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for today's Christian doctor

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dementia

spiritual support in palliative care, social action, stem cells, staff behaving badly, theology of harm reduction, physician assisted dying, reviews, the wider horizon

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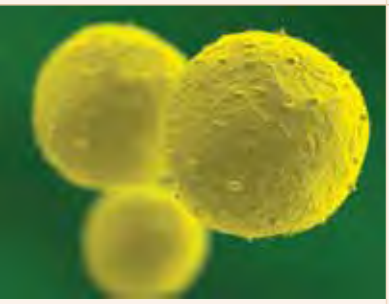
Stem cells

The truth (gradually) comes out



Almost ten years ago, after the 1999 Donaldson Report recommended allowing scientists to clone human embryos for stem cell research using somatic cell nuclear transfer (SCNT), *Triple Helix* called the research 'unethical and unnecessary' and sounded a strong note of caution. We said that the enthusiasm for this new technology was 'based more on political expediency than wise reflection' and warned that 'the prospect of revolutionary new treatments (would) undoubtedly entice investors to move funds away from other less glamorous, but potentially more promising avenues of research'.[1]

Since 2000 we have witnessed the glorious failure of scientists to produce patient-specific stem cells from cloned human embryos. Subsequently, the limited availability and dangers of harvesting human eggs for research fuelled the shift to using cytoplasmic animal-human hybrids ('cybrids'). This was supported by a massive propaganda campaign in 2007-8 involving scientists, patient groups, and politicians, and led by Liberal Democrat MP Evan Harris with the willing co-operation of *Times* Science Correspondent Mark Henderson.[2] As a result, in an impassioned *Observer* article last May, Prime Minister Gordon Brown welcomed animal-human hybrids as 'a profound opportunity to save and transform millions of lives' and expressed his commitment to this research as 'an inherently moral endeavour that can save and improve the lives of thousands and over time millions of people'. The measure was supported in a heavily whipped vote as part of the Human Fertilisation and Embryology Bill.

Now it appears, before the new Act has even come into force, that stem cells from animal-human hybrids are seen as a poor investment and almost certainly won't work. In January, the two leading UK researchers who had been granted licences for this work, Stephen Minger of Kings College London and Lyle Armstrong at Newcastle University Centre for Life, were denied funding by the Medical Research Council.[3] The *British Medical Journal*[4] reported that the grant applications had been turned down because the reviewers considered that they were not competitive in the face of the lack of overall funding for medical research in the United Kingdom. Minger himself admitted that he believed the distribution of research funding should be competitive, based on assessment of scientific value and cost, and noted that induced pluripotent stem cells are cheaper to set up than human-animal hybrid stem cell research. No one it seemed wanted to invest money in the new research, given the low likelihood of it ever yielding results and the emergence of cheaper ethical alternatives.

Less than three weeks later, in a landmark paper in *Cloning and Stem Cells*, Robert Lanza and colleagues from Advanced Cell Technology, Massachusetts, demonstrated that animal oocytes lack the capacity to fully reprogramme and activate adult human cells, and specifically the pluripotency-associated genes needed for stem cell production.[5] The hybrid embryos from mouse, cow and rabbit eggs looked microscopically normal but were genetically flawed. Journal Editor Sir Ian Wilmut, the British cloning pioneer involved in the 1996 creation of Dolly the sheep, concluded that 'production of patient-specific stem cells by this means would (now) be impracticable'.[6]

Wilmut had himself already abandoned embryonic stem cell research, in favour of iPS, induced pluripotent stem cells (produced ethically by dedifferentiating somatic cells to produce embryonic-like stem cells). Yamanaka and Thomson's seminal work in this area in late 2007[7] was later dubbed *the* scientific breakthrough of the year by the magazine *Science*.[8] Some scientists had expressed concern that Yamanaka had used virus vectors to transfer the genes which would reprogramme the somatic cells. But on 1 March, in the very latest twist, a UK and Canadian team succeeded in turning somatic cells into embryonic-like stem cells, without using viruses.[9,10]

These recent developments along with advances in adult stem cell technology were highlighted in a debate in the House of Lords on 3 March, where Innovation and Skills Minister Lord Drayson struggled to find arguments to justify the government position. In a further ironic development, while the government has seemingly been driving up a scientific dead-end street, leading British adult stem cell scientists like Newcastle's Colin McGuckin have migrated abroad. They blame the British government's obsession with embryonic stem cells for siphoning off funding for more promising adult stem cell research.[11]

Perhaps the last word belongs to leading US stem cell scientist James Sherley, who commented on these latest findings: 'For those trained in the science, this is not news, but instead a completed fate that was known from the beginning'[12] – a timely reminder that in good science the end does not justify the means (Romans 3:8).

Peter Saunders *is CMF General Secretary*

references

1. Saunders P. Therapeutic Cloning. *Triple Helix* 2000; Autumn:3
2. Henderson M. Animal-human embryo research is approved. *The Times* 2008; 18 January. *www.timesonline.co.uk*
3. Connor, S. Funding Halted for Stem Cell Research. *Independent* 2009; 13 January. *www.independent.co.uk*
4. Lack of Funds slows human-animal stem cell research despite legislation in favour. *BMJ* 2009; 338:194-5
5. Lanza R *et al*. Reprogramming of Human Somatic Cells Using Human and Animal Oocytes. *Cloning and Stem Cells* 2009; 11(2):1-11
6. Animal eggs not suitable substitutes to produce stem cells. *Genetic Engineering and Biotechnology News* 2009; 2 February. *www.genengnews.com*
7. Saunders P. Stem Cell Delusions - The government juggernaut rolls on. *Triple Helix* 2008; Easter:4
8. Sample I. Leading journal names the top 10 scientific breakthroughs of 2008. *The Guardian* 2008; 18 December. *www.guardian.co.uk*
9. Hayden E, Baker M. Virus-free pluripotency for human cells. *Nature* 2009; 458:19. doi:10.1038/458019a *www.nature.com*
10. 'Ethical' stem cell creation hope. *BBC News Online* 2009; 1 March. *http://news.bbc.co.uk/1/hi/health/7914976.stm*
11. Corbyn Z. You would barely know adult stem cells exist. *Times Higher Education* 2008; 23 October. *www.timeshighereducation.co.uk*
12. *http://spuc-director.blogspot.com/2009/02/end-of-human-cloning.html*

news reviews

Obama and global health

What will the Presidency mean for the world's most vulnerable?

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

Barack Obama's inauguration as US President has largely been seen around the world as positive, but what will it mean for global health? Two major breaks with previous policy have gone almost unnoticed.

The first was the forced resignation [1] of Ambassador Mark Dybul, the controversial head of Bush's $48 billion President's Emergency Plan for AIDS Relief (PEPFAR) [2] the day after Obama's inauguration. The second came when Obama overturned the Mexico City Protocol, [3] which prevents US aid to overseas organisations providing or discussing abortion-related services.

PEPFAR has always courted controversy: [4] for pumping billions into programmes for just one disease, for promoting abstinence-only prevention, for not funding family planning services, for being bilateral when it is argued funds are better funnelled through the multilateral Global Fund for AIDS, TB & Malaria, [5] and for being seen as driven by a conservative Christian agenda. [6] But PEPFAR has been far more effective than credited: it got 2.1 million people in 15 countries onto antiretroviral therapy, distributed 2.2 billion condoms (countering the charge prevention's focus was abstinence-only), and gave access to anti-HIV therapy to prevent mother-to-child infection to 1.2 million women. Only 7.4% of its budget went to abstinence-only programmes. [7]

Obama will honour the December 2008 PEPFAR act to pump nearly $50 billion extra into HIV prevention, care and treatment over five years. More of that money will probably now go to family planning services that will undoubtedly save lives. [8] That some of those services will promote and provide abortion causes concern.

The world will watch Obama with interest. If he can live up to and exceed Bush's legacy in the developing world, it will be good news for many. But uncertainties remain about the other forces that may move his hand less helpfully. Let us uphold him and all leaders [9] in prayer.

references

1. Gershon M. Weasels vs AIDS Relief. *Washington Post*, 28 January 2009, *http://is.gd/kdYd*
2. *www.pepfar.gov*
3. Goldenberg S, MacAskill E. Ban on US abortion funding lifted as Bush ideology is rolled back. *The Guardian*, 24 January 2009, accessed at *http://is.gd/kdZP*
4. *www.pepfarwatch.org*
5. *www.theglobalfund.org/en*
6. Goldberg M. Ending the Compromise Era on AIDS. *The American Prospect*, 13 February 2009, accessed at *http://is.gd/ke0K*
7. PEPFAR Results 2008. Progress Achieved through September 30 2008, accessed at *http://is.gd/ke1r*
8. Huber D *et al*. International Family Planning: Christian Actions and Attitudes - A Survey of Christian Connections for International Health Member Organizations, August 2008, accessed at *http://is.gd/ke2W*
9. Romans 13:1-7

Coroners and Justice Bill

Hijack attempt underway

Review by **Peter Saunders**
CMF General Secretary

In recent months and as part of a concerted campaign, assisted dying has constantly been in the media spotlight through the Debbie Purdy case (seeking immunity for her husband from prosecution should he accompany her to commit suicide abroad), Craig Ewart's *SKY Real Lives* documentary (covering his death at the Dignitas suicide facility in Zurich), the BBC drama on the January 2006 suicide of Bath GP Anne Turner, and the double suicide of Peter and Penny Duff. [1] While British deaths at Dignitas remain small (100 in five years or 1 in 30,000 British deaths) these high profile 'hard cases', it is claimed, call for a change in the law.

Since the defeat of Lord Joffe's *Assisted Dying for the Terminally Ill Bill* in May 2006 the pro-euthanasia lobby have been regrouping for another assault on Westminster. It is now clear that this will come via the *Coroners and Justice Bill*. [2,3] The Bill was introduced into the House of Commons on 14 January 2009, was debated at Second Reading on 26 January, has been since scrutinised by a committee of MPs, and will have its Report Stage and Third Reading in late March, thereafter passing to the House of Lords.

This complex government Bill actually contains nothing about assisted dying, but rather has provisions to tighten up the Suicide Act 1961 in the wake of the Bridgend suicides. [4] We expect though that from Commons Report stage on there will be repeated attempts to hijack it to legalise assisted suicide.

This has been made explicit by former Health Minister Lord Warner, [5] by *Dignity in Dying* CEO Sarah Wootton in a letter to *The Times*, [6] by David Winnick MP in an Early Day Motion (EDM 230) signed by over 100 MPs, by Liberal Democrat MP David Howarth in speeches to Parliament, and through *Dignity in Dying* running a grassroots campaign.

To legalise assisted dying, especially at a time of economic crisis, would inevitably place pressure on vulnerable people to choose to end their lives for fear of being a financial or emotional burden upon others.

The Prime Minister twice in December 2008 expressed his opposition to any change in the law to allow assisted dying, [7] and there appears to be no government intention to do so. However, the price of freedom is eternal vigilance, and the voices of Christian doctors in writing and speaking to MPs, educating churches and colleagues, and commenting in the media will be essential in safeguarding the law and in promoting better care for those who are terminally or chronically ill.

references

1. All reviewed at *www.carenotkilling.org.uk*
2. *www.carenotkilling.org.uk/?show=673*
3. *www.dyingwell.org.uk/images/pdfs/march2009brief.pdf*
4. *The Times* 2008; 19 February. *www.timesonline.co.uk/tol/news/uk/article3399528.ece*
5. *The Times* 2008; 14 December. *www.timesonline.co.uk/tol/life_and_style/health/article5337761.ece*
6. *The Times* 2009; 26 January. *www.timesonline.co.uk/tol/comment/letters/article5586104.ece?print=yes%26randnum=1232983879020*
7. *www.carenotkilling.org.uk/?show=633*

Like a virgin?

The details prove that social factors encouraging virginity do show benefit

Review by **Trevor Stammers**
CMF Chairman, GP, and Lecturer

The Chief Medical Officer advocates total abstinence from alcohol for under-15s,[1] but encouraging abstinence from underage sex is usually ridiculed. No surprise therefore that misleading headlines about a new study[2] on US virginity pledges were universally along the lines of 'Virginity pledge ineffective against teen sex despite government funding'.[3] The study showed those who made an abstinence pledge were just as likely to have had sex at age 21 as those who had not pledged, and were less likely to have used condoms at first intercourse.

Recently however, the RAND Corporation found that virginity pledges did delay sexual intercourse and did *not* decrease condom use.[4] Why then the differing findings? As so often, it all depends on the sampling. The RAND study included those as young as 12 and examined sexual experience 1-3 years later, whereas Rosenbaum only sampled over-15s and examined their sexual experience 5 years later when aged 21-23. Both studies carried out propensity score matching[5] to try and eliminate variables other than pledging. This meant that both pledging and non-pledging samples were matched, eg, for religiosity.

Perhaps it is not surprising then that, at 21-23, Rosenbaum's pledgers and matched non-pledgers did not differ in premarital sex, sexually transmitted diseases, anal and oral sex variables, since they all came from similar home backgrounds whether they pledged or not. What went largely unreported, however, was that *both* Rosenbaum groups demonstrated less teen pregnancy; fewer friends who used drugs; less premarital vaginal sex than US teenagers overall; and that the average age of first intercourse for both groups was 21 against the US average of 17.[6]

The Rosenbaum study then actually shows common factors in both matched groups that delay first intercourse by around four years, confirming many studies showing religion, family structure[7] and parental attitudes to sex[8] have a major influence on age of first coitus with no evidence of increased harm. STI rates were not statistically different at 5% level, even though they reported far less condom use. In fact the chlamydia rates were over 40% lower in the pledging group. For Rosenbaum to conclude that 'virginity pledge programmes do not prepare pledgers to protect their health if they have sex' and for the UK media to propagate it, is yet another case of the blind leading the blind.[9]

references

1. *www.timesonline.co.uk/tol/life_and_style/health/article5607712.ece*
2. Rosenbaum J. Patient Teenagers? A Comparison of the Sexual Behavior of Virginity Pledgers and Matched Nonpledgers. *Pediatrics* 2009; 123 No 1 January: e110-e120 (doi:10.1542/peds.2008-0407)
3. Hopkins Tanne J. Virginity pledge ineffective against teen sex despite government funding. *BMJ* 2008; 337:a3168
4. Martino SC *et al*. Virginity Pledges Among the Willing: Delays in First Intercourse and Consistency of Condom Use. *Journal of Adolescent Health* 2008; 43, 4, October: 341-348
5. *http://en.wikipedia.org/wiki/Propensity_score_matching*
6. McGurn W. Like a Virgin: The Press Take On Teenage Sex. *Wall Street Journal* 6 January 2009 *http://online.wsj.com/article/SB123120095259855597.html*
7. Stammers T. Teenage pregnancies are influenced by family structure. *BMJ* 2004; 329:174
8. Stammers T. Sexual Health in Adolescents. *BMJ* 2007; 334:103-4
9. Luke 6:39

End of life care in Scotland

Comprehensive palliative provision or physician assistance to die?

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

CMF has about 450 doctor and 100 student members in Scotland, and since devolution of health policy, they have had to face some different challenges. At the time of writing, two Members of the Scottish Parliament are reviewing results of their radically different consultations on end of life care.

Margo MacDonald MSP has Parkinson's disease and supports assisted dying. In December 2008 she sought views on her proposed End of Life Choices (Scotland) Bill.[1] CMF is now mainly opposing euthanasia through its membership of the Care Not Killing Alliance[2] which brings together disability and human rights organisations, healthcare and palliative care groups, and faith-based organisations to promote palliative care, prevent weakening or change of the law, and influence public opinion. Their robust response[3] criticises the consultation's lack of clarity (does it advocate euthanasia or physician assisted suicide or both?) and its lack of detail, particularly about 'safeguards'. CMF Scotland's submission[4] develops some specifically Christian arguments and amplifies medical and public policy concerns. MacDonald needs 18 MSP signatures to have any chance of her proposed Bill being debated in the Scottish Parliament.

Meanwhile, Roseanna Cunningham MSP has been consulting[5] on a proposal to make needs-based palliative care uniformly available across Scotland. She 'highlights the uneven access to palliative care in Scotland' and 'aims to place a statutory duty on health boards in Scotland to provide high-quality palliative care to those who need it'.

This edition of *Triple Helix* features[6] some of the conclusions of an innovative primary care research group in Edinburgh developing palliative care which is accessible for people with all life-threatening illnesses, is delivered in the community, and explores spiritual distress at the end of life. There are characteristic trajectories of physical decline at the end of life which also have a spiritual dimension, and this understanding allows spiritual support to be planned and delivered to patients and their carers to relieve distress and help in the search for meaning and purpose. CMF supports care, not killing.

references

1. The proposed End of Life Choices (Scotland) Bill. Consultation document. *www.scottish.parliament.uk/s3/bills/MembersBills/pdfs/EndOfLifeChoicesConsultation.pdf*
2. *www.carenotkilling.org.uk*
3. *www.carenotkilling.org.uk/?show=682*
4. *www.cmf.org.uk/ethics/submissions/?id=59*
5. The proposed Palliative Care (Scotland) Bill. Consultation document. *www.scottish.parliament.uk/s3/bills/MembersBills/pdfs/PalliativeCareConsultation.pdf*
6. Murray S. Spiritual support in palliative care. *Triple Helix* 2009; Easter:8-10

Cameron Swift calls more Christians into caring for people with dementia

DEMENTIA

key points

After reviewing aspects of dementia and commenting on its impact, the author reflects on recent coverage, both negative and more positive.

While the challenges presented may appear to be ethical ones, they can often be radically reduced or eliminated by the professional competence and skill of care providers working as teams.

Because we find the prospect of euthanasia abhorrent, Christian doctors must get more involved at the intellectual, advocacy, clinical, scientific and professional levels.

The syndrome of dementia comprises a range of disorders. The most common are significantly age-associated: Alzheimer's disease, dementia with Lewy bodies (DLB), frontotemporal dementia, vascular dementia and dementias of mixed origin. The estimated prevalence is 1% in those aged 65-69, rising to 34% in those over 95.[1] Increase is predicted by 2050 in proportion to the relative numbers of the population achieving advanced age. Some important generalisations:

- Dementia is by definition progressive and irreversible, but its natural history and severity (including prognosis for life – sometimes 20 years from diagnosis) are variable and often unpredictable.
- Diagnosis may prove difficult. Both premature misdiagnosis and delayed diagnosis (sometimes because of concealment) are common.
- There has been substantial progress in the neuroscience. Responders, a subset, derive useful short-term cognitive benefit from cholinomimetic agents, but effective disease-modifying interventions are awaited.
- Levels of distress, often prolonged, are characteristically though not invariably greater amongst loved ones than amongst sufferers themselves. The social and microeconomic consequences are frequently far reaching.

Recent coverage

In September 2008 an interview given by Baroness Warnock to the Church of Scotland magazine *Life and Work* was reported:

The veteran Government adviser said pensioners in mental decline are 'wasting people's lives' because of the care they require and should be allowed to opt for euthanasia even if they are not in pain. She insisted there was 'nothing wrong' with people being helped to die for the sake of their loved ones or society. The 84-year-old added that she hoped people will soon be 'licensed to put others down' if they are unable to look after themselves.[2]

Dame Joan Bakewell was recently appointed official 'voice of older people' and, at least by implication, later linked her new role to her support for debating assisted suicide and her advocacy of living wills.[3]

The Nuffield Council on Bioethics undertook a more balanced national consultation on ethical aspects, seeking to examine the experience of dementia, implications for personality and identity, decision making, aspects of care delivery, carers' needs, and research priorities and conduct.[4] CMF responded[5] and the final report is still awaited.

Dementia presents challenges which appear to be 'ethical' in three main areas:

- adverse prognosis and end-of-life care
- loss of capacity and its management
- resource allocation and economics

Advance directives

Carefully prepared advance directives may have a place if their real aim is to facilitate consensus between clinicians and proxies. However, meddlesome intensivism in treating dementia sufferers is rare in my experience. It would be exceptional not to factor in a known prior diagnosis of clinically significant dementia when deciding the capacity to benefit from advanced life support, and it would be a clear exclusion criterion for many major invasive procedures.

Interpreting an advance directive often becomes difficult and must ethically be set in the context and balance of other indicators of 'best interest'. For example, for a femoral fracture, hip surgery (normally with antibiotic prophylaxis) is now usually the best, kindest and most cost effective treatment, even for individuals with dementia and poor mobility, such that 'conservative' alternatives are inhumane and expensive by comparison.[6] This might require some considerable persuasion with a nominated proxy holding a directive. Best technology is not always synonymous with disproportionate intensivism.

Sadly, Dame Joan's spectre of 'a lot of enormous machinery that can keep them pumped up'[3] portrays a simplistic, populist distortion of clinical decision making that is inappropriate to her current role. Sufferers from early dementia should not be frightened or pressured into instigating such directives, either to 'defend' themselves from inappropriate medical 'interference' or because relatives, Baroness Warnock or Dame Joan Bakewell assert this is inherently a good thing.

Paradoxically, far more common and potentially far more damaging is applying a 'label' of dementia as a pretext for 'DNDA' – do not do anything (including pursue a diagnosis!) An advance directive might better stipulate that clinical rigour be sustained unless and until proven of no demonstrable benefit, and a far better solution still would be to eliminate the perhaps justifiable fear amongst older people that health care as a whole may not always guarantee their best interests.

Personhood, ethics, and expertise

However severe and distressing the case, we cannot scientifically, professionally or ethically determine whether or when dementia's manifestations might conceivably annul personhood, identity, or (importantly) relationships. A daughter responding to Dame Joan wrote:

*How does one judge that one's identity has faded away exactly? The Dad I had before his dementia diagnosis was a completely different Dad to the Dad I have today. Definitely his old identity has faded away, however he now has a new identity and it was born from his struggles to fight this damn disease. I'll be ******** if I'll put up with outsiders thinking they know what is best for him and what he wants when they will never know what his life is like unless they have lived it…Oh dear, I ranted didn't I?*[7]

I don't think so. Our biblical understanding of *homo divinus* – man's God-given and permanent identity in his image[8] – directly applies; but outside Christian circles the non-destructibility of personhood still squares with reality, and society erodes that concept at its peril.

The successful clinical, rehabilitative and social management of dementia sufferers challenges the best multidisciplinary skills of health and social care professionals. The frequency of 'ethical' concerns in decision making and care provision, like using restraint or 'truth telling', can be radically reduced or eliminated by the professional competence and skill of care providers working as teams in an appropriately configured environment. 'Ethics' may sometimes be invoked as absolution for poor standards or systemic neglect.

Euthanasia

The fundamental objections elaborated by CMF[9] and elsewhere apply absolutely. Baroness Warnock's prosecution of it in this context effectively discards any prior professed commitment to its allegedly voluntary basis, and exemplifies the 'slippery slope' by arguing (?for the first time) an explicitly economic and social rationale. Thankfully, it remains an accepted human standard within 'post-Christian' Britain to strive to overcome disadvantage and care for those disadvantaged, but can we be complacent?

Independently of the moral rationale, the 'economic tsunami' argument, though complex, is by no means established in evidence. The Royal Commission on Long Term Care[10] refuted the 'demographic timebomb' concept. Informed contemporary debate is balanced,[11] but economic alarmism is energetically invoked by those with deeper ideological motives. Conversely, co-ordinating and delivering quality services leads to substantial cost efficiency gains.

Pursuing excellence vs doctrine of despair

Dementia services can be done magnificently. I have been privileged to witness some of the best examples, not least the skills of some outstanding nurses in old age psychiatry, both in the community and in specialist units. Significant progress has been made in understanding, organising and providing health and social care for dementia sufferers. Benchmark centres and standards have emerged although access to the best and most skilled care is still very patchy. Key is the identification, recognition and comprehensive support of the often immeasurable care delivered by families and informal carers.

Effective collaboration between the specialist old age services in psychiatry and medicine, and between primary and secondary care, is essential and effective.[12,13] There is gradual progress, not least in recognising achievement in the delivery of 'conventional' medical/social care (as distinct from radical 'blue-skies' science). More long-term data is needed. There are promising new lines of research in basic and clinical neuroscience, but research expenditure is disproportionately low in relation to health care cost.

NICE has produced specific guidance.[14] Although the pharmacological recommendations have proved controversial, much of the clinical guidance is excellent. The designation 'Cinderella service' is a contradiction in terms, a perception underpinning the current enquiry of the All-Party Parliamentary Group on Dementia into training,[15] and the launch of a National Dementia Strategy.[16]

A Christian response

Get involved.[17] As we have begun to see in good palliative care, the best response to unethical 'solutions' is to render them superfluous by advances in knowledge, good professional practice and technical expertise. This is true for dementia services. If as Christian medics we find the concept of economic euthanasia abhorrent, we all have a duty to engage directly at the intellectual, advocacy, clinical, scientific or professional levels. There are Christians in old age psychiatry but not enough.

In her little book *If it's not too much trouble* Ann Benton states 'the one thing I knew I wanted to do was to get Dad out of the hands of professional 'carers'. Bring on the Christians.'[18] But we cannot endorse this dichotomy, can we?

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references

1. Dementia UK. The full report. LSE, King's College London, Alzheimer's Society, 2007. *www.alzheimers.org.uk*
2. Beckford M. Dementia sufferers may have a 'duty to die'. *Daily Telegraph*, 19 September 2008. *www.telegraph.co.uk*
3. Beckford M. Don't keep pensioners alive indefinitely, says old people tsar Dame Joan Bakewell. *Daily Telegraph*, 17 November 2008. *www.telegraph.co.uk*
4. Dementia: ethical issues. Consultation paper. Nuffield Council on Bioethics, 2008. *www.nuffieldbioethics.org*
5. Submission from the Christian Medical Fellowship to the Nuffield Council on Bioethics' Consultation: Dementia: ethical issues, 2008. *www.cmf.org.uk*
6. *The care of patients with fragility fractures: the 'blue book'*. NHS National Library for Health, 2007. *www.library.nhs.uk*
7. Anon. Don't keep pensioners alive indefinitely – Dame Joan Bakewell says. *Daily Dementia News*, 17 November 2008. *www.dailydementianews.com*
8. Genesis 1:26-7
9. *www.cmf.org.uk/index/euthanasia.htm*
10. *With Respect to Old Age: Long Term Care – Rights and Responsibilities*. The Stationery Office, 1999. *www.archive.official-documents.co.uk*
11. Comas-Herrera A *et al*. Cognitive impairment in older people: future demand for long-term care services and the associated costs. *Int J Geriatr Psychiatry* 2007; 22(10):1037-45
12. Bullock R *et al*. Can we afford not to have integrated dementia services? *Age and Ageing* 2007; 36:357-8
13. Jolley D. Integrated services for people with dementia. *Age and Ageing* 2008; 37(2): 237
14. CG 42 Dementia: NICE guideline. National Institute for Health and Clinical Excellence, 2006. *www.nice.org.uk/Guidance*
15. MPs launch enquiry into dementia workforce. *Alzheimer's Society news*. 29 January 2009. *www.alzheimers.org.uk*
16. *Living well with dementia: a National Dementia Strategy*. Department of Health, 2009. *www.dh.gov.uk*
17. Isaiah 1:17; James 1:27
18. Benton, A. *If it's not too much trouble. The Challenge of the Aged Parent*. Christian Focus Publications, Fearn, Scotland, 2007

Scott A Murray on spiritual needs at the end of life

Spiritual support in palliative care

key points

The author leads an innovative research group developing palliative care which is accessible for people with all life-threatening illnesses, is delivered in the community, and explores spiritual distress at the end of life.

There are three characteristic trajectories of physical decline at the end of life: a cancer trajectory with steady progression and usually a clear terminal phase; an organ failure trajectory with gradual decline punctuated by episodes of acute deterioration and eventually a seemingly unexpected death; and a frailty trajectory of prolonged gradual decline, typical of physical frailty and dementia.

These trajectories also have a spiritual dimension, and this understanding allows spiritual support to be planned and delivered to patients and their carers to relieve distress and help in the search for meaning and purpose.

Scott Murray graduated in Aberdeen, and served as a medical missionary at Chogoria Hospital, Kenya for seven years. Returning to general practice in Edinburgh, he used a community participatory approach learnt in Africa to help develop medical and social care in an economically poor area in central Edinburgh. More recently he has started to research the experiences and needs of people at the end of life, suspecting that the spiritual dimension may be relatively neglected in current palliative care practice.

He currently leads an innovative group at Edinburgh University that seeks to carry out research to develop palliative care which is accessible for people with all life-threatening illnesses, is delivered in the community where more people may wish to die, and which explores spiritual distress at the end of life. In 2008 he won a competition in the *BMJ* by highlighting end of life care beyond cancer as a neglected area in medicine. 'Palliative care for all' is now prioritised by the *BMJ* and its sister journals for publishing research and for developing learning resources.

Dying is a multidimensional experience. It is not just a physical demise, and as doctors we must strive to identify and meet the multidimensional needs of people with progressive disease. Centuries ago, spiritual care dominated end of life care. Although palliative care set out 40 years ago to address the suffering of 'total pain', including lack of personal integrity and inner peace, spiritual distress at the end of life has been relatively unexplored.[1] But it is accepted that quality of life is modified by all dimensions of personhood.[2]

Three characteristic trajectories

Recent studies in the USA[3] and by our Primary Palliative Care Research team in Edinburgh University[4] have identified that most people with progressive chronic illness follow one of three characteristic trajectories of physical decline at the end of life.

These include a **cancer** trajectory with steady progression and usually a clear terminal phase; an **organ failure** trajectory with gradual decline punctuated by episodes of acute deterioration and eventually a seemingly unexpected death; and a **frailty** trajectory of prolonged gradual decline, typical of physical frailty and dementia. Figure 1 illustrates this, and estimates the number of patients each year who die on each trajectory per general practitioner with a list of 2,000 patients. These trajectories have recently informed End of Life Strategies in England and in Scotland and are now in the mainstream of palliative care education. Consideration of these patterns may help clinicians anticipate likely physical needs in the last year of life and plan care that integrates disease modifying and palliative care.

Other dimensions of need

But what is going on with the other dimensions of need? Spiritual issues are frequently very significant for people living and dying with lung cancer and heart failure.[5] Might there be typical patterns of social, psychological and spiritual needs towards the end of life? We conducted a secondary analysis of in-depth serial interviews which we had carried out in recent studies to answer this question.[6,7]

Defining and assessing spiritual needs is problematic. We used a definition relevant in the secular UK NHS context: *spiritual needs are the needs and expectations that human beings have to find meaning and purpose in life; such needs may be specifically religious but even people who have no religious faith or who are not members of an organised religion have belief systems relating to meaning and purpose.*[8]

We did indeed find characteristic social, psychological and spiritual end of life patterns as we read and re-read the in-depth serial interviews which were conducted every three months in the last year of life, with participants talking about their main worries and concerns.[9] In lung cancer, the social trajectory mirrored physical decline while the psychological and spiritual wellbeing decreased together at four key transitions: at diagnosis, after getting home after initial treatment, during disease progression, and in the terminal stage. In advanced heart failure, social and psychological decline both tended to track the physical decline while spiritual distress exhibited background fluctuations (see Figures 2 and 3).

We have published our detailed findings[9] but an outline of the spiritual 'trajectories' follows:

Lung cancer

For patients with lung cancer we learned that most people at diagnosis considered the prospect of suffering and dying – and many considered it even earlier, during the period leading to a formal diagnosis. Returning home at the end of inpatient treatment, many patients expressed issues about emptiness and searching, struggled to return to their own life, and questioned their self worth and their value to others.

At disease progression or recurrence, some people wondered what they had achieved in their lives and what needed to be done before death. Some patients, perceiving they had no future, felt that their life in the present was pointless.

In the terminal phase an acceptance of death was sometimes apparent. Some worried if they had been good enough during their life and feared to die, and others felt confident in their death knowing that death was a transition rather than the end: 'It oscillates terribly between a total and absolute panic and an excitement to see what it's going to be like'.

Figure 1.
Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients.

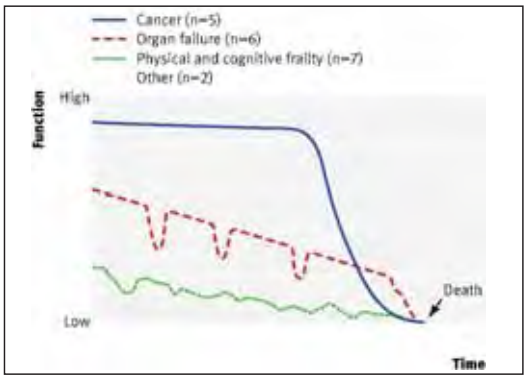


Figure 2.
Physical, social, psychological and spiritual wellbeing in the last year of life.

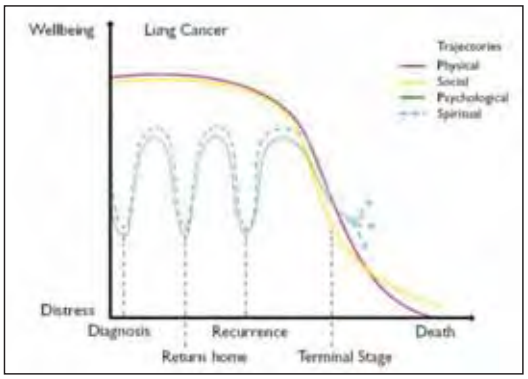
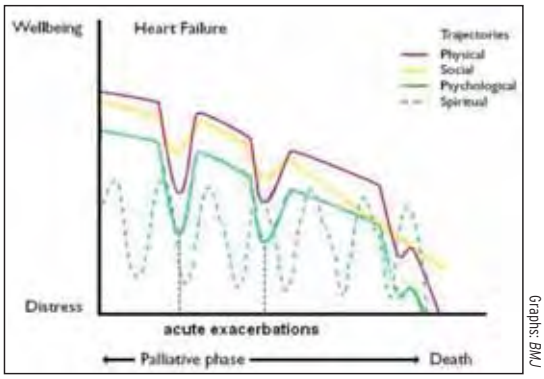


Figure 3.
Physical, social, psychological and spiritual wellbeing in the last year of life.



Graphs: *BMJ*

Heart failure

Spiritual needs in people with heart failure reflected a progressive loss of identity and growing dependence. As their illness incapacitated them, patients who felt valued and affirmed described being more able to come to terms with their life and retain a sense of worth and meaning. Suffering was sometimes moderated by positive aspects such as love, hope, trust, and forgiveness. While some were supported and comforted by their religious belief, others wondered about judgment or divine indifference. 'Where is God in all this? Has God forsaken me?'

'4D' care planning

The extent to which these findings from Scotland are generalisable to different national, social,

Dying is a multidimensional experience. It is not just a physical demise, and as doctors we must strive to identify and meet the multidimensional needs of people with progressive disease

ethnic and religious groups is unknown. Individual patients will die, some unexpectedly, at different stages in these trajectories and rates of progression vary. However, I have found that mapping out these patterns to medical students and doctors has allowed them to understand that care planning must be four dimensional, or '4D'.

We can anticipate and share with patients when they are likely to be distressed. Explanation to patients and their carers about when practical, emotional and existential issues might be expected to occur, and the services available, can empower them and their carers, and this can be very reassuring for all. In Hippocrates' day, the physician who could foretell the course of the illness was the most highly esteemed, even if he could not alter it.[2]

This mapping thus helps build a big picture, a wide perspective to help us understand and anticipate the likely needs of individuals. This holistic approach, considering each dimension of need, may moderate the current 'technological imperative' when care is focused on interventions to prolong life, with sometimes overzealous and futile treatment. Considering these different trajectories brings spiritual assessment and care into focus, and highlights that many patients have spiritual issues from *diagnosis* of cancer or chronic life threatening illness, not just at the very end of life.

What is 'spiritual support'?

The implication of this is that spiritual support should be available for patients from diagnosis, sooner rather than later. But what is spiritual support? We asked a number of patients with advanced illness in the community how they got 'spiritual support', and they tended to reflect and respond as follows: 'It was the nurse who sat down and listened and…' A patient-centred approach that supports people in their own worldview while allowing for expression of fear, doubt and anxiety may help patients in their search for meaning and purpose, and prevent spiritual concerns amounting to disabling spiritual distress. As Dr Derek Doyle used to teach, we need both the courage and to take the time to 'sit down and shut up'.

Adopting patient-centred supportive care: possible questions[10]

- What's the most important issue in your life right now?
- What helps you keep going?
- How do you see the future?
- What is your greatest worry or concern?
- Are there ever times when you feel down?
- If things got worse, where would you like to be cared for?

spiritual support should be available for patients from diagnosis, sooner rather than later

Allowing patients to raise spiritual and religious issues may be therapeutic, as may the use of a gentle prompt, such as: 'You seem fine today, but do you ever feel down or a bit low?' This may allow them to reveal their personally-felt narrative, rather than the public account they may tend to offer, as patients often have competing narratives in their minds. Patients may sometimes ask us about our own beliefs. When asked about my own faith I've often found it useful to acknowledge the question and say that I will explain, but first I tend to reflect the question back to the patient to ask them about their beliefs. This is because they may just be looking for an opportunity to express where they are on this issue.

A welcome innovation

The concept of illness trajectories, not only physical, but also those of social, psychological and spiritual wellbeing or distress, is a welcome innovation to help understand the lived experience of dying. Carers may also have social, psychological and spiritual issues simultaneously with their loved one. We must now use this understanding to plan services which respond to patients' needs, which will include holistic care from the diagnosis of a life-threatening illness. Lessons learnt in caring for patients who die of cancer must also be extended to embrace patients in general – the majority of whom die from other conditions.[11]

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references

1. Saunders C. Into the valley of the shadow of death: a personal therapeutic journey. *BMJ* 1996; 313:1599-1601
2. Cassell E. *The nature of suffering*. New York: Oxford University Press, 1991
3. Lunney J *et al*. Patterns of functional decline at the end of life. *JAMA* 2003; 289:2387-2392
4. Murray S *et al*. Illness trajectories and palliative care. Clinical Review. *BMJ* 2005; 330:1007-11
5. Murray S *et al*. Exploring the spiritual needs of people dying of lung cancer or heart failure: prospective qualitative interview study. *Pall Med* 2004; 18:39-45
6. Grant E *et al*. Spiritual issues and needs: perspectives from patients with advanced cancer and non-malignant disease. A qualitative study. *Pall Supp Care* 2004; 2:371-78
7. Murray S *et al*. Dying of lung cancer or heart failure: prospective qualitative interview study of patients and their carers in the community. *BMJ* 2002; 325:929-32
8. Institute of Medicine. *Approaching death, improving care at the end of life*. Washington DC: National Academy Press, 1997
9. Murray S *et al*. Patterns of social, psychological and spiritual decline towards the end of life in lung cancer and heart failure. *Journal of Pain & Symptom Management* 2007; 34:393-402
10. Murray S *et al*. Palliative care in chronic illness. *BMJ* 2005; 330:611-612
11. Murray S, Sheikh A. Care for all at the end of life. *BMJ* 2008; 336:958-959

Katy Lane on social action

Photo: PA Photos

A New Year resolution

I write this at the start of a new year, when many people make resolutions. It's an opportunity to make a change – a positive action to stop doing one thing, or start doing something else. Although never particularly drawn to resolutions, I have been challenged to rethink my attitude and behaviour by a Christmas-present book. *A Heart of Compassion*[1] is written by a Christian GP, who recounts all he has learned through his interactions with the downtrodden in society.

He writes: 'God's grace, his love, and his heart of compassion, do not seek a reason to be offered. God simply sees each one of us as beautiful, the most handsome of men, the most beautiful of women, and he simply loves us for who we are.' He challenges the reader to live this compassionate life, to see everyone through God's eyes, and to take action.

Social action

Sara Morgenstern is a junior doctor working in London. She explains why and how she got involved in social action, the challenges and the rewards, and why we too should reach out:

I believe God is passionate about 'social action', specifically 'social justice' and that's why I'm involved in it. In Micah we are told to 'act justly and to love mercy and to walk humbly with your God'.[2] *The prophet Amos describes how much God hates hypocrisy; how he is more interested in justice than in Israel's sacrifices and outward piety.*[3] *Throughout both Old and New Testaments we see God's desire for justice to be done, and his concern for the poor and downtrodden. We also see his anger against those who ignore injustice or actively oppress others. Jesus quotes Isaiah when he declares that he has been sent to 'preach good news to the poor…to release the oppressed'.*[4] *I do not think it is possible to follow Jesus and ignore injustice in our world.*

My personal involvement started during my teenage years, when I began to understand God's heart for the poor. I helped out in 'Soul Survivor' days, clearing litter and generally serving people on rough estates. I arrived at uni particularly wanting to work with homeless people, and got involved in the homeless soup run at my university. It was a great way to start as the time commitment was whatever you could afford; although I went on to help organise, and then chair the group for two years! I still drive the minibus when I can.

Through running the group God gave me many other opportunities, including visiting an elderly lady via a Christian charity in Roehampton called Regenerate-RISE.[5] *I've now gone on to become a trustee for them, and still visit the lady, who's become my friend.*

There are many rewards from being involved in social action, doing something practical to express God's love to the disadvantaged and to counter injustice in the world. Through the soup run we see our views on homeless people challenged and changed, just by getting to know them and their situations. I for one realised that they too were God's children, deserving to be treated as such. Feedback from the homeless who come has remained overwhelmingly positive, which also spurs you on when it's raining, or when challenges come. As a Christian I found I had many opportunities to have discussions with people about God, often initiated by them rather than me! I've even been able to pray for the occasional person on the street with the group's agreement… and this despite it not being a Christian group. In my work with RISE the most satisfying thing is to see God's character embodied, specifically his love and care for those who are lonely or isolated, and to see people changed by it.

> There are many rewards from being involved in social action

The challenges are as you would expect – getting funding, prioritising time to be able to get to meetings, and overcoming differing points of view as to the way forward. But through it all I've seen God at work behind the scenes, bringing in his kingdom.

I now see social action not as something we are called to do once a week, but as a way of life. My dream (one that I pray God has put on my heart) is to be a GP, living and working in a community not only to meet peoples' health needs, but also their social and spiritual ones. What's yours?

Having a heart of compassion

As junior doctors we face many different time pressures, and many of us will already be involved in outreach and service. You may not be challenged to the same extent of involvement as Sara, but in our daily practice we all face those in far less fortunate situations, those who are vulnerable, and those who society tries to ignore. How do you respond to these patients? We do not have to go out onto the streets to begin to reach out: it's a way of life, it's a change of heart and a fresh reminder of grace, it can start right where you are, right now.

Open my eyes, Lord, to people around me,
Help me to see them as You do above;
Give me the wisdom and strength to take action
So others may see the depth of Your love.[6]

***Katy Lane** is an FY1 doctor in Leeds*

references

1. Clarke P. *A Heart of Compassion*. Authentic Media, 2006
2. Micah 6:8
3. Amos 5
4. Luke 4:18
5. *www.regenerate-rise.co.uk*
6. de Haan K. Cited in *Our Daily Bread*, December 2008-February 2009

Rachael Pope on negative behaviours in the workplace

STAFF BEHAVING BADLY

key points

Following personal experiences the author, a physiotherapist, became interested in negative behaviours in the NHS. She discusses published examples which illustrate national data.

Seeing these behaviours as broader than 'bullying', she conducted research into workplace incivility and aggression as well, and recorded that all these had a negative impact on job satisfaction, motivation, commitment and co-operation. All negative behaviour damages the individual and the organisation, and has implications for the quality of care delivered to patients.

Considering other research about the qualities of effective leaders and managers, she points the reader towards Christ, the servant leader of all.

A matron in a small community hospital where years ago I worked as a physiotherapist was asked by a local GP how they could get rid of me. This was one of several GPs who were behaving quite negatively towards me, and the result of that conversation was an overwhelming feeling of intimidation and vulnerability.

Over a period of time my confidence was destroyed and I found it extremely difficult to go into work. When I saw certain cars parked I would feel physically sick. Though the actual incidents were few, the fear of something else happening eroded my confidence and professional ability. The situation was complicated and worsened because two of the GPs were actually churchgoers, though sadly they behaved aggressively and arrogantly.

You feel at the time you are the only one. The feelings of failure, shame and embarrassment were immense and because of this I didn't initially share my predicament with other staff. I did leave however, as one of several who couldn't manage the situation. Later, I was asked to go to two industrial tribunals as a witness. Just reliving the experience was a trauma and despite the RCN winning the cases, the whole process was psychologically and emotionally damaging.

I am convinced that if it weren't for my Christian faith I would have had a breakdown. What helped me were the words of the song 'In heavenly armour' holding me together: 'No weapon that's fashioned against you will stand; the battle belongs to the Lord'.

Negative behaviour

This experience started me looking at negative behaviour between staff in the NHS, and its effect. It gave me a passionate interest in issues of fairness and justice in the workplace, which has been worked out in a trade union representative role where I have attempted to support people experiencing negative behaviour and tried to improve policy. In 2003, working with an HR colleague in another Trust, we initiated a Harassment Advisor service to run across the two Trusts.

I have now seen far too many people in the NHS damaged by negative behaviours from colleagues and managers. As a result, when I completed my MSc in Human Resource Leadership it didn't take me long to choose the topic for my dissertation research. When looking at literature on negative behaviour in the workplace I came across a moving 2001 *BMJ* article [1] which described the experiences of a junior doctor being intimidated and traumatised by the behaviour of their surgical consultant. They described themselves as disillusioned and wrote 'I don't know why bullying still has to be part of medical training'. They closed by suggesting that 'perhaps some doctors should ask themselves whether they are part of the caring profession at all'.

In 2002 the *Nursing Times* [2] asked: 'Why is bullying in the workplace such an intractable problem in the 'caring' professions?' More recently Mark Cheesman stated that bullying is 'alive and well, an integral part of NHS culture' and importantly expressed the view that 'it's high time we confronted it'. [3] He gave good advice on ways to do that in the context of maintaining a Christian response.

This January an anonymous writer who had been in a senior NHS position shared [4] a very damaging experience of being bullied by people at the top of the organisation. He or she considered that Human Resource personnel were implicated and used the phrase 'institutional bullying'.

These comments and stories are supported by national research data. The most recent Staff Attitude Survey (2007) confirms that across the country the problem continues. Eight percent of staff reported 'harassment, bullying and abuse' from managers and team leaders and 13% reported it from colleagues.[5] In the first surveys in 2003 and 2004 the total for these two groups was only 16%.[6]

Broader than 'bullying'

The language mostly used is the language of 'bullying'. In 2005 I conducted research in two primary care trusts,[7] and wanted to look at a broader range of behaviours than 'bullying'. For the purpose of the research, negative workplace behaviour was defined as: 'Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations.'

Negative behaviour was then defined in three categories:

- **Workplace incivility**: Rude, insensitive or disrespectful behaviour towards others in the workplace with ambiguous/unclear intent to harm.[8]
- **Aggression**: Aggressive behaviour with the unambiguous, clear, intent of causing harm to a person.[8]
- **Bullying**: Offensive, abusive, intimidating, malicious or insulting behaviour or abuse of power, which makes the recipient feel upset, threatened, humiliated or vulnerable, undermines their self confidence and may cause them stress.[9]

I wanted to find out what behaviours were experienced as well as prevalence, frequency, effects, and people's responses. I then asked staff to define behaviours as incivility and/or aggression, and to state whether they also thought the behaviour was bullying or not. Some of the results were unexpected.

Research results

With experienced and/or witnessed behaviour, the incidence rate was very high (63 and 52.8%). The most common negative behaviours identified from a list of 27 were:

- Claiming credit for someone else's work.
- Setting out to make a member of staff appear incompetent and/or make their lives miserable through persistent criticism.
- Deliberately withholding information/providing incorrect information.
- Isolating/deliberately ignoring/excluding someone from activities.

Most behaviour was described as incivility, with approximately half also classed as bullying, while the rest was incivility not perceived as bullying. What was particularly interesting and unexpected was that the incivility not classed as bullying had almost identical levels of effect as the incivility also viewed as bullying. The smaller number of people who experienced aggression clearly identified greater effect and aggression was always described as bullying. Lower frequency behaviour (now and then) had similar effects to higher frequency behaviour.

All categories of behaviour had a negative impact on job satisfaction, motivation, commitment and co-operation, and those affected avoided communication and direct contact with the perpetrators. Some people admitted to retaliating (my only regret was not asking them what they did!), and some people moved jobs within their organisation. Many experienced an increase in stress levels.

Though I recognise this study was small, the findings clearly have implications for how we view negative behaviour. We have to look beyond the word 'bullying'. Organisations seem preoccupied with whether or not behaviour is bullying – if not considered 'bullying', people seem to think it doesn't count. However, all negative behaviour is damaging to the individual and the organisation, and has implications for the quality of care delivered to the patient.

Organisations need to be proactive in addressing the problems. There needs to be a clear expectation of positive behaviour throughout the organisation, of treating colleagues and subordinates with dignity and respect. Also, the emphasis needs to be on prevention and early resolution of all negative behaviour, in contrast to toleration, which is so prevalent. Any situation that is ignored escalates, and it is then difficult, if not impossible, to resolve issues sensibly without separating individuals. By then people are psychologically and emotionally damaged. Cheesman[3] describes formal resolution as 'Going nuclear'! And it is. At the formal stage a person may get justice, but the damage is huge for all concerned.

We must neither condone nor tolerate negative behaviour to ourselves or others: 'And if you see it happening to someone else, don't just look away'.[4] We must come alongside people and support them. We must not turn away even if that is costly. If we ourselves have behaved negatively we need to restore relationships swiftly.

The servant of all

As Christians we return to the scriptures and the challenges of 'Love your neighbour [colleague] as yourself'[10] with its requirement for dignity and respect for all. I am also challenged by research[11] which showed that the most effective leaders and managers firstly show a genuine concern for the wellbeing of others. They model other key positive qualities including an ability to communicate and to inspire, they empower others, and they demonstrate transparency (integrity, honesty and consistency) and accessibility and flexibility.

A good leader is 'servant, rather than hero'.[11] Familiar? We come back to following the one who truly empowers, the inspirational communicator who loves us despite our weaknesses and failings, the servant of all.

Rachael Pope *works in Dorset as a clinical specialist physiotherapist in women's health. She has started a PhD to research negative behaviour between NHS staff*

A good leader is 'servant, rather than hero'

references

1. Anon. Bullying in Medicine. *BMJ* 2001;323:1314. doi:10.1136/bmj.323.7324.1314
2. Chan P. Pull no Punches with Serial Bullies. *Nursing Times* 2002; 98(32):18
3. Cheesman, M. Bullying in the NHS. *Triple Helix* 2004; Winter:8-9
4. Anon. What do you do if your bosses are bullies? *BMJ* 2009;338:a3108
5. Healthcare Commission. National NHS staff survey for 2007. *www.healthcarecommission.org*
6. Healthcare Commission. National NHS staff survey for 2004. *www.healthcarecommission.org*
7. Burnes B, Pope R. Negative Behaviours in the Workplace: A Study of two Primary Care Trusts in the NHS. *The International Journal Of Public Sector Management 2007*; 20(4): 285-303
8. Pearson CM *et al*. When Workers Flout Convention: A Study of Workplace Incivility. *Human Relations* 2001; 54(11):1387-1419
9. Chartered Society of Physiotherapy. *Bullying at Work. Employment Relations and Union Services Health and Safety Briefing Pack No 5*. CSP, London, 1997
10. Mark 12:31
11. Alimo-Metcalfe B, Alban-Metcalfe R. Heaven can Wait. *Health Service Journal* 2000; October 12:26-29

Dewi Hughes considers the theology of harm reduction strategies

Friend of 'SINNERS'?

key points

Harm reduction strategies aim at reducing the consequences of harmful behaviour rather than at reducing the behaviours that result in lifestyle related disease. They cause lively debate within CMF.

The author argues that Old Testament law mixes absolute ideal principles and prescriptions for situations that are less than ideal, and that Jesus was a friend of 'sinners'. Following Jesus must therefore involve friendship with sinners and commitment to their total wellbeing.

While doctors' primary professional responsibility is to protect people from the health consequences of socially acceptable practices, as Christian citizens we should take every opportunity to teach God's ideal and restore a moral context to behaviour.

In his 2003 Rendle Short Lecture[1] which stimulated much debate, paediatrician Chris Richards argued that much government health policy was aimed at 'harm reduction' rather than at reducing the behaviours that result in lifestyle related disease. Key examples include measures aimed at reducing the consequences of teenage sex (condoms, antibiotics, abortion) and drug addiction (methadone, needle exchange, injecting rooms).

He argued that the effects of 'harm reduction' are often to increase rather than decrease the incidence of the behaviour that underlies the problem. Instead, Christian doctors have a prophetic responsibility to warn patients about the health consequences of sinful behaviour; not to do so is to be unfaithful both to the truth and to the Gospel.

In 2006 the advent of HPV vaccine, intended to reduce cervical cancer in women, re-ignited the lively debate about harm reduction.[2,3] For many clinicians this concept, whatever its consequences, remains an important issue and *Triple Helix* is grateful for this theological contribution.

That these applications of the concept of harm reduction have been contentious is not surprising. It is not only Christians who object to anything that deflects from the ideal answer to the harm caused by intravenous drug abuse or sexual intercourse outside a mature stable relationship. From a theological and biblical perspective the ideal answer is clearly to abstain from taking drugs and from sexual intercourse outside monogamous heterosexual marriage.

This is the optimum way of reducing harm and it prefigures the world where there will be 'no more...mourning or crying or pain'.[4] The question to be examined briefly here is whether there is any biblical or theological reason to countenance the type of harm reduction strategies referred to above, *as well as* the fail safe strategy of abstinence.

Old Testament Law

The law is clearly a mixture of absolute ideal principles and prescriptions for situations that are less than ideal. This is sometimes so obvious that it almost sounds as if the law contradicts itself. In Deuteronomy 15:4 it declares that 'there should be no poor among you' while verse 11 of the same chapter states: 'There will always be poor people in the land'. Perfect obedience would mean prosperity for all, but God provides for failure to reach that norm. Given the equation of *obedience = plenty* in verses 5-6, those with plenty could be tempted to think that it was always the result of their obedience, and that the poverty of some was always the result of their disobedience. However, this was not a judgment God allowed the prosperous to make, as he commanded them not to be hard-hearted or tight-fisted in their lending to the poor. Mercy was to be shown even to those perceived to be damaged by disobedience.

Taking action in a situation that is far from perfect, in order to reduce harm to those who are vulnerable, is clearly prescribed in the law. The divorce law in Deuteronomy 24:1-4 is a clear case in point. The practical effect of this law was to 'protect the unfortunate woman from becoming a kind of marital football, passed back and forth between

irresponsible men. It is likewise for the woman's protection that a *certificate of divorce* is to be given to the woman...since it proves her status as free to marry the second man.'[5]

What the law does in this case is reduce the harm that could be done as a result of divorce, which was allowed even though it fell short of God's ideal. While affirming the ideal, the law also recognises that the real world in which we live falls far short of it, and provides legislation that mitigates the damage resulting from this falling short. It can be argued that we have a principle here that justifies harm reduction even when subsequent actions contravene God's absolute standard. If some of the laws of the Old Testament were meant to reduce harm then it may be right in principle in a world that falls short of God's ideal to seek to reduce the harm caused by sin – especially if that ensures the physical survival of those addicted to harmful behaviour.

Jesus

The difference between Jesus and the Pharisees was that he saw religion as a matter of faith in himself leading to inward and hence outward transformation, while they saw it as outward conformity to ritual laws. Jesus was, therefore, happy for 'unclean' people, or 'sinners', in both the ritual and moral senses, to come close to him because it was through realising who he was that they could enter into a transformed life of spiritual and moral purity. The Pharisees, on the other hand, kept 'sinners' at a distance because of their polluting effect and expected them to change before they could be accepted into their exclusive religious 'club'.

When Jesus refers to himself as our paradigm he emphasises readiness to deny self and take up the cross.[6] Since being a 'friend of…"sinners"'[7] was one of the reasons for the hatred that led finally to the cross, following Jesus must involve friendship with sinners. In our context this will almost inevitably involve close contact with substance abusers and/or the sexually promiscuous. Friendship in the way of Jesus means commitment to the total wellbeing of our friend.

Is it possible to call ourselves the friend of a drug addict or a promiscuous person, who is not yet prepared to repent and believe in Jesus but where HIV infection is a real risk, while refusing to countenance any harm reduction strategy? Some may object to this question because of its bias, but in many parts of the world today the alternatives that face those who make friends with such 'sinners' are stark. Do we insist on total abstinence and almost certain death from AIDS, or adopt a harm reduction strategy that could preserve the life of the friend?

Jesus made it very clear that he had not come to condemn. Refusing to give clean needles or condoms to our 'sinner' friends is tantamount to condemning them to death and, therefore, incompatible with the spirit of Jesus. In this world that is so very far from God's ideal there is no contradiction between giving a 'sinner' friend the means to preserve their earthly life while also encouraging them to believe in Jesus, turn away from their sinning, and enter into a more abundant life.

Protecting the vulnerable

Protecting the vulnerable is a fundamental principle of biblical ethics.[8] It is now claimed that the surest way for a woman to become HIV-positive in many African countries is for her to marry! Ironically most marriages are conducted in churches, many of which are unwilling to countenance the use of condoms to reduce the harm caused by HIV/AIDS. Added to this, women are also made vulnerable because of cultural practices and poverty, the latter being the main engine that drives the worst horrors of the sex trade.

And it is not the women only who suffer but the children who are left motherless when they die, or who are born to them HIV-positive. Not to promote the use of condoms by men in this situation is nothing short of callous. Biblically, protecting women and children should far outweigh any scruples we might have about making it possible for men to sin safely – and we can warn such men that no one is ultimately allowed by God to sin with impunity. God will be their judge.

Contractual commitments

In the UK most medical practitioners are public servants who are under obligation to serve the common good of the society that pays for their services. For better or ill, medical practice in the public service has been professionalised. This means, for example, that the GP's relationship with the overwhelming majority of his or her adolescent patients is unlikely to make it possible to give strong moral/spiritual advice about the dangers of casual sex.

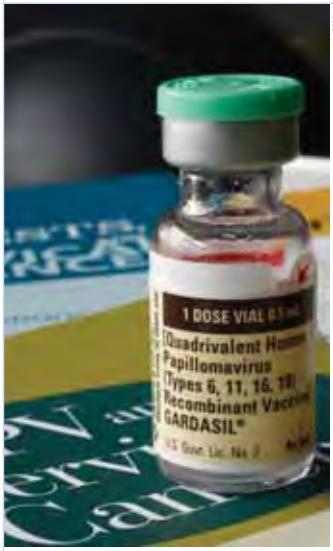
Challenging the cultural context

So, how can medical practitioners be 'friends' to adolescent girls in an appropriate professional way? Maybe a key factor is to recognise the cultural pressure on girls (and boys) to conform to the common belief that sexual intercourse is a trivial recreational activity. Since most young people do not grow up in a moral context at home or church or mosque where resolve not to engage in casual sex can be bred, most are very vulnerable.

They are still responsible before God but their social responsibility is diminished, and since medical practitioners are social/public servants their primary responsibility in this anarchic moral context is to protect the young from the consequences of what have become socially acceptable practices.

However, Christian doctors as citizens will want to take every opportunity that church and various Christian agencies give to teach God's ideal and restore a moral context to behaviour.

Dewi Hughes *is the full time Theological Advisor for Tearfund*



Photos: PA

Jesus made it very clear that he had not come to condemn

references

1. Richards C. Sleeping with the Enemy, 2003 Rendle Short Lecture. *Triple Helix* 2003; Autumn: 11-13
2. Letters from Richards C and Stammers T. *Triple Helix* 2006/2007; Winter: 21
3. Letter from Tomkins A. *Triple Helix* 2007; Spring/Summer: 21
4. Revelation 21:4
5. Wright C. Deuteronomy. *New International Biblical Commentary*. Peabody, Massachusetts: Hendrickson/ Paternoster, 1996. p254
6. Matthew 16:24; Mark 8:34; Luke 9:23
7. See Matthew 11:19 and Luke 7:34
8. The main vulnerable categories in the Bible are orphans, widows, resident aliens and the poor. As representative of a very large number of references see Exodus 22:21-24; Psalm 10:14,18; Psalm 68:5; Psalm 146:9; Malachi 3:5. Malachi is particularly interesting because he prophesies that care of the vulnerable will be a characteristic of the age of the Messiah

God is not a God who stands back and watches

'Pray and act now – Zimbabwe is bleeding.' This was last November's cry for help from CMF Zimbabwe. They are in the midst of the worst cholera epidemic Africa has seen for 15 years, with over 89,000 cases reported, the death toll over 4,000. Cholera is a visible manifestation of the collapse of the entire health system. Water and sanitation systems have broken down, most hospitals and clinics are closed, and government doctors are paid the equivalent of 22 pence per month.

Doctors and medical students from CMF Zimbabwe are working with Celebration Health, a church-based organisation which is now running three cholera treatment centres as well as supporting clinics in two hospitals. Over 7,000 patients have been treated. One of the doctors writes about the night the work began in December:

We started last Friday in response to an urgent cry for help from the Ministry of Health as huge numbers of patients were flooding in from a high density suburb of Chegutu – one night 250 patients came like a tidal wave to the clinic and overwhelmed the three sisters on duty. They saw huge mortality. The outbreak was caused by sewage being sucked into the area's water supply due to low water pressure and vandalised pipes. We arrived and started work at midnight and we gave 1,200 litres of fluid in seven hours to the 150-200 patients on site at Chegutu Polyclinic. We saw the mortality come down from 15 people a day to one per day.

Water and sanitation systems have broken down

CMF Appeal

We launched an appeal (*www.cmf.org.uk/appeal/zimbabwe*) in December to provide supplies for this work. There has been an amazing response and we have raised almost £30,000, which has provided treatment for almost 5,000 patients. It is a privilege to be part of what these brave teams are doing in a desperate situation, enabling them to fulfil their calling as doctors. It was soul-destroying for them to see enormous needs and be powerless to help – but now they are able to use their skills and make a difference. One leader writes:

Doctors and nurses who had lost vision are now gaining vision as they serve on the front line – and their faces are shining as they save many lives! Health care workers' and students' lives are being transformed and reformation in the medical sphere is happening before our eyes.

CMF's ambassador

FY2 doctor John Greenall went out to visit in January. Having seen the appeal on our website, he felt moved not just to give money but to go and stand with the workers on the ground, to encourage them, and to raise awareness here of what is happening. He writes:

It's the early hours of the morning and I'm standing in a cholera camp looking at the scene around me. There are people everywhere – on beds, on benches, on the floor, even lying in wheelbarrows. Sunken eyes look up at me as I look at the line of IV drips and giving sets attached to patients, the stench of chlorine lingering in my nose. The number of people is overwhelming – there are around 700 patients in a camp with a capacity for 200.

Walking amongst them in the hastily erected tents is a team of nurses, doctors and medical students who are tending to the sick, cleaning up the vomit and diarrhoea, setting up IV drips for some and giving oral rehydration to others. One student is praying for a particularly sick elderly man. As I turn around a 7-year-old is carried in – he looks about four, malnourished, barely breathing. A cannula is sited and we pray he might live.

The team are also sharing the gospel and seeing many come to Christ. The work is tough and they are obviously tired. But one of the students said to me:

'God is not a God who stands back and watches...Jesus is in this cholera camp, amongst the vomit and the diarrhoea, full of compassion for these people. I asked myself where Jesus would be at Christmas and I knew he would be here, so I wanted to be here too.'

***Vicky Lavy** is CMF Head of International Ministries*

eutychus

Healy-feely telly

Changes over 40 years in the content of Dutch non-fiction medical television programmes probably mirror the changing times. Expert speakers have had less time allotted to them, while lay people have had more and more say. The scientific origins of the story are now emphasised less, and patients and the public are given more airtime to express their tensions and feelings. 'The results suggest three periods of medical television: a scientific, a journalistic and a lay period.' (*Public Understanding of Science* 2008;17:461-472)

The emotional bank account

Drawing on the term Covey used in *The seven habits of highly effective people*, CMF member Nick Wooding reflects on the 'emotional bank account'. Every time we do something good with people we relate to, we make a deposit into their 'trust account'. He writes: 'The appropriate diagnosis, the kind word, the effective treatment, the concern for the person and their family, are all ways of making deposits...Of course, it is also possible to make withdrawals', and illustrates these possibilities from his consultations. (*BJGP* 2009; February:141)

Public 'favour religious values'

A recent BBC poll suggests that the majority of people in Britain want 'religion' and the values derived from it to play an important role in public life. ComRes questioned 1,045 people and 62% were in favour, while 63% agreed that laws should respect and be influenced by the UK's traditional religious values. Robert Pigott writes 'even at a time when baptisms, church weddings and attendance at Sunday services are declining, people are unwilling for secularism to displace religion altogether'. (BBC News 24 February 2009. *http://news.bbc.co.uk/1/hi/uk/7906595.stm*)

'As an atheist, I truly believe Africa needs God'

A headline like that was bound to get this piece in *The Times* widely circulated over the New Year, and probably makes columnist Matthew Parris one of those 'unwilling for secularism to displace religion altogether'. To assess a charity project, he returned to the Malawi he'd known as a boy as Nyasaland, and gives a wonderful testimony to the quiet witness of indigenous Christians. The article is subtitled: 'Missionaries, not money, are the solution to Africa's biggest problem – the crushing passivity of the people's mindset'. (*The Times* 27 December 2008, *www.timesonline.co.uk/tol/comment/columnists/matthew_parris/article5400568.ece*)

Ordination and donation

CMF is non-denominational but not just Anglican members will be encouraged by Church of England statistics in October 2008 showing an increase in the number of clergy being trained and ordained in 2007: 552 compared with 481 the year before. Weekly giving by parishioners increased by 6% between 2005 and 2006 to an average of £5.38, and Christmas and Easter attendances were up in 2007 compared to 2006 by 7% and 5% respectively. (Christian Research *Quadrant*, 2009; January:1)

Trust me, I'm a doctor

They still do. For the 25th year running, doctors topped a poll in which the general public was asked which profession they trusted to tell the truth. 92% trusted doctors to tell the truth, with teachers next at 87%, then professors (79%), judges (78%), and clergy (74%). Journalists came last with just 19%. Commissioned by the Royal College of Physicians, Ipsos MORI interviewed 2,029 adults aged 16 in late 2008. (*BMJ Careers* 2009; 21 February:GP58)

'God healed him'

In the *BMJ*'s 'Medical Classics' column, Professor Harold Ellis reviewed the 1951 publication of *The Apologie and Treatise of Ambroise Paré*, edited by Geoffrey Keynes. Describing Paré as 'my surgical hero', Ellis tells of 'perhaps the first controlled clinical trial' after which Paré never again used boiling oil on gunshot wounds, and concludes 'Paré was essentially a kind and humble man...he ends his description of the treatment of a bullet wound...with perhaps his most famous phrase: "I dressed the wound, and God healed him"'. (*BMJ* 2009;338:b203)

A Coptic Orthodox priest

Eutychus loves the stories in obituary columns, and was drawn to a photo of the late Nabil Fakry Salama who graduated in Egypt, and worked in O&G in Nigeria, Libya, Saudi Arabia and Gibraltar. In 1995 he was ordained a Coptic Orthodox priest and as Father Mikhail Ibrahim Salama ministered in Golders Green, daily giving communion to patients in hospital. In 2002 he set up the Coptic Medical Society. The photo shows him in full clerical attire, holding a baby whom perhaps he has just christened. (BMJ 2009;338:b359)

Online networking and health

A poll at CMF's national students' conference showed that a majority spend significant periods each day on social networking sites like Facebook, but there are now warnings this may not be healthy. Dr Aric Sigman claims that the reduction in levels of face-to-face contact may harm health. 'Social networking sites should allow us to embellish our social lives, but what we find is very different. The tail is wagging the dog. These are not tools that enhance, they are tools that displace...There does seem to be a difference between "real presence" and the virtual variety.' (BBC News 19 February 2009. *http://news.bbc.co.uk/1/hi/uk/7898510.stm*)

Long hours and dementia risk

A Finnish-led study analysed 2, 214 middle aged British civil servants and found that those working more than 55 hours a week had poorer mental skills (problems with short term memory and word recall) than those doing standard hours. Those doing the most overtime recorded the lowest scores in tests of reasoning and vocabulary. The researchers wonder 'whether long working hours predict more serious conditions such as dementia'. (BBC News 25 February 2009. *http://news.bbc.co.uk/1/hi/health/7909464.stm*)

David Robertson takes a biblical look at 'Voluntary Euthanasia Reassessed'

Is there a Christian case for ASSISTED DYING?

key points

This very recent book was written in order to undermine the perceived religious opposition to voluntary euthanasia, and claims to argue a Christian case.

The reviewer counters that the few biblical quotes are taken out of context and misused, that the theological arguments are woefully inadequate, and that there is an inappropriate and non-Christian emphasis on autonomy.

He concludes: 'The highly selective and infrequent use of the Bible, the pick 'n' mix theology, the fundamentalist view of human autonomy, and the slapdash use of Church history do not constitute a 'Christian' case at all'.

Paul Badham is an Anglican priest, a patron of *Dignity in Dying*, and Professor of Theology and Religious Studies in the University of Wales, Lampeter. It is therefore significant when such a man publishes on the 'Christian' case for voluntary euthanasia. Does this book live up to its title? Is there really a Christian case?

We would do well to hold to what Professor Badham states: 'If one is attempting to make a Christian case for any position it is axiomatic that one must attempt to build on a foundation of Christian belief, and in allegiance to the teaching and example of Jesus Christ'. Exactly. But how are we to know what Christian belief and the teaching and example of Jesus Christ are?

The answer of course is the Bible – a point apparently conceded by Badham when he accepts Noel Biggar's self critique of his book *Aiming to Kill*[1] for containing 'barely a single handful of direct references to the text of the Bible' and that therefore 'some Christians might think that his approach can hardly be truly Christian'. There are numerous moral, rational, societal, legal and anecdotal arguments both for and against voluntary euthanasia, and this review will not examine all of them. We are specifically concerned with 'the Christian case' and therefore with the criteria Badham himself establishes. What does the Bible say? What does Jesus teach?

Out of context

Badham makes a moving anecdotal case from the death of his parents and other close relatives. Indeed reading this account in 'the personal dimension', one can fully understand his support for voluntary euthanasia. Who would not want to relieve the suffering of those involved? But there are other issues – not least the provision of palliative care, the wider consequences for society, and the role of the doctor.

The biggest problem and inconsistency with the book is that the vast majority of its 123 pages is concerned with many of the other arguments and very little with the Bible. Even when mentioned, it is done out of context and in a way that anyone with a reasonable understanding of both Scripture and logic would find puzzling. As a result the theological understanding is extremely limited. Indeed the whole impression is given of someone who has pre-determined the final result , and in effect hunts for quotes to find support. If we are honest this is something we all have to beware, but it is a horrendous way to treat the Word of God – making it say whatever we want it to say, while completely ignoring or dismissing what disagrees with us. As Augustine said, 'If you believe in the Bible what you like, and leave out what you do not like, it is not the Bible you believe but yourself'.

Misuse of Scripture

Leaving aside citations to Ecclesiasticus and other Apocryphal books, Badham's use of Scripture is quite extraordinary. This includes using Jesus' teaching that 'no one by taking thought can add anything to their span of life'[2] as somehow being opposed to modern day healthcare; managing to imply that Jesus' teaching 'no one takes it from me, but I lay it down of my own accord'[3] is an example of humans choosing when to die; using Paul's magnificent statement 'for me to live is Christ and to die is gain'[4] as an example of choosing voluntary

death; and declaring that there are six cases of assisted dying in the Old Testament – although he only mentions two, Samson and Saul.

Taking these two alone, they offer no evidence at all for the current debate. Samson wanted to kill as many Philistines as possible – it was not about committing suicide.[5] The fact that Saul asked to be killed is described in the Bible as something that happened – without comment.[6] Badham admits this but nonetheless tries to suggest that because there is no negative comment, this is evidence for assisted dying. Only if one takes the most extreme view of the Bible as little more than a collection of moralistic tales is it possible to take such interpretations seriously. It is a classic example of a post-modern reading of Scripture, making it mean whatever one wants.

Theological arguments inadequate

When we move away from the handful of biblical texts cited, perhaps we can expect 'Christian' arguments based upon theology. But again these are woefully inadequate. Using doctrines of resurrection and eternal life to imply that Christians should want to ask for assisted suicide is the equivalent of the medieval Spanish peasants who had to be prevented from mass suicide because they wanted to go to a 'better place'.

Of course Christians can look forward to what comes after death, but death is still the last enemy and we are not to face it lightly. All our days are determined by the Lord[7] and we must not overthrow God's sovereignty in that respect. Again, as with the citation of Scripture, this is real pick 'n' mix theology. For example, Badham clearly rejects the doctrines of Hell and judgment – despite telling us to adhere to the teaching of Jesus who taught more about Hell than anyone else in the Bible.

Speaking of Christ, what of the logic that says that because we are to love our neighbour as ourselves, then we are to think of what our neighbour would want and grant it to them? Since when was human desire the absolute? If my neighbour desires my money or my wife does that make it right? And who am I to determine what is best? Sometimes we cannot make those kinds of decisions.

Emphasis on autonomy

Badham emphasises the doctrine of human autonomy. In this he is not alone. A 2005 report[8] by the Department of Human Services in Oregon analysed the end-of-life concerns of all who had actually obtained a medically assisted death between 1998 and 2004. The major concerns were losing autonomy (87%), being less able to engage in enjoyable activities (84%), losing dignity (80%) and losing control of bodily functions (59%). Astonishingly, relief from pain or concern about pain were only cited by 22% as a reason. (Badham admits that 'No one who obtained assistance to die actually suffered from uncontrolled pain'.)

But the quest for human autonomy is not a Christian one. Was it not the original temptation that we should 'be like God'?[9] The desire for human autonomy has created so much harm and disruption in human relationships and has had consequent effects on the environment. How strange that a 'Christian' case for euthanasia rests on something the Bible regards as sin.

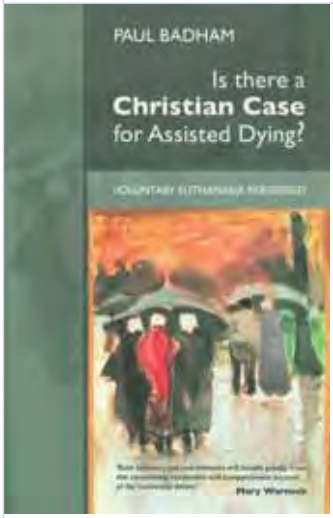
Sometimes there is an astonishing naivety about human nature in the argument. Badham admits that he does not discuss the financial arguments for or against the legalisation of euthanasia. He simply states *ex cathedra* that 'it is not the case that the motivation of saving money is currently a factor'. But according to the scriptures, the worship of mammon and the desire for wealth are significant factors in human decision-making – 'for the love of money is a root of all kinds of evil'.[10] This is clearly relevant to life and death decisions regarding issues like dwindling inheritance, hospital funding, and 'being a burden'.

This naivety is positively dangerous when Badham utters the chilling words 'if the average age of death continues to rise much faster than the number of years of healthy life we can expect to have, there will come a time when adequate support for an ageing population will become economically unsustainable'. He gets away from this by declaring that this problem is 'something that may be left to the next generation of moralists'. But that will not do. It is here that the slippery slope argument comes into play. It is not the biblical or Christ-like thing to ignore the consequences of our actions today for tomorrow. To his credit, Badham admits that 'what was never foreseen was that legislation to allow abortion in hard cases would lead to 200,000 legal abortions a year'. Given this past experience, it is not unreasonable to 'foresee' what will happen to our elderly as they become 'economically unsustainable'.

Conclusion

Professor Badham has written this book in order to undermine the perceived religious opposition to voluntary euthanasia. He is trying to create the impression that this is a debate within Christian circles. He does not succeed. His arguments in favour of voluntary euthanasia are largely based upon personal experience, anecdotal evidence, reports from authors who support his pre-determined conclusion, and an appeal to emotion. The highly selective and infrequent use of the Bible, the pick 'n' mix theology, the fundamentalist view of human autonomy, and the slapdash use of Church history do not constitute a 'Christian' case at all.

David Robertson *is the Minister of St Peter's Free Church in Dundee, the author of* The Dawkins Letters, *and editor of* The Monthly Record



- SPCK 2009
- £10.99 Pb 144pp
- ISBN 978 0 28105 919 5

references

1. Biggar N. *Aiming to Kill: The ethics of Suicide and Euthanasia*. London: Darton, Longman and Todd, 2004
2. Matthew 6:27
3. John 10:18
4. Philippians 1:21
5. Judges 16:23-30
6. 1 Samuel 31 and compare with 2 Samuel 1
7. Psalm 139:16
8. Seventh Annual Report on Oregon's Death with Dignity Act, 2005. *www.oregon.gov/DHS/ph/pas/docs/year7.pdf*
9. Genesis 3:5
10. 1 Timothy 6:10

Against Physician Assisted Suicide
A Palliative Care Perspective
David Jeffrey

Radcliffe Publishing Ltd 2008
£14.99 Pb 120pp ISBN 978 1 84619 186 2

This book presents the case against physician assisted suicide (PAS) from the point of view of an experienced palliative care physician. Dr Jeffrey writes clearly, making the book accessible to both healthcare professionals and members of the public. Although the structure of some chapters is a little weak, all the major arguments are presented. Ethical and philosophical concepts are acknowledged and explained, but the book emphasises practical and patient-centred viewpoints.

The dangers of legalising PAS are described and the case made that better palliative care is the way to address the needs of the dying. Chapters on experience in Oregon and the Netherlands, and on PAS in clinical practice, are particularly compelling. A great strength of the book is that most arguments are supported by substantial reference to published research and literature, making it a valuable resource for those wishing to study in more detail.

The debate around the legalisation of PAS will not go away. All healthcare professionals who deal with dying patients owe it to themselves and their patients to understand the arguments against PAS and the evidence that substantiates them. This book would be a good place to start.

Kathy Myers *is a palliative care consultant in Hertfordshire*

Care of the cancer patient
A quick reference guide
Wesley Finegan and Angela McGurk

Radcliffe Publishing 2007
£19.95 Pb 328pp ISBN 1 84619 128 9

This book is a palliative care textbook by Finegan, a recently deceased CMF member and palliative care physician, and McGurk, a nurse. It covers a wide range of issues pertinent to those looking after patients with cancer. There is a large section on communication skills, an A-Z overview of how to manage common symptoms, and a section on ethical and spiritual issues. It concludes with a series of quick practical guides on subjects as diverse as dictating letters, appraising a research paper, and how to relax!

Written with warmth and humanity, this is a helpful book. It is laid out clearly with a consistent structure that will help systematic assessment and management. The advice given is simple and straightforward, although perhaps a little brief at times. Clear examples and a personal touch come from the extensive use of anecdotes in certain sections. These are very helpful but make the text cumbersome at times, hindering quick reference.

This is a good generalist cancer palliative care text. However, it is not a specialist palliative care text, so readers who desire greater detail may decide to read it in conjunction with one of the resource texts listed at the beginning of the book.

Kerry Waterfield *is a palliative care doctor in Gateshead*

Talking about Spirituality in Health Care Practice
Gillian White

Jessica Kingsley Publishers 2006
£18.99 Pb 175pp ISBN 978 1 84310 305 9

The author is a dietician with long experience of teamwork in hospital and palliative care. Although mentioning her Anglican background, she writes for a secular readership a secular book pleading strongly for integration of spiritual care in all aspects of healthcare. She differentiates this dimension of reality from faith or religious belief, seeking to alert carers to this general characteristic and need of all people.

Founded on academic research, the book describes her experience of leading numerous small professional teams through their own tentative spiritual explorations, in order to enrich their personal understanding, and thus benefit their clients. She is passionate about the potential benefit for all concerned, detailing the process of these explorations and quoting enthusiastic feedback from colleagues. Repetition might have been replaced by reviewing more current evidence, acknowledging that spiritual care is inherent in primary care and lately in many medical schools, and discussing the restrictions of operating within a 'tick box' NHS.

The book does not seek to tackle any specific Christian concerns, but encourages those daring to start exploring spirituality with their own secular teams.

John Caroe *is a semi-retired GP, and a co-founder of PRIME*

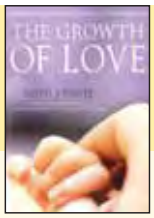
Spirituality, Ethics and Care
Simon Robinson

Jessica Kingsley Publishers 2007
£16.99 Pb 208pp ISBN 978 1 84310 498 8

How does spirituality relate to ethics? Robinson's book explores this relationship using case studies. He carefully considers how spirituality and ethics can be integrated in the practice of health and social care. There are many illuminating passages, eg on the meaning of *agape* love and its inclusive commitment to others. The case study on the family whose elderly father has Alzheimer's disease demonstrates clearly how each family member is attempting to make sense of the situation by trying to apply ethics 'previously worked out', and being tested by that. The author notes that addressing patients' spiritual needs is now a recognised part of the therapeutic response, but that there are no guidelines on achieving this. He endeavours to provide a practical framework so those in the caring professions can engage with the spirituality of their patient. He also challenges the reader's spirituality and how it affects ethical decision-making.

This book requires careful reading in order to engage with the author's approach. It is a book to return to, perhaps guided by the helpful index. I found this a refreshing exploration of a difficult subject and would recommend it to healthcare professionals who make ethical decisions with their patients and clients.

Clare Cooper *is Associate Director of PRIME*



The Growth of Love
Understanding five essential elements of child development

Keith J White

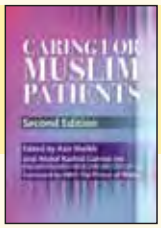
The Bible Reading Fellowship 2008
£8.99 Pb 240pp ISBN 978 1 84101 461 6

At a time when solutions to manage troubled children and teenagers vacillate between liberal and punitive extremes, this book challenges contemporary views of childcare to provide a secure framework for enabling children to develop their full potential as people made in God's image.

Dr White draws on a lifetime's experience of working alongside children and young people who have known separation and loss. He applies expertise in theology and psychosocial theory, underpinned by biblical understanding and living faith, to develop five essential elements of development.

These are: security in the knowledge they are loved; clear boundaries for behaviour that leave them free to explore; assurance of their worth and significance; inclusion in nurturing communities that enable them to flourish; and an environment with opportunities for creative play, worship and recreation. The children's stories make this enjoyable as well as informative. Despite being erudite and far-reaching, this book is very readable. All involved in parenting, teaching or pastoral care of children within and outside the Christian community will gain new insights from it.

***Kirsty Saunders** is a community paediatrician in Hertfordshire*



Caring for Muslim Patients (2nd edition)

Aziz Sheikh and Abdul Rahid Gatrad (Eds)

Radcliffe Publishing 2007
£24.95 Pb 156pp ISBN 1 85775 812 9

The book explores 'what it means to belong to a sacred tradition, explore the intricate connection between faith and health for Muslims and consider some of the implications of this relationship for those striving to deliver culturally competent and sensitive heath care'. The life of the Prophet Muhammad and the devotion he inspires, Islamic thought on healthcare and bioethics, and attitudes to death and family life are described. There is a useful chapter on managing the fasting patient.

The book is academic and draws on classic Islamic sources. This does not help us understand the many British Muslims from non-Arab cultures who combine Islam with pre-Islamic occult beliefs. Vignettes to introduce the reader to 'real' Muslims are generally too short to cover in depth issues raised.

There are several omissions. The chapter on family life does not mention polygamy or arranged marriages. Discussion of the different male and female worlds in Muslim society is limited. Tips on negotiating a consultation with a woman in a *hijab* would have been helpful.

Cross-cultural work is always demanding and difficult. Unfortunately, the book gives no hint of the rewards, joy and fun of working in a Muslim community.

***Robin Fisher** is a GP in Derbyshire*

Living Through Bereavement
With the help of Christian thought and prayer

David Owen

SPCK 2007
£9.99 Pb 160pp ISBN 978 0 28105 934 8

Owen is a retired minister whose wife died after they had been together for 45 years. He has shared the journey of bereavement with others, and travelled the road himself. The first two chapters brilliantly take us through the biblical view of death and the afterlife, before moving on to the concept of the soul. Later chapters explore early death, and death in disaster and war. Owen faces the issues of fear and faith, solace in grief, and reminds us that heaven awaits.

Each chapter has a short and thoughtful introduction followed by reflections and prayers from various sources. Owen rightly says that bereaved people are helped by reflecting on what others have written. However, the content and style left me unsure about whom the book is aimed at and when it would best be read. Perhaps some will want to dip in to the places they feel drawn to when the time feels right. I warmed to the author. Perhaps it is a compliment to him that I wanted his thoughts, reflections and prayers.

***Jean Maxwell** is a retired consultant in palliative medicine and co-ordinator of hospice23*

Teaching Medicine - A Christian Approach

Huw Morgan

PRIME 2008
£5.00 A4 Pb 76pp ISBN 978 0 95595 270 8

What can Christians contribute that is different from any other conscientious teacher? Morgan proposes that scientific medicine has dehumanised us because behaviour is seen as mere product of biochemical reactions. He reminds us that Christians believe human beings are made in God's image and have infinite value. We must, therefore, counteract secular humanism and restore human value to medical education and practice. This includes teaching the importance of spirituality.

Suggestions are given on how to raise Christian values, particularly by highlighting ethical issues in everyday practice. A patient-centred approach to consultation and a learner-centred approach to education are recommended. Using the Hippocratic Oath to stimulate discussion and allow overt expression of Christian values is interesting, as is the use of Jesus' methods as a teaching template. Teaching should include narrative.

These suggestions are thought-provoking. However, patient-centredness, learner-centredness and narrative are established concepts in medical education. Even spirituality is recognised as an important part of clinical care. This book encourages and challenges me to bring my Christian faith into my teaching, but leaves me dissatisfied because it does not fully explore the challenges of applying Christian insights to a largely secular environment.

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Is this how God sees the world?

Retired member ***Stephen de Garis****, living in Switzerland, writes from his own extensive experience of work overseas:*

I feel I must comment on Vicky Lavy's article in the last issue[1] which followed Helen Barratt's.[2] I wring my hands in despair at the topic, as will surely all people of good will. The answer to the question is surely: Yes, that is how God sees the world. No one with any information would dispute the enormous wrongs so eloquently put in both articles. That is not the issue – we know the problems; the analyses to address the issues are the problems – in both articles!

Most would go along with at least part of the 'Millennium Development Goals' and with Vicky Lavy's 'What could you do?' recommendations, but appealing to Christian doctors is missing the goal. Helen Barratt refers to the 'Make Poverty History' campaign, established in 2005 when the UK hosted the G8 summit, and she then rightly notes that halfway to the MDG target date of 2015, further action is needed and governments must be held to account. My question is: which governments? Vicky Lavy refers to 'the $700 billion which the US government is finding to rescue its financial system', implying that this measure might be wrong, instead of channelling at least some to 'the world according to child mortality'.

I found a most interesting remark in Peter Armon's article[3] on his experience revisiting Malawi: there were 'more tarmac roads and posh hotels' but 'the statistics I was given were no better, and in some cases worse, than they had been 40 years ago'. Sadly this is the reality, but why? That is why I find Dr Lavy is 'comparing oranges with apples'. The divide is not so much that between rich and poor countries, but that within the needy countries themselves. This is why meeting the need is not financial from outside. Politics, administrative mismanagement and corruption cover the major issues for addressing poverty and disease. Would any sensible person or government give money now to the Mugabe regime? Yet we all know the tragedy of this erstwhile 'bread basket' of Southern Africa.

Then what about the brain drain of doctors from Africa and other continents to western countries? Apart from postgraduate training (which is valuable aid), should the recipients not then go home to address the needs of their own people? Should western countries be penalised for employing doctors from Developing World countries for their own health services?

I am merely trying to show that the way to meet the desperate needs is not simply by sending funds and western doctors. Finally, lest it be thought I am unsympathetic to these problems, I have been privileged to work in some poor countries and have seen how things operate. I am now ageing and can only give on a discriminating basis to work overseas, as I am no longer able to go personally. May the Lord give all concerned guidance on how we might help realistically to meet the ongoing challenges of controlling and treating disease overseas!

references

1. Lavy V. The wider horizon. Is this how God sees the world? *Triple Helix* 2008; Christmas:21
2. Barratt H. Act justly. *Triple Helix* 2008; Easter:6-7
3. Armon P. News from abroad. *Triple Helix* 2008; Easter:20

Vicky Lavy *replies:*

The issues around global health inequality are complex and challenging – my short article merely highlighted one aspect; that of the enormous divide between rich and poor countries. The issues of injustice and corruption within poor countries themselves are very real barriers to development, as Dr de Garis rightly points out, and encouraging the richer nations to share their financial and manpower resources is not the whole answer. 'In sub-Saharan Africa, 3% of the world's health workforce cares for 10% of the world's population, bearing 24% of the global disease burden.'[1]

Developing countries need an extra 4.3 million health workers – this must be addressed on many levels: improving training, fighting the brain drain, and addressing unethical recruitment by rich countries of health workers who are desperately needed to stay in their own resource-poor countries. However, I believe there is still a place for western doctors to go and stand alongside their national colleagues and share both the training and clinical workload.

I also believe there is still a case for a more equitable sharing of financial resources between rich and poor countries. Europe and USA currently consume 85% of the world's health expenditure, while Africa enjoys less than 1%. Even in the absence of any corruption or mismanagement, this will never be enough. The question is, do we wait until we can be completely assured that financial support will be used well before we give it? While we must make every effort to ensure responsibility and accountability, I believe we have to accept that there is always an element of risk in giving.

It is interesting that Dr de Garis cites Zimbabwe as an example of a country to whom it would be unwise to send financial support. CMF is currently doing this – but not via the government. We have found a channel which we believe is secure and reliable, and while our support is unlikely to have any lasting effect on the development of the nation, we are responding to the desperate need of the people our Zimbabwean colleagues are seeking to serve.

I am grateful for Dr de Garis' thought-provoking letter which highlights the complexities of these issues, and agree with him wholeheartedly that we need God's guidance to respond wisely.

reference

1. McColl K. Fighting the brain drain. *BMJ* 2008;337:a1496

Peter Phillips and colleagues think prayer triplets are time well spent

'A cord of three strands'[1]

We first met as a medical prayer triplet in November 2007. The thought of dragging myself out of bed at about 6.30 to cycle in the cold and dark to a friend's house for 7am prayer was not an opportunity I necessarily relished when we first started. I have to say the three of us – GP, dermatologist and geriatrician – have been pretty regular in attending our monthly Wednesday morning meetings. One of the advantages of having three rather than two is that there's a sense of not wanting to let the side down.

We rotate among our three homes which are sufficiently close to cycle to (or drive if running late), then leave for work at about 8 am. We start with breakfast and a general chat and lapse into issues at work as well as family and church matters. There's usually plenty to pray about arising from that, as we all have our ups and downs, on both personal and professional levels.

Whereas other church groups often provide mutual prayer support, non-medics do not necessarily understand the issues and frustrations which concern us in the health service. A medical triplet can get down to the nitty-gritty of the problems which we need to share with each other and with God. The close relationship which develops within the group allows other personal, family and church matters to be shared in prayer. Then there is the joy of having prayers answered – sometimes with dramatic results!

This is just one example of a prayer group for health professionals. A weekly multidisciplinary prayer group in the hospital chapel can also be very rewarding, and sometimes feels like the best use of my time in the working week. The possibilities are endless according to whatever time, place, frequency or occupational group suits you.

So why not approach some colleagues and float the idea of forming a prayer triplet? I'm sure you will reap rich rewards through being closer together with colleagues and with God.

Peter Phillips *is a geriatrician and writes for GP* ***Owen Thurtle*** *and dermatologist* ***Sam Gibbs****. All live and work in Ipswich*

reference

1. 'A cord of three strands is not quickly broken.' Ecclesiastes 4:12

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