended more for the doctor's benefit than for theirs. Doctors are for the sick, and not the sick for doctors. Freedom from disease is about restoring autonomy, which is incompatible with fostering dependence.

Jesus never condemns

He never condemns any of the behaviours of those who come to him for help and healing. The man at the pool of Bethesda gets a clear challenge and a warning not to continue with his previous behaviour, but he is not condemned for it.

Jesus is never afraid to do what is right

The story of Jesus healing on the Sabbath reminds us that he did what was right for his patients in the face of inappropriate rules and regulations. In the West we are increasingly constrained to follow rules and guidelines for patient management. These certainly have their place and have been shown, overall, to improve the standard of patient care. However, there are occasions where what might be right for the majority of patients will be inappropriate for an individual. Sabbath rest is a good principle, but Jesus knew when to step outside it.

Jesus is flexible

Jesus' flexibility shows itself in the way that he chooses treatments. Sometimes he touches patients, sometimes he doesn't; sometimes he uses mud on blind patients, sometimes he doesn't. Presumably these approaches reflect the individual needs of the patient. This is what you would expect from a God who knows each one of us by name.

Jesus is sensitive

He responds to need, not to status. Jesus' patients come from every part of society and include the very poor, the very rich, Jews, Gentiles, Samaritans – in other words, anybody who has need. Jesus respects his patient's need for privacy. This is not always possible when somebody approaches him in the middle of a huge crowd. However, on several occasions he takes care to protect the patient from the eyes of the crowd.⁶ Jesus is sensitive to the need to maintain his patients' dignity while he is treating them.

Jesus is persistent

Not all of Jesus' healing and miracles seem to have been instantaneous. He needs to put his hands twice on the eyes of one of his blind patients before his sight is restored.⁷ The Son of God is prepared to persist until his treatment goals have been achieved.

Jesus checks his patients for motivation

'Do you want to get well?' he asks the invalid of 38 years.⁸ He looks for what is really going on underneath the illness. He checks out people's treatment goals and what exactly they want to happen: 'What do you want me to do for you?'⁹

Jesus is not afraid to get his hands dirty

This is not just a question of using mud. It involves getting into religious and social situations which the more delicate and fastidious might avoid.

Jesus knew the healing power of words

Maybe the majority of Jesus' healing miracles involve the use of words. Sometimes, where the problem was demonic, that was the only healing modality used. However, his words were also used to reassure, to comfort and to strengthen.

Doctors are for the sick, and not the sick for doctors

Jesus taught medical students

The disciples were sometimes unable to cure patients and wanted to know why. Jesus tells them on one occasion: 'This kind [of deafness] can come out only by prayer'.¹⁰ His students have not chosen the right sort of treatment for this particular case and Jesus sets them straight. Teaching was the major part of Jesus' ministry, and here we see him combining healing with teaching.

Jesus' motive was not money

There is no record of Jesus ever having asked for any payment, and sometimes he didn't even get thanks.¹¹ Nevertheless, his physical needs and those of his disciples were supplied by those who followed and respected him.

I am humbled by the dedication of many of my Christian colleagues in Eastern Europe who work for a salary which is insufficient to live on. They do this because they are called to be doctors. They look to Jesus as their role model.

David Chaput de Saintonge was a physician at the Royal London Hospital and now works with PRIME (Partnerships in International Medical Education) as director of education



Photo: Welcome

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Steve Fouch reviews progress with three specific diseases

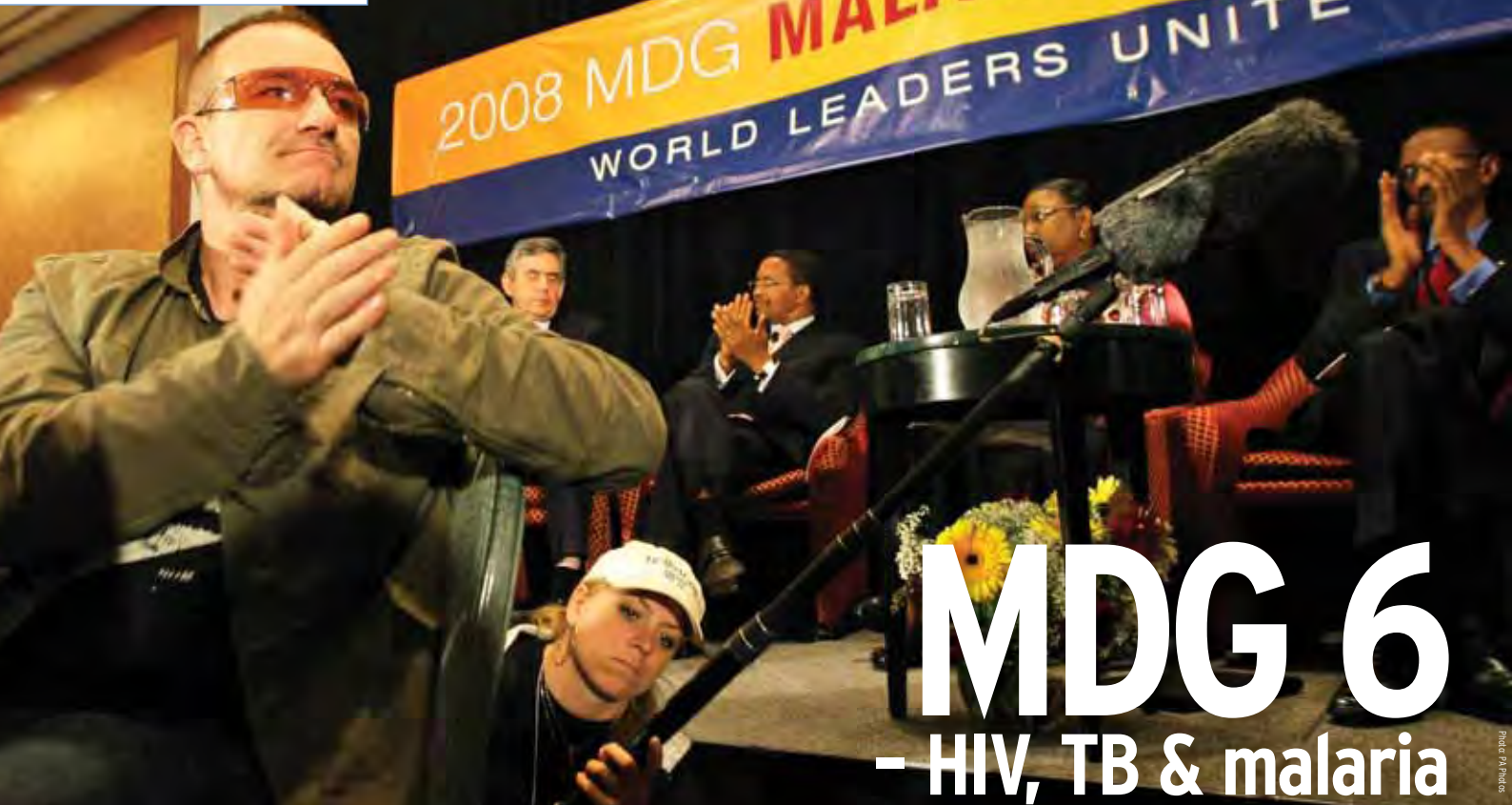


Photo: P. Photos

key points

The Millennium Development Goals are eight key commitments made by 192 member countries of the United Nations to address global poverty, with targets to be achieved by 2015. Three have an explicit health focus.

Current achievements against specific targets are reviewed for HIV and AIDS, malaria, and TB and at present they are going to be met at best only partially.

The author compares the extra billions needed to achieve these targets with the trillions in economic stimulus packages and bailouts recently committed by developed world governments, and asks whether the real issue is the commitment our governments, and we to whom they are accountable, have towards tackling the global health crisis?

Triple Helix has previously highlighted the Millennium Development Goals (MDGs),¹ eight key commitments made by 192 member countries of the United Nations to address global poverty, with explicit targets to be achieved by 2015.² With six years left to that deadline, the next three editions of *Triple Helix* will review the three MDGs which have an explicit health focus.

MDG 6: Specific targets

- By 2015 to have halted, and begun to reverse, the spread of HIV/AIDS
- By 2010 to achieve universal access to treatment for HIV/AIDS for all who need it
- By 2015 to halve the prevalence of TB globally
- By 2015 to have halted, and begun to reverse, the incidence of malaria

Progress towards these targets is regularly reviewed by the UN and other international bodies. It now seems few if any will be reached by 2015, but some progress has been achieved. The news is not as good as it should be, but is also not as bad as it might be.

A big concern raised time and again is that the global credit crunch and recession will have a downward pressure on spending to meet these targets.³ The 2009 Data Report⁴ shows that the G8 countries have given to date only \$7 billion of the \$21.5 billion in aid they had promised in 2005 to deliver by 2010. While a global debate rages over

whether aid actually achieves anything in terms of development and poverty reduction,^{5,6} there is evidence it can have an impact in healthcare. This is especially true in the delivery of affordable and effective treatments and prevention for malaria, TB and HIV/AIDS.^{7,8,9}

HIV and AIDS

Access to antiretroviral therapy (ART) for HIV/AIDS rose by 42% in 2007.¹⁰ This represents an unprecedented scaling up of treatment for any major infectious disease in the developing world, largely financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.¹¹ By the end of 2007, the number receiving ART in developing countries reached 3 million, and deaths from AIDS-related illnesses had declined from 2.2 to 2 million a year.¹²

However, significant as that progress may be, the reality is somewhat grimmer. An estimated 9.7 million people need ART, and while 950,000 were put on ART in 2007, there were 2.7 million new HIV infections that year. So ART is getting to less than a third of those who need it, and new infections outstrip threefold the increase in treatment access. The scale up has been massive, but is still way behind what is needed. Universal access to ART is unachievable by 2010 and very unlikely by 2015.¹³

If treatment is falling behind need, what about preventing new infections? 75-85% of HIV-positive adults have been infected through unprotected intercourse, mostly heterosexual. Recent evidence shows that sustained, intensive behaviour change

programmes promoting increased use of condoms, delayed sexual initiation, and fewer sexual partners are reducing HIV incidence.¹⁴

In 2007 international funding for such programmes in low and middle-income countries reached \$10 billion – a tenfold increase in less than a decade; again, an impressive achievement. Yet this sum still falls short of the \$18 billion in aid that UNAIDS estimates is required annually for AIDS prevention. Overall, the rate of new infections is declining only slowly, and shows no sign of going into reverse by 2015.¹⁵

Malaria

The picture is not really any better when it comes to malaria, which causes 250 million cases of fever a year, and claims the lives of about a million people. In sub-Saharan Africa it is the largest infectious cause of death for children.¹⁶ One of the most effective ways to prevent infection is to sleep under an insecticide-treated bed net, and a major prevention initiative has been distributing these nets (which cost ~£5 each) to all those in at-risk areas.¹⁷

A huge amount has been achieved in this one simple initiative. By 2007, 95 million nets had been distributed – 65 million in three years. All sub-Saharan African countries with endemic malaria have seen bed net distribution increase. However this is still below target, and while the UN Secretary General has urged this initiative to continue so that universal coverage is reached by 2010, it looks questionable whether this is still achievable. Nevertheless, universal bed net coverage may be achieved by 2015.

Treatment has seen less progress, however. Although treatment among febrile children is moderately high across sub-Saharan Africa, few countries have expanded coverage since 2000, and most patients often receive less effective medicines. In 22 sub-Saharan African countries (accounting for nearly half the region's population) the proportion of children with a fever who received anti-malarial medicines dropped from 41% in 2000 to 34% in 2005.

Furthermore, artemisinin-based combination therapies, regarded as the most effective, are not only not being used as widely as they should, but recent evidence from Cambodia suggests that the malaria parasite is developing resistance to the drug. There is a very real risk that effective treatment options for malaria will decrease over the next few years.¹⁸

Tuberculosis

While HIV and malaria targets look at best likely to be met only partially, the picture for TB is possibly even worse. Figures from 2008 show that worldwide two billion people are infected with TB! 14.4 million have active TB infections; there are 9.2 million new cases each year, and two million deaths. Around one million new cases each year are due to HIV

co-infection, and 300,000 people each year are infected with multi-drug resistant strains.¹⁹

The target of reducing TB prevalence and mortality by 2015 is not going to be met, especially in Africa and the former Soviet Union, where TB is a growing public health problem.²⁰ There is some good news, however. Where they are in place, Directly Observed Treatment Short-course (DOTS) programmes are achieving an 85% success rate in cure and prevention of transmission. There are 4.6 million people on DOTS worldwide, but this is still only a fraction of the 14.4 million in need of treatment.²¹

malaria causes 250 million cases of fever a year, and claims the lives of about a million people

Conclusion

MDG 6 is off target in every area. The scale of health problems in the developing world is outweighing the considerable efforts and funding that have been put in so far, and in the current climate these will be hard to sustain both politically and economically.

The irony is that the extra billions in funding needed to achieve these targets are but a drop in the ocean compared to the trillions in economic stimulus packages and bailouts recently committed by developed world governments. Perhaps the real issue is not the scale of the problem, but the commitment our governments, and we to whom they are accountable, have towards tackling the global health crisis?

Yet at the local level and on smaller scales, some amazing work is being done, much of it by Christians. As much as 60% of the healthcare in many parts of sub-Saharan Africa is coming from churches and Christian hospitals, especially in response to HIV and AIDS,²² and in other parts of the developing world Christian health initiatives are a smaller but still significant response.²³

While swine flu and the credit crunch make the headlines,²⁴ we should not be forgetting these major public health challenges that affect the lives of tens of millions – health challenges with effective solutions. We should be holding our governments accountable for the aid they give, while supporting those working on the front line.²⁵

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David Albert Jones
revisits a controversial
passage

EXODUS 21

and abortion

key points

While the word 'abortion' does not appear in any translation of the Bible, the Scriptures almost always have more to say on a question than we realise.

Traditional interpretations of Exodus 21:22-25 are reviewed and the author concludes the passage refers to harm to both mother and child.

More importantly, he emphasises how in the face of a dramatic rise in abortion numbers, contemporary theologians now draw attention to a wealth of other relevant Scriptures.

What does the Bible say about termination of pregnancy? Those in favour of a legal right to elective termination often argue that 'the Bible is silent on the subject of abortion'.¹ 'The word "abortion" does not appear in any translation of the Bible!'² Nevertheless, it is a mistake to suppose that where the Scriptures are not explicit on a question they have nothing to say. The Scriptures almost always have more to say on a question than we realise.

A controversial passage

In relation to abortion, perhaps the single most discussed Bible passage has been Exodus 21:22-25. The English Standard Version provides a good literal translation:

When men strive together and hit a pregnant woman, so that her children come out [yatsa], but there is no harm [ason], the one who hit her shall surely be fined, as the woman's husband shall impose on him, and he shall pay as the judges determine. But if there is harm, then you shall pay life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, stripe for stripe.

This passage contains a key ambiguity that becomes apparent if we ask the questions: 'no harm' to whom? Is the punishment of 'life for life' imposed only for harm to the woman? Or is it also imposed for harm to her children?

Harm only to the woman?

The Revised Standard Version translates 'her children come out' with the phrase 'there is a miscarriage'. This implies that the 'harm' refers only to the woman. This

is explicit in the New Jerusalem Bible: 'she suffers a miscarriage but no further harm is done'. On this interpretation the death of the unborn child merits a 'fine' but *further* harm to the mother merits 'life for life'. In favour of this interpretation is the witness of Josephus in the first century AD:

He that kicks a woman with child, so that the woman miscarry, let him pay a fine in money... as having diminished the multitude by the destruction of what was in her womb...but if she die of the stroke, let him also be put to death.³

The same interpretation is evident in the Talmud and has become authoritative in Orthodox Judaism. It is because of this interpretation of Exodus 21 that even conservative Orthodox Jews say that in Jewish law the unborn child does not have the status of a person. Where abortion is a sin, it is not the sin of homicide. Unsurprisingly, this interpretation is much quoted by modern advocates of 'reproductive choice'.

While many Jewish and Christian scholars find this interpretation persuasive, others point to difficulties. The word *yatsa* does not usually mean miscarriage. It is an ordinary word for giving birth (Genesis 25:26, 38:28; Job 3:11, 10:18; Jeremiah 1:5, 20:18). The more specific word for miscarriage (*shokol*) is not used in this passage. More fundamentally, the text does not state explicitly that the 'harm' refers only to harm to the woman, so on this key point the interpretation goes beyond the text.

Harm only to the 'formed' foetus?

A second ancient interpretation of this passage allows that 'harm' applies to the unborn child, but only after this child is 'formed'. The most influential

Greek translation of the Old Testament, the Septuagint, makes a distinction not between harm to the unborn child (a fine) and the woman (life for life) but between harm to the unformed embryo (a fine) and the formed foetus (life for life). The Jewish philosopher Philo, an older contemporary of Josephus, follows this interpretation:

*If the child within her is still unfashioned and unformed, he shall be punished by a fine...But if the child had assumed a distinct shape in all its parts, having received all its proper and distinctive qualities, he shall die.*⁴

How did the Septuagint come to translate the Hebrew word *ason* ('harm') by the Greek word *exeikonismenon* ('fully formed')? Many scholars have pointed to the influence of Greek philosophical ideas. For Aristotle, an unformed embryo was not yet a human being. If the foetus is 'fully formed' then miscarriage would harm a human being. However, if it is unformed then it is not yet human and so there is no serious harm. This seems to be the underlying idea.

The Greek translation was popular among Christians and shaped the first Latin translation. This encouraged Christians to make a moral distinction between the 'unformed' embryo and the 'formed' foetus, a distinction that was sometimes identified with 'ensoulment'. In recent times the Septuagint translation of this passage has been quoted by Christians arguing in favour of a 'gradualist' view of the status of the embryo.^{5,6} Nevertheless, this interpretation clearly goes beyond the text, creating a moral distinction that has no basis in the Scriptures themselves. It should also be noted that this interpretation implies the passage pays no attention to the woman; the focus is only the foetus and its stage of development.

Harm to mother or children?

Ancient and medieval interpretations of this passage tended to follow either the Talmud or the Septuagint. However, at the time of the Reformation there was a renewed spirit of reading the words of Scripture without the lens of received traditional interpretation. It was in this context that Calvin decisively rejected both exclusive focus on the woman and exclusive focus on the stage of development of the foetus:

*This passage at first sight is ambiguous, for if the word death [ie harm, ason] only applies to the pregnant woman, it would not have been a capital crime to put an end to the foetus, which would be a great absurdity; for the foetus, though enclosed in the womb of its mother, is already a human being.*⁷

Calvin's interpretation applies harm to mother or children. This implies that the children might 'come out' and yet might not be seriously harmed. The delivery might not be a miscarriage. In this

interpretation a fine would be imposed because of the assault on a pregnant woman and the danger it posed, even though it caused no serious or lasting harm.

In contrast, if mother or children were harmed the penalty would be 'life for life, eye for eye, etc'. Calvin's interpretation has influenced the New International Version and other modern versions that translate 'her children come out' as 'she gives birth prematurely'.

Faced with these three traditions of interpretation, the Christian should not start by asking which interpretation would be most convenient. Rather, we should ask who God intends to protect in this passage. The answer to this question should be informed by our reading of other scriptural passages.

A wealth of other passages

Until recent times, when Christians have reflected about the status of the unborn child they have rarely thought far beyond this one passage of Scripture, or they have preferred their moral intuition and natural reason to any use of Scripture. The wealth of the rest of the Scriptures has gone largely untapped. It was only in the late twentieth century, in the face of a dramatic rise in abortion, that Christians began to turn to a much wider range of texts to inform their beliefs.

Theologians now appeal not only to Exodus and the Commandments, but also, for example, to the many passages in the Scriptures which refer to God forming, naming and calling the child in the womb (eg Job 10:8-12; Psalm 139:13-16; Isaiah 44:1-2, 49:1-5; Jeremiah 1:5; Galatians 1:15).

The infancy narratives, especially the slaughtering of the innocents by Herod (Matthew 2:16-18), the presence of Jesus in the womb of Mary,⁸ and the leaping of John the Baptist in the womb of Elizabeth (Luke 1:41-44) are also now invoked in the critique of the practice of abortion.

Theologians also relate abortion to the identification of Christ with 'the least' in society (Matthew 25:40) and to the parable of the Good Samaritan (Luke 10:29-37). Dare we say that the unborn child is not our neighbour?⁹

Not all of these other texts are equally relevant. Nevertheless, the broadening of the number and scope of texts discussed in relation to abortion is undoubtedly a positive thing. It encourages us to ask not simply what the Jewish law says about abortion, but where we see Christ in this situation – which is surely both in the mother and in her children.

Professor David Albert Jones is Director of the Centre for Bioethics and Emerging Technologies at St Mary's University College, Twickenham



the Christian should not start by asking which interpretation would be most convenient. Rather, we should ask who God intends to protect in this passage

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Taking time out

'I've always wanted to work abroad but...' is a phrase I often hear from junior doctors who have moved from the carefree days of student electives into the harsh realities of postgraduate training and the Modernising Medical Careers system. Many have the impression that time out to work in developing countries is not an option while in training, and may jeopardise their career. However, several government reports have recognised the benefits of international experience,^{1,2} not just for the individual doctor and those with whom they work abroad, but also for the NHS which is enriched by the skills they bring back.

The reports recommend that health professionals should be allowed to interrupt their training to work abroad, and that educators and employers should make it possible for them to do so. The BMA's new handbook, *Broadening your horizons*,³ is a useful guide to the different ways of taking time out of training or employment. One such option is the OOPE – Out Of Programme Experience. Here's what two CMF members have done.



Orthopaedic OOPE in Malawi

Verona Beckles, orthopaedic SpR, is currently at the Beit Trust Cure International Hospital in Malawi. She writes:

You can go! Yes, You! If you had spoken to me five years ago, there was no way I could see myself living in Africa for over a year. I planned to be a serious surgeon, you know. Then I met some amazingly inspiring surgeons who work in Malawi, serving patients and training doctors. Although there are committed local health care professionals here, they are few in number – coming to support and encourage them has taught me so much about what is important in life. Yes, it took a bit of planning and there were administrative obstacles to overcome but I tell you what – there is absolutely nothing like being in the place where God wants you and then looking back at the ways in which he's equipped you and blessed you.

It is possible to come at any stage of training. I have met some who have come as medical students, others who have come after foundation years (and flown back to get two offers of training programmes), and many registrars and consultants from all around the world. The opportunities are endless as there is a lack of skilled personnel at all levels in this part of the world. I've had brilliant trainers in the UK but the truth is that here in Malawi I have had training which is second to none – a delicate balance of empowerment and supervision. I have opportunities to teach on courses, to do research, and to operate on far more cases than in the

UK. I've also learnt how to play tennis! I have never been so healthy financially, physically and spiritually in my working life.

Yes, I miss Japanese food and Häagen-Dazs, and grammies with fractured necks of femur, and power tools – hand drilling is completely overrated! And, obviously I miss my family and friends back in the UK but God's provision of a wider adopted family and friends here continues to be so astounding that I'm staying an extra three months!

Ophthalmic OOPE in Sudan



Matt Hawker, ophthalmology SpR in Norwich, spent two months in Sudan with his young family as part of his hospital's link programme with Gezira Hospital. Some of the time was counted as study leave, the rest as OOPE. He had done a one week visit in 2007, when a three year plan to set up a glaucoma service was initiated. He returned this year to help implement this plan, building on the relationships he had already made:

It was an amazing opportunity to use the knowledge and skills I have gained through my training here. There was masses to do – I saw hundreds of people in clinic and operated on patients aged four months to 70 years. I gave tutorials twice a week – people were so keen to learn. As a family we experienced what life is like for the majority of the world. It was good, it was hard, there were a few tears, but overall it was great fun.

Hospital link

Hospital links are a great way for health professionals here to contribute to services in developing countries. Lasting relationships develop as repeated visits are made in both directions and there are opportunities for training and service in different fields. Why not consider forming a link at your hospital? The Tropical Health Education Trust (THET) will advise.⁴

Vicky Lavy is CMF Head of International Ministries

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Jewish Medical Ethics

This classic by former Chief Rabbi Immanuel Jakobovits was published 50 years ago, and a *BMJ* review brings pithy reminders of priorities: '...we speak of human duties, not of human rights, of obligations not entitlement. The Decalogue is a list of Ten Commandments not a bill of Human Rights. In the charity legislation of the Bible, for instance, it is the rich man who is commanded to support the poor, not the poor man who has the right to demand support from the rich.' (*BMJ* 2009; 338:b2138)

Another 'medical classic'

Another review in the same series looks at John Wesley's 1747 *Primitive Physic: Or, an Easy and Natural Method of Curing most Diseases*. Wesley's uncle was a physician, and his Puritan great grandfather had studied theology and medicine at Oxford. Wesley's '20 rules for a healthy life' attracted criticism not from the medical profession but from 'fellow divines, who believed that some diseases were God's punishment for sin'. (*BMJ* 2009;338:b908)

Liberating the laity

Christian history also provides a metaphor for considering the effect of the information revolution on doctor-patient relationships. Martin Luther and the Reformation are credited with empowering the laity through translations from Latin and putting Bibles into more people's hands, thus threatening the paternalistic power of the Catholic church in Europe; so the availability of medical information through the internet has 'brought the canon of medical knowledge...into the hands and homes of ordinary people'. (*BMJ* 2009; 338:b1080)

Obama, abortion, and conscience

The US President is considering rescinding protections the Bush administration adopted to enforce three federal conscience laws. A poll in March showed 87% of 800 adults believed it important to 'make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections'. President Obama has already restored US funding for the UN Population Fund with its controversial involvement in the Chinese forced abortion programme, and overturned the US ban on funding the pro-choice groups the International Planned Parenthood Federation and the Center for Reproductive Rights. (lifenews.com/nat4975.html)

Debt and mental health

The Royal College of Psychiatrists has produced a particularly eye-catching 'Final Demand' booklet about the relationship between debt and mental health, subtitled 'What people want health and social care workers to know and Do'. One in four people has a mental health problem; one in four of those is in debt; and debt may be a cause and consequence of mental health problems. With the recession worsening, and a 70% increased risk of suicide among the unemployed, the practical advice in the booklet is timely. (www.mhdebt.info)

Medicine top career choice no longer

The Children's Mutual - a child trust fund provider - asked 1,000 customers what their 5-6 year olds wanted to be when they grew up. The job of doctor has dropped from first to second place since 2008. Eutyclus is surprised that it is teaching that has gone up from third last year to take top spot. (*BMA News* 2009; 30 May:3)

Discrimination against Christians

A recent *Sunday Telegraph* poll revealed that 50% of British Christians had suffered some sort of persecution for their faith; 44% said they had been mocked by friends, neighbours or colleagues; 20% said they had faced opposition at work; and 19% said they had been 'ignored' or 'excluded' because of their beliefs. Anecdotal evidence suggests these problems may be particularly prevalent in the National Health Service. (*Sunday Telegraph* 30 May 2009. www.telegraph.co.uk/news/newstoppers/religion/5413311/Christians-risk-rejection-and-discrimination-for-their-faith-a-study-claims.html)

What Britons believe

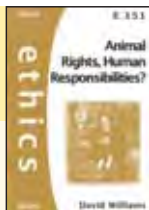
Other polls reveal more about the confusing picture of spiritual beliefs in Britain today. 70% believe in the human soul but only 53% believe in life after death. 39% believe in ghosts, which is up from 10% in 1950, and 22% believe in astrology, again up from 7% in 1950. (MORI and the *Daily Telegraph*, quoted in *Quadrant*, May 2009 p6)

Fearing the process of dying

Yet another poll, by public theology think tank Theos, suggests that half the population have the Woody Allen approach: 'I'm not afraid of dying; I just don't want to be there when it happens'. In a poll of over 1,000 adults, 20% admitted they feared both the way they will die and death itself. 30% feared the way they will die but not death itself; while 25% fear neither death nor the way they will die. The highest proportion fearing both was among 18-24 year olds (26%). 42% of over-65s believed their religious faith helps them deal with the death of a loved one and prepare for their own death, compared with only 23% of the 18-24s. (www.theosthinktank.co.uk)

So we do need chaplains

With secularists campaigning that chaplains should be paid for by the church and not out of NHS budgets, these figures show the significance of spiritual aspects of health care. Further strong anecdotal support is provided by the death of Adrian, a 25 year old journalist, from leukaemia. Adrian's blog recorded his appreciation of the chaplain's listening; the chaplain writes 'Adrian's case highlights the fact that asking whether a patient is religious or not is an inappropriate way to discern whether chaplaincy support would be of benefit to them'. (*BMJ* 2009;338:b1403)



Animal Rights, Human Responsibilities?

David Williams

- Grove Books Ltd 2008
- £3.50 Pb 28pp
- ISBN 978 1 85174 701 6

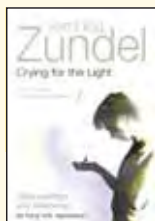
This short booklet is part of the Grove Ethics Series which aims to provide 'fast moving explorations of Christian life and ministry'. As a practising vet who also teaches in Cambridge, David Williams draws on a wealth of experience in tackling questions about the Christian view of the status of animals, and our responsibilities to them.

Rapidly touring both the biblical status of animals and philosophical standpoints taken, from Descartes to Singer and beyond, he proceeds to cover issues around animal sacrifice, vegetarianism, and how Jesus' priority for the weak might relate, culminating in a discussion of how the new creation could

inform our ethics. Each chapter ends with questions for thought or discussion, making this a good resource for a group interested in getting to grips with these issues.

Throughout, his love for animals and extensive experience of both their relationships with people, and their care, shine through. This not an exhaustive discussion however, more a helpful raising of the issues. If you are looking for detailed analysis, try elsewhere, but if you simply wish to begin thinking these things through, this inexpensive booklet by someone with a great deal of relevant experience will serve you well.

Matthew Welberry Smith
is an SpR in nephrology in Leeds



Crying for the Light
Bible readings and reflections for living with depression

Veronica Zundel

- The Bible Reading Fellowship 2008
- £5.99 Pb 159pp
- ISBN 978 1 84101 565 1

Depression is a common problem and can present particular challenges for Christians, being viewed by some as evidence of weak faith, unconfessed sin or demonic activity.

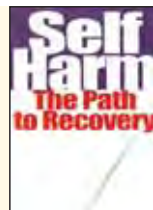
Veronica Zundel has long experience of depression and writes from a Christian perspective. *Crying for the Light* is 'not a self-help book, a medical textbook or a complete guide to depression'. Rather it is a collection of Bible texts and paraphrases, personal comments and reflections, poems and prayers, information and advice.

Zundel's frankness about her own experience will undoubtedly connect with some, helping them

to feel less alone. Mindful of those with impaired concentration, she offers bite-sized readings and reflections. She gives important information about depression and debunks some myths. Several poems are thought-provoking.

However, the unsystematic use of paraphrased Scripture and of the Apocrypha is rather superficial at times, while some potentially misleading advice lacks biblical balance – for example, avoid church if you find it unhelpful. I would hesitate to recommend this book, but some may find it helpful.

Everett Julyan
becomes a consultant psychiatrist in Glasgow on 1 August



Self Harm
The Path to Recovery

Kate Middleton and Sara Garvie

- Lion Hudson 2008
- £7.99 Pb 144pp
- ISBN 978 0 74595 319 9

This is a self help book which is practical and uses real life examples to good effect. The first section addresses 'What is self harm and how does it develop?' The authors explain the role of emotions and explain why some people deal with intense emotions by self harming. They emphasise that the first step towards recovery for the person who self harms is actually to want to be helped.

They recommend that the person should consult the GP and constructively discuss topics which can usefully be raised by the patient with the GP at this consultation. The second section of the book is called 'Recovering from self harm'. The authors explain the unhelpful reactions to

strong emotions such as anger, frustration, anxiety, and sadness, and how these emotions can be managed effectively. The third section is 'For those caring for sufferers', where the importance of carers and the common mistakes they may make are discussed.

This is a book aimed at patients who self harm and their carers. There is minimal reference to the broader medical literature, and there is no discussion of a Christian perspective on the issue of self harm, but this book should prove useful for both patients and their carers.

Dominic Beer
is a consultant psychiatrist in London



Learning to be the Patient
A Doctor's Cancer Journey

Hazel Butland

- AuthorHouse 2008
- \$11 Pb 292pp
- ISBN 978 1 43439 696 9

CMF member Hazel was a GP, police surgeon, and a doctor at a local hospice; someone full of energy and outside interests; a Christian, a wife, and a mother. She was diagnosed with breast cancer at the age of 50. This book stems from her journal, mixing narrative and reflection on issues like the diagnosis, telling the family, the treatment with its uncertainties and side effects, and her efforts to continue working and socialising.

It provokes all sorts of questions about getting the balance right. Somehow she manages to be both doctor and patient – even by attending the day hospice where she is known as the doctor, yet benefiting

enormously from making a mosaic. Alongside her cancer journey she deals with past hurts from a previous position in general practice, old pain resurfacing when facing new trauma.

This book is well worth reading – but do bear with her and remember why the journal was written. In places it becomes a little tedious and it is tempting to skip the recurring thoughts and the detail on drug regimes and constipation! Initially I couldn't put the book down. It is perhaps overlong, but it is honest, insightful, and describes a journey of faith.

Jean Maxwell
is a retired palliative care consultant in Essex



Pictures in AIDUcation

Edwin Mavukina Mpara

- Trafford Publishing 2008
- £9.92 Pb 181 pp
- ISBN 978 1 42515 757 9

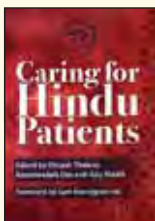
The author writes from two decades' experience responding to the AIDS crisis in his native Zambia, in Botswana, and most recently in the UK. During that time, as well as caring for and treating affected individuals and families, he has also been actively developing a strategy for educating whole communities to respond to HIV using a mixture of images (mostly culled from TALC's educational slides library), stories, and African proverbs.

The aims of the strategy are to equip communities to protect themselves against HIV, to tackle stigma, and to care effectively and compassionately for those affected. Tackling prejudice, denial, ignorance and stigma head on, this approach has inevitably brought him into conflict with community leaders and others. Yet in the long run, the impact has been positive,

with evidence of increased health-seeking behaviour, including access to voluntary testing and counselling services, by members of local communities who have been involved with this educational approach.

The book is part history of the response to HIV in Zambia and Botswana, part autobiography, part a manual for the AIDUcation approach, and part an overview of the AIDS pandemic in southern Africa today. It makes interesting reading, although is hampered without the pictures Dr Mpara uses in his AIDUcation programmes. Nevertheless, for those seeking an effective educational strategy for HIV prevention, this book is a useful addition to the growing literature.

Steve Fouch is CMF Head of Allied Professions Ministries



Caring for Hindu Patients

Diviash Thakar, Rasamandala Das and Aziz Sheikh (Eds)

- Radcliffe Publishing Ltd 2008
- £24.95 Pb 130pp
- ISBN 978 1 85775 598 5

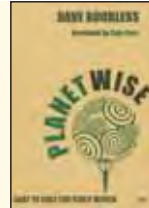
This book does 'exactly what it says on the tin!' It is clear, well presented, simple, concise and practical. The book will help all health professionals care for their Hindu patients. The contributors come from varying perspectives: Hindu and Muslim, medical and non-medical, and primary and secondary care.

I found the case studies and the practical examples in the chapters, the websites, the

leaflets in the appendices, and 'Key Point' summaries at the end of each chapter very helpful.

The book is great on what I should know and do. But what I longed for was some biblical power to motivate my spirit to follow Jesus' example of loving my neighbour to the glory of God.

Neil Menon is a GP programme director in Northampton



Planetwise

Dare to Care for God's World
Dave Bookless

- Inter-Varsity Press 2008
- £7.99 Pb 160pp
- ISBN 978 1 84474 251 6

A number of recent books rightly respond to the fact that Christians have not taken their responsibility towards God's earth seriously. *Planetwise* is by Dave Bookless, a vicar and director of A Rocha UK, a Christian environmental movement.

The first half is a biblical theology of 'creation care', drawing out the big picture of our responsibility for the environment. It is refreshingly readable and hopeful, not merely aiming to induce guilt. It reminds us that creation and redemption are inseparable, and that Jesus is right at the centre of both. Bookless anticipates questions and addresses them, providing helpful exegesis of tricky passages.

The second half explores how we 'live it out'. This section seems theologically weaker, sometimes resorting to proof-texting. Bookless needs to do more work to convince us of some of his points. This is a shame given the fact that this section is helpful in not simply reciting common lists of 'green top tips'. In particular, the direct experiences from the author's family life are refreshing.

If you're looking for an introduction to the issue I wouldn't start here. Try John Stott's *New Issues Facing Christians Today*. If you know more, and want some creative practical applications, then this book is helpful.

Rachel Roach is a part time environmental policy consultant



AIDS: I'm Not at Risk, Am I?

Joy and Ray Thomas

- Judah Trust/OM 2005
- No price given. Pb 224pp. The full text is available on the Judah Trust website: www.judahtrust.org
- ISBN 978 0 95529 170 8

Now in its third imprint, the Thomas's book was written to answer the many questions and concerns they have responded to in the course of two decades of ministry around the world. Aimed at the lay reader, including the worried well, the bereaved, those living with HIV and AIDS, and those who care for them, this book is nevertheless comprehensive.

It goes into technical detail about the virus and about tests and treatments, as well as looking at issues around counselling and helping the bereaved, including those who have lost children to AIDS. It looks at biblical responses to HIV and the issues it

raises, and at practical pastoral care for those living with the spiritual pain and isolation that an HIV-positive or AIDS diagnosis can bring.

Using stories, power point slides in the form of a lecture, and other illustrations, the book aims to communicate complex issues in direct and practical ways. It is a useful resource for churches, and while the clinical sections are not detailed enough for a physician to find useful, it does address psychosocial and spiritual issues in a manner that will be relevant to any Christian doctor with HIV-positive patients.

Steve Fouch is CMF Head of Allied Professions Ministries

Friend of 'sinners'?

Dewi Hughes's consideration of the theology of harm reduction strategies (Easter 2009:14-15) has stimulated responses from both sides of the debate. **Hilary Cooling**, who works in sexual health in Bristol, writes:

Thank you for publishing Dewi Hughes's thoughtful article on harm reduction strategies. His theological view is refreshingly practical and much needed, addressing useful examples from my field of work: sexual health. It sometimes feels there is no area of medicine more likely to call forth criticism from Christians than sexual health (and its earlier incarnations: GU medicine, family planning, etc). Adolescent sexual activity is increasing worldwide in most societies. Limiting the damage caused by unwanted pregnancy or sexually transmitted infections is worthwhile, and NHS campaigns do invite young people to consider whether they are ready to be having sex, and if they could say 'no' (see eg www.ruthinking.co.uk).

Jesus spent much of his time associating with the weak and vulnerable, and rather than judging them, met these people at their point of need with wisdom and compassion. My prayer is for God to enable me to treat people with respect and care, to be aware of spiritual needs, and to know when and how to challenge unhealthy choices and behaviour and refer on where necessary, including when there are concerns about child protection.

Rachael Pickering is a police surgeon in North Yorkshire:

Congratulations to *Triple Helix* and to Dewi Hughes. The other side of the harm reduction debate has been given prominence at the CMF National Conference and subsequently in print,¹ so it was encouraging to read a pro-harm reduction piece. Dewi got to the heart of the matter: 'Is it possible to call ourselves the friend of a drug addict...while refusing to countenance any harm reduction strategy?' I agree that the answer is 'No!'

I haven't yet swapped my silver Fishy Badge for a rubber *WWJD* bracelet but actually it would be better because I often forget to ask, 'What would Jesus, the Friend of "Sinners",² want us to do with this patient?' He would surely tell us to be *true* friends, albeit professional ones: to listen, and offer support and advice; to stick by our patients in spite of the fact we don't agree with their lifestyle choices; and, while not doing anything designed to hurt them, to help our patients get out of their tricky situations.

Regardless of what national statistics may (or may not) say, I have seen that, deployed in the *right* way, harm reduction techniques can be truly life-saving. Patients and their families can and do gradually get out of their 'dark corners' and walk into brighter, safer places in the world.

What the harm reduction machine needs is an *influx* – rather than an exodus – of Christian practitioners. It is both interesting and sad that most of its critics work outside the specialties where it is most needed and deployed. We fear most what we do not know or understand. To remedy this, perhaps those with doubts could spend a week's study leave shadowing CMF members working in these hard places?

references

1. *Triple Helix* 2003; Autumn:11-13
2. Matthew 11:19

Newcastle consultant paediatrician **Chris Richards** began this debate. He maintains that 'harm reduction' is really harm promotion:

Dewi Hughes offered a biblical defence of harm reduction strategies, which I had rejected in the 2003 Rendle Short Lecture. I take issue with his definition and the biblical basis of his conclusions. First, he did not critique these strategies as I defined them – 'policies or activities which attempt to soften the consequences of future sinful behaviour'. Such strategies must be distinguished from a) preventative medicine, attempting to reduce future harm through legitimate interventions; and b) medical care for patients suffering because of their own past sins.

He, nevertheless, proposes that doctors can sometimes legitimately be a 'friend to sinners' through harm reduction programmes. We can only follow in Jesus' footsteps if we walk as he did in humble obedience to his Father's will.¹ Jesus never promoted sin when he befriended prostitutes and outcasts but on the contrary told them to 'sin no more'.^{2,3} God's law enables us to distinguish approaches that heal from those that harm. We cannot do good by encouraging wrong.

Dewi implies that if we refuse harm reduction, we are responsible for the moral decision of our patients if they go ahead and suffer the consequences. However, it is not us making the decision, but them. The real situation is quite the opposite – we would be wrong to aid and abet their sinful action. He seems to view preservation of life as the ultimate ethic; our supreme responsibility is to honour God through obedience to his commands.

Medical studies affirm the biblical sanction. There is much evidence that condom provision to the unmarried, needle exchanges⁴ and methadone replacement⁵ to drug abusers have each failed to produce the expected benefits, but rather made matters worse. Why do harm reduction strategies actually promote harm? First, they attempt to reduce the effects of sin, thus making sinning more attractive, so encouraging further sin and suffering as a consequence. Since the 'safe sex' message, sexual activity has risen in teenagers, partly because they think they can sin safely. This has in turn led to a rapid rise in STIs and abortions.

Secondly, health professionals resign themselves to sinful action and so stop trying to change sinful behaviour. Education programmes promoting 'safe sex' rarely include any substantial challenge to consider abstaining from sexual activity outside marriage. Thirdly, trusted state-employed professionals affirm sinful behaviour and give official legitimacy to sinful actions.

Dewi states most doctors cannot warn patients not to sin. Most doctors would warn patients about alcohol excess; it is society's moral sensibilities that deter us regarding sexual immorality. Such warning is more likely to cause offence – for this reason we need wisdom in doing it. We may have to be content with the powerful witness which ensues from our refusal to take part in such programmes, but surely we must 'fear God rather than man' as we refrain from promoting sin.

references

1. John 8:29
2. John 5:14
3. John 8:11
4. Strathdee S *et al.* Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS* 1997;8:F56-65
5. Tiny numbers leave NHS drug treatment 'clean'. Christian Institute 2008 news archive. www.christian.org.uk



Why DID I join CMF?

I was challenged by the penultimate paragraph in Andrew Brown's article (p6-7). Reviewing 60 years of CMF, he wonders why more Christian doctors don't join? It was 1976.

I'd been a Christian four years, was doing my house surgeon job in the sticks, and a consultant physician there was a CMF member. He discovered I was a Christian (I don't remember how), found out I wasn't a member, and suggested I join. He handed me a form the next day.

I wasn't working directly for him, so contacts were few and far between and it was easy to do nothing. It's another story for another day, but I became an SHO (and later a registrar) on his firm. He asked me again about CMF. I did nothing. He gave me another joining form. I still did nothing. He took me in his rather nice Rover to a CMF meeting. Another joining form appeared the next day, and I suppose in the end it was the parable of the persistent widow and the judge (Luke 18:1-8). I suppose I also thought, well, I will need a reference in a year or so – and I joined. I've just checked the date on the CMF database here; it is recorded as 1 April 1977!

I started going to more local meetings; a conference or two; was asked to join the Junior Doctors' Committee; got seconded to the

Medical Study Group; and the rest as they say is history. I joined the staff on 1 April 1989, became General Secretary in 1990, and stayed until the end of the millennium. Seven years and some globetrotting later, I came back.

So, what's my point? As Andrew Brown challenges us, there are many Christian doctors out there who could be members but aren't. (We did a little research in the mid-1990s and concluded that for every Christian doctor who was a member there were at least two and probably three who could be members but weren't.)

We need each other. I think every Christian doctor should join CMF – well, he would say that, wouldn't he? But we join organisations for one or both of two reasons: what's in it for me? And is it a worthwhile ministry that I should support? I think CMF scores on both counts.

In the autumn we're having a recruitment blitz – we'll send you a DVD to introduce the Fellowship to colleagues and to your churches, and another copy of that attractive new joining form. And it's easy now to join online. Back in the 1970s, my boss persisted. You must know somebody who could rejoin or who hasn't joined yet...

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