Spring/Summer 2007

for today's Christian doctor

triple helix

Slavery

Wilberforce, slave children, an abolitionist physician, cannabis, euthanasia, hybrids, MMC, breaking point, perfectionism, dissociative identity disorders, reviews, news from abroad

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Freedom from slavery

Applying the challenge from Wilberforce

Photo: Bristol Bay Productions / Walden Films

...as Christian doctors we are called to be active in countering slavery in all its modern forms

On 25 March 1807, two hundred years ago, the British Parliament finally voted to make slave trading illegal throughout the Empire. The film *Amazing Grace* graphically recounts how a disparate group of campaigners, led by William Wilberforce, caused an entire nation to confront its guilt and to act. The title is derived from the famous hymn written by John Newton, the repentant slave trader, who knew Wilberforce and who features in the drama. Wilberforce's thirty year battle in the face of corruption, apathy and treachery almost led to his own death through sickness and despair. But, whilst others failed to stay the course, and motivated by his strong Christian faith, through relentless perseverance he changed the course of history.

In the late 18th century when Wilberforce began his fight, most people accepted slavery as a fundamental part of a functioning economy. No civilisation had ever lived without slaves, and at the time Parliament was institutionally (and constitutionally) corrupt, and unaccountable. Ordinary citizens had no vote.

The campaigners needed first to win over the minds and hearts of the people and then work through parliament. They employed leaflets, petitions, lapel badges and boycotts to mobilise public support and then used parliamentary procedure to their advantage. The reforms they brought were just some of those won by the Clapham Sect, evangelicals with a passion for justice, who built on the 18th century Christian revival under Wesley and Whitefield.

Slavery is the theme of this edition of *Triple Helix*. David Alton (6,7) applies the challenge of Wilberforce to some of the battles we fight today, from abortion to destructive embryo research. Nigel Pocock (16) gives us insight into the less well known Christian abolitionist physician, Thomas Winterbottom. Janet Goodall (5) asks who will stand up today against child slavery. Other articles address subtler forms of human exploitation – dissociative identity disorders after abuse and trauma (14,15), and the plight of junior doctors in the MMC debacle (12,13). After being required to 'make bricks without straw' [1] some juniors now face being left on the unemployment scrapheap. A hard-hitting article on Christian perfectionism (10,11) raises the question of whether some enslavement is of our making.

The freeing of slaves is a dominant biblical theme. Redemption, after all, is a term derived from the slave market. And redemption is at the very heart of God. Just as God sent Moses to deliver the Israelites from 400 years of slavery in Egypt, so he sent Jesus Christ to deliver people from bondage to the power, consequences and penalty of sin. God's intervention to save his people from persecution, oppression and despair is as much part of *Revelation* as it is of *Exodus*.

The prophet Isaiah decried the shallow pietism of his day - empty prayers, assemblies, fasting, festivals and feasts - to remind God's people that true religion was about seeking justice, freeing and encouraging the oppressed, defending the fatherless and the widow, and turning from sin. [2,3] Part of Jesus' Nazareth manifesto was 'to release the oppressed' [4] and part of following in his footsteps today must be that as Christian doctors we are called to be active in countering slavery in all its modern forms, from the sweat shops of Asia to 'human trafficking' and the bondage brought by false belief and self-destructive behaviour.

Two hundred years after Wilberforce, there are still millions living in slavery. People trafficked as part of the sex trade are living in ordinary suburbs across London. And in our surgeries and hospital wards we see every day the results of a different kind of bondage and enslavement through alcohol and drug addiction, gluttony, pornography, legalism, sexual immorality, materialism and other substitutes for God.

The story of Moses, the Exodus of the 'Children of Israel' from Egypt and the idea of a God who responded to the desperate cries of his people and saved them from their oppressors, resonated deeply with enslaved Negroes on the plantations of the West Indies and the United States. And it was there they crafted their impromptu field songs into the intricate, multi-part harmonies of struggle and overcoming, faith, forbearance and hope that have come to be known as 'Negro Spirituals'.

When, perhaps in the midst of rugby world cup fervour, you next hear a rendition of 'Swing Low Sweet Chariot', do remember that it was originally written by people who, whilst longing for release from their slavery, also recognised that man's greatest need was to be rescued by God. And whatever challenges you are facing, professionally or personally, never forget that God, who through Jesus Christ conquered Satan, the flesh and the world to save you, [5] holds you firmly in his grip, [6] and will never let you go. [7] Let's enjoy that freedom and bring it to others.

***Peter Saunders** is CMF General Secretary*

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news reviews

Cannabis – an *Independent* view?

Broadsheet comes clean at last

Review by **Rachael Pickering**
Triple Helix Associate Editor

After ten years of campaigning for the decriminalisation of Britain's most widely available drug, the *Independent* newspaper has decided to come clean. In dramatic fashion, its 18 March front page announced an apologetic U-turn over its position on the legalisation of cannabis.[1]

Many of us recall their 1997 campaign: 'Today, the *Independent on Sunday* calls for personal use of cannabis to be decriminalised…the paper's campaign will continue until the law is changed and possession of marijuana [cannabis] is no longer an offence'.[2]

The *Independent* is a respected broadsheet and its editors carry social and political clout. So, although its campaign wasn't *entirely* successful – cannabis for personal use has never been formally decriminalised – there is no doubt that it did do immense damage. Despite clear warnings from a variety of professional bodies including its own Drugs Czar,[3] the Government eventually went ahead and downgraded cannabis into a Class C drug. At the time, the *Independent* happily received credit for forcing this reclassification; and ever since then, millions in the UK have happily received the message that cannabis is harmless.

What has caused the editors of the *Independent* to make such an apology? Apparently, it comes on the back of statistics showing that the number of people requiring treatment after using cannabis has almost doubled over the last two years.[4] They also claim that things have changed, that modern-day skunk is so much more dangerous than the 1990s' brands. And they plead ignorance – their retraction headline: 'If only we had known then what we can reveal today…'[1] – citing evidence about the danger of cannabis that was published in the *Lancet* later the same week.[5]

In today's society where admission of error is often perceived as a sign of weakness, it was refreshing to read the *Independent's* apology. However, their plea of innocence on grounds of ignorance is both saddening and unconvincing. In the last issue of *Triple Helix*, psychiatrist Dominic Beer pulled together very convincing evidence – dating back to *five years before* their campaign began in 1997 – that cannabis most definitely is harmful to the mental health of thousands of UK citizens, most especially young people.[6]

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Euthanasia

Latest developments in the campaign for legalisation

Review by **Peter Saunders**
CMF General Secretary

Over the last ten years the British pro-euthanasia lobby has very effectively used high-profile 'hard cases' of motor neurone disease to champion its cause: Annie Lindsell, Reginald Crew, John Close and, most famously, Diane Pretty. She sought her husband's assistance in her suicide, and in 2002 took her case to the European Court, and lost.

The 2006 campaign to legalise assisted suicide was built around Dr Anne Turner, a Bath GP with progressive supranuclear palsy, who committed suicide at the Dignitas Clinic in Zurich, Switzerland on 24 January that year.[1] The British Voluntary Euthanasia Society had interestingly rebranded itself as *Dignity in Dying* the day before Turner's death[2], and the second reading (debate stage) of Lord Joffe's *Assisted Dying for the Terminally Ill Bill* was planned for 12 May, the day after the fourth anniversary of Diane Pretty's death.

Lord Joffe's Bill was defeated by 148-100 in the House of Lords after a successful campaign led by the *Care Not Killing Alliance*, in which CMF played a key role. A new strategy soon emerged. Having had both euthanasia and assisted suicide blocked by parliament, the pro-euthanasia lobby now seems to be seeking to bring in euthanasia 'via the back door' through a combination of 'terminal sedation' and 'living wills'. As part of this they are encouraging supporters to write to Lord Hunt, the health minister, to establish a national electronic database of 'advance directives' and to register their own living wills with MedicAlert.[3] The *Mental Capacity Act*, which introduces legally binding 'advance directives', comes into full force on 1 October.

The public face of this year's campaign has been Kelly Taylor,[4] a 30-year-old Bristol woman with Eisenmenger's syndrome, who sought High Court permission to be sedated with morphine until unconscious, and then starved and dehydrated to death under an advance directive. Taylor dropped her action on 18 April after the High Court denied her an adjournment,[5] but the case prompted letters from leading palliative medicine doctors to both national newspapers[6] and the *British Medical Journal*[7]. They pointed out that properly used, morphine does not hasten death and that its sedative effects wear off quickly, making it useless for sustaining unconsciousness. Rather than changing the law to allow the active ending of life by terminal sedation and dehydration, they commended Baroness Ilora Finlay's *Palliative Care Bill*,[8] which seeks to improve access to good palliative care.

Christian doctors need to stay abreast of these issues – both by promoting palliative care, and by opposing any moves to weaken the law to allow assisted suicide or euthanasia. We should also pray that the Finlay Bill, which had an unopposed second reading in the House of Lords on 23 February, is granted the necessary parliamentary time to proceed.

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Human-animal hybrids

Government must maintain its proposed prohibition

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

In 2005 the Department of Health consulted widely on the future of the Human Fertilisation Embryology (HFE) Act, and CMF made a substantial Submission[1]. One of the many questions asked concerned creating human hybrid and chimera embryos, which would contain genetic material from both humans and non-human animals. Of the 336 specific responses, 277 were opposed[2]. On this basis, the Government recommended in a December 2006 White Paper that 'the creation of hybrid and chimera embryos in vitro, should not be allowed'[3].

Early in the New Year, the science community, with the backing of the biotechnology industry and (later) 223 medical research charities and patient organisations[4] mounted a skilful campaign that currently threatens to overturn this proposed prohibition. After a media blitz during which an ambushed Prime Minister appeared to reverse policy on the hoof, the House of Commons Science and Technology Committee ran a hastily convened consultation. CMF contributed to this[5] but with the outcome leaked well in advance, this Committee reported in April in favour of allowing the creation of such embryos provided they are not allowed to develop beyond the 14-day stage and are not implanted into a woman[6]. The HFE Authority is organising a full public consultation, and Parliament should have the final say this autumn.

What are the issues here? First, it is the shortage of human ova that has led to the idea that human genetic material should be inserted into the hollowed-out nuclei of cow or rabbit eggs, for research leading to the production of human embryonic stem cells. Second, much has been made of the so-called *Yuk!* factor and certainly tabloid headlines last year about 'Frankenbunnies' did not help the debate.

CMF has argued that people's intuitions do amount to more than a *Yuk!* factor, and concur with a Christian critique of the proposals. In the *CMF File* on the subject[7] that accompanies this mailing, it is argued that while biology perhaps does not give us clear enough boundaries to justify a prohibition, then concepts arising from a Christian view of humanity certainly do. The 'image of God', the Genesis language of 'kinds', the importance of historicity or lineage, and the significance of human relationships all provide strong arguments against deliberately combining humans and non-human animals. And of course, these proposals add insult to the injury of human embryos.

As we seek to argue this watershed issue within the ever-declining degree of democratic dialogue, let us be well armed for the forthcoming war of the worldviews.

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Slave children

We need another Wilberforce to free the child slaves of today

Review by **Janet Goodall**
Retired consultant paediatrician, Stoke on Trent

A slave is a person who is owned by another and is forced to work in degrading conditions. Despite the supposed abolition of slavery in the United Kingdom, we still house many trafficked individuals, who are the slaves of today.

Less well known than trafficking of adults, the United Nations estimates 8.5 million child slaves exist worldwide, 1.2 million of whom have been trafficked. Children such as five-year-old shepherds in rural Africa are not counted as slaves, for they still live at home and are helping their families. Yet elsewhere, children as young as seven are being sold for pitifully low sums by desperately poor parents. Imagine the fear and mounting despair should the new 'master' be harsh, or (as with many of the 24,000 children to be found in Jeddah) smuggle them into a strange land and force them to beg. Some have undergone deliberate mutilation to elicit more sympathy and more cash. They constantly risk deportation, while their new owners do not. Their young lives lurch from crisis to catastrophe.

Less noticeable are the 50,000 children employed in the sweatshops of Delhi, producing attractive handiwork for the tourist or textile trades. To the price of elaborately embroidered saris must be added the cost of a child's freedom. Detained illegally, these children often work 18 hours a day, sleeping in the shop and receiving minimal food. After years of this life, one 13-year-old was rescued and excitedly returned to his village. On seeing him, his poverty stricken mother wailed, 'Why have you come back to add to my sorrows?' His shocked, helpless bewilderment lingers in the mind and heart.

Elsewhere, children are kidnapped to become child soldiers or sex slaves, leaving them with indelible emotional damage. In Cambodia alone, a million children are trapped into commercial sex. They have either been kidnapped or promised good jobs by unscrupulous traders. Likely to be free at first from HIV, virgins as young as twelve are eagerly bartered for. Raids on brothels in the last decade have released a mere 3,000 young girls, but the pimps are rarely convicted.

So what can we do? Our Lord had – and has – a special heart for children. We too should therefore esteem and love them. In the so-called developed world, children can be enslaved by advertisements or by personal and parental ambition as much as by more obvious forms of abuse. Yet surely the huge problems of slave children in other parts of the world demand more than our prayers. We must search for and support appropriate agencies working where the action is.

Could it be that someone somewhere will also be called to become a Wilberforce for the world's enslaved children?

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Lord Alton draws lessons from Wilberforce's life

WILBERFORCE

key points

This year we celebrate the bicentenary of the abolition of the slave trade in Britain. This lifetime work of William Wilberforce post-dated his conversion to Christianity, and he saw abolition as one of two callings 'God Almighty has set before me'.

He was active in prayer in the Clapham Sect, and worked with a broad-based alliance that sought to change public attitudes as well as parliamentary opinion, knowing that without the former, he would not achieve the latter.

The author challenges us about modern dragons that need slaying, and finds examples in abortion and destructive embryo research, and in contemporary slavery.

As MP elected for Hull in 1780, William Wilberforce became the youngest member of the House of Commons. Over the next 53 years he also became its principal spokesman against slavery.

On 22 February 1807 the Commons voted to abolish the slave trade and 1 May 2007 marked the bicentenary of its enactment. Yet it took until the night before Wilberforce's death in 1833 for Parliament to enact the final emancipation measures, including paying off the slave owners. Hearing this news, Wilberforce gave thanks to God: 'I have lived to witness the day on which England is willing to give 20 million pounds sterling for the abolition of slavery'.[1]

What can our generation learn from this remarkable life? From his patient endurance, perseverance, methods, strategy, tactics? And what dragons are waiting to be slain today?

Single-minded zeal

In trying to understand Wilberforce's motivation, it stands out that he never held high office, but I doubt he entered politics devoid of ambition. At Cambridge he was already marked out for a successful political career. He and Pitt the Younger formed an enduring friendship and many believed that it was Wilberforce, rather than Pitt, who was destined to lead the nation.

This decision to eschew the usual ministerial career path and use his parliamentary position instead to champion a great cause teaches us a lot. In assessing today's aspiring politicians we might usefully ask ourselves: 'What are their causes?' If their sole purpose is simply to climb the greasy pole, to *be* things rather than to do things, then this probably tells us everything we need to know. Wilberforce though had a passion to *do* things. He had single-minded determination and zeal.

Politics and conversion

Yet it remains the case that politics initially attracted him, not abolishing slavery. Aristotle, the father of democracy, reminds us that the call to political service is among the greatest virtues and that shame - *aidos* - attaches to those who simply opt out.[2] What would Wilberforce have made of those who self-righteously assert their cynical disregard for the political classes, and opt out of communal responsibilities?

Wilberforce brought to political life a good education. He was articulate, well informed, compassionate, and a man of deep integrity, but so, no doubt, were many contemporaries. What marked him out and changed his destiny was his decision to embrace Christianity. It redefined how he saw humanity - *imago Dei* in all men; it changed his perception of political service.

Wilberforce's conversion post-dated his entry into Parliament and orientated all his subsequent actions. Cardinal John Henry Newman said that God appoints a task for each of us, given to no one else. We each need to find what that task is and never lose sight of it.[3] For Wilberforce, the task became clear seven years after he entered the Commons and, despite setbacks

Photos: Bristol Bay Productions / Walden Films

and defeats, he never gave up. After a deeply affecting encounter in 1787 with the Quaker abolitionist, Thomas Clarkson, Wilberforce knew he had found his appointed task. He wrote in his diary: 'God Almighty has set before me two great objects, the suppression of the slave trade and the Reformation of society'.

Alliances and coalitions

How Wilberforce translated this spiritual insight into action is instructive. Along with Clarkson, Newton, Equanio, Wedgwood, Roscoe and many others, he formed a broad-based alliance that sought to change public attitudes as well as parliamentary opinion. He knew that, without the former, he would not achieve the latter.

Adam Hochschild, the author of *Bury The Chains*, brilliantly sets out the details of the campaign that was waged throughout the UK.[4] Abolition was not a single-handed feat achieved by William Wilberforce alone, and those who neglect the role of the campaign coalition miss a crucially important point.

Nor did Wilberforce believe he could succeed through his own strength. He knew there was a spiritual dimension. A notable member of the Clapham Sect, a group of Christians who met at the Clapham home of Henry Thornton, he offered regular prayer. The Clapham Christians understood the importance of St Augustine's maxim, 'Pray as if everything depended on God. Work as if everything depended on you.' Wilberforce never neglected to do both.

One of Wilberforce's many detractors was William Hazlitt, a scion of radical endeavour who accused him of being obsessed with misery in far away places. Thornton defended his friend, stating it was like attacking Christopher Columbus for discovering America but for failing to go on to discover Australia and New Zealand as well.

Success in politics is governed by an abiding sense of what matters, by priorities, by not being distracted by every daily dust fight, and by not being deflated or deterred by personal attacks.

Modern day dragons

It took Wilberforce 40 years to abolish slavery and, whilst this year is the 40th anniversary of the Abortion Act, there is no prospect of its imminent repeal. Nearly six million unborn babies have now been aborted in the UK, and one million human embryos have been destroyed or experimented upon. The law still permits abortion up to birth for disability and legislation to permit therapeutic cloning has been enacted. At the other end of life, attempts continue to legalise euthanasia.

Looking abroad, Britain still indirectly funds the coercive one-child policy in China. Recently, the blind barefoot lawyer, Chen Guancheng, was given a four year prison sentence for exposing the forced abortion or sterilisation of 130,000 women in Shandong Province.[5] We should be deeply ashamed that a man with no sight can see so clearly what many of us choose to ignore.

Two hundred years ago Wilberforce won his argument because men like Captain John Newton - a leading Liverpool slave trader, and composer of *Amazing Grace* - changed their minds. We, too, need to change many minds. And doctors are in a unique position to help create a mentality that appreciates the unique sanctity of every life.

Contemporary slavery

What of other evils? Perhaps 27 million people continue to be enslaved. The International Labour Organisation estimates that 8.4 million children are held in slavery, approximately one child out of every 175 in the world.[6] In addition, it is said that around 700,000 people are trafficked every year - generating billions of pounds worldwide.

Modern day forms of slavery, based on discrimination because of racial origin, and on forced labour, child trafficking and debt bondage, all underpin the economic and trade relationships from which we continue to benefit. Compared with 1807, modern day slavery tiptoes around in carpet slippers, but it remains pernicious and all too real.

A rekindling

There is no shortage of contemporary dragons to be slain. We must hope and pray that out there somewhere is the next generation of men and women who will search for their appointed tasks and rekindle the spirit of William Wilberforce.

Lord Alton *is a Crossbench Peer and a national patron of LIFE and Right To Life.*

Photos: Bristol Bay Productions / Walden Films

God appoints a task for each of us, given to no one else

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Annie Hargrave looks at the issue of perfectionism in medicine

Be perfect therefore...

key points

Christian medics are in a double bind – part of a medical culture that says 'No errors allowed' and a Christian tradition that says 'Be perfect therefore'.

Perfectionists focus on their shortcomings and failures, and easily burn out, trying to achieve unrealistic expectations. They cannot allow themselves the freedom to come to terms with themselves as they really are.

From clinical experience and from a consideration of Bible commentaries, the author argues that if we substitute 'Be whole and fit for purpose...' for 'Be perfect...' then Matthew 5:48 opens up a more humane challenge for living.

One of the most poignant moments of my professional life was when I met a nurse who was hugely experienced both in the west and in some of the poorest and most challenging parts of the world. She had worked hard to treat sick and deprived people and to promote healing, and she had passed on both her skills and her passion by training others. But now she was angry.

An unforgivable error?

She had been in charge of a man's care but had missed a deterioration in his condition. Subsequently he had died. Having gone over and over it in her mind, she couldn't forgive herself. She was angry with herself, blaming herself for his death and unable to imagine her nursing future. It was as if this mistake had wiped out her entire career. She refused to consider the possibility of the grace of acceptance, which, whilst not diminishing the gravity of her error, might restore her to nursing and help her come to terms with her human fallibility.

Medical mistakes

As a doctor as well as a human being, there will be occasions when you fall short. You may make an error of judgement; you might miss something, or maybe you will fail to do something you should do. Occasionally, your mistake may not be correctable. Accepting the fallibility of human nature is likely to be a huge protective factor against bad practice. Seeking supportive colleagues and putting supportive structures in place can enhance good practice and keep you open to ongoing learning and development.

The Medical Protection Society has already written an excellent set of practical guidelines dealing with the issue of doctors in general making mistakes.[1] But what about *Christian* medics? Isn't the pressure to be perfect even more intense for followers of the Great Physician?

Double bind

Christian medical personnel can find themselves in a double bind: you're part of the 'no errors allowed' medical culture *and* your Christian tradition says 'Be perfect therefore!'[2] Church preaching and teaching often suggest, sometimes explicitly, that Christians should be better than other people. Yet we know from experience that none of us is perfect. None of us lives without faults and mistakes. We are all sometimes driven by desires that we later regret. From a Christian understanding of human nature, we know that 'If we claim to be without sin, we deceive ourselves and the truth is not in us'.[3] So, how are we to live?

Unachievable perfection?

Amongst the many cries of delight greeting the recent birth of my new granddaughter was, 'Oh,

she's perfect!' Of course, this doesn't mean that she won't make mistakes or that we expect her to be a saint. Rather, it means that we rejoice in her wholeness. She has everything she needs to have a go at life: her fingers with their little fingernails and her eyes opening and reacting to brightness.

The biblical commentators give a variety of interpretations of Matthew 5:48: 'Be perfect, therefore, as your heavenly father is perfect'. They are all agreed that moral perfection is impossible for human beings, and point out that this is assumed to be the case in the gospels. They also agree that the word translated as 'perfect' has a wide scope with strands of meaning encompassing 'wholeness' and 'fitness for purpose'. So, actually, its meaning is closer to our cry of delight over a new baby than the stern demand for unachievable Old Testament perfection which lives so doggedly in many people's consciences.

As a psychotherapist, I find this makes sense of the need we all have to understand that it is beyond our possibilities to live without error. Perfectionists weigh themselves down, focusing on their shortcomings and failures. They easily burn out, trying to achieve unrealistic expectations. And they cannot allow themselves the freedom to come to terms with themselves as they really are.

A more humane challenge

If we substitute 'Be whole and fit for purpose…' for 'Be perfect…' then Matthew 5:48 opens up a more humane challenge for living. It allows the possibility of accepting the inevitable messiness, pain and surprises we discover both around and within us. None of us can be everywhere at once or meet all the need and clamour of demand. This human limitation is known to God in the incarnate being of Christ. The gospels tell of Jesus' encounters with people, including those miracles we find so exciting and attractive. These miracles present an ideal of success, but they don't tell the stories of all the disappointed people who hoped in vain that Jesus might pass their way. Furthermore, the gospel accounts don't follow up those people who were involved in Jesus' miracles. Did that haemorrhaging woman relapse or did she die of something else?[4] And how did the man called Legion cope with life in the community after Jesus delivered him of all those evil spirits?[5]

Be whole – Don't pretend, hide, shut things out or blame others inappropriately. Accept yourself and allow forgiveness and mercy to yourself as well as to others. Look after yourself, body, mind *and* spirit.

Be fit for purpose – this is the challenge to professionalism: be well trained, expanding your skills and applying yourself to the hard work involved so that you grow to be more and more 'fit for purpose'. It is also the challenge to the way we live our lives in every part: our prayer life, our friendships and families, our business dealings, our compassion, our bodies, our 'whole'. So then, as the biblical commentators highlight, we will be 'fit for purpose' in the sense that we are in the best place to seek God.

This approach is not a cop-out! Aiming to be 'whole and fit for purpose' is a life long quest, but it can *incorporate* human fallibility rather than promote the doomed belief that error can be eliminated.

Annie Hargrave *is a psychotherapist at InterHealth in London*

Ensure your counsellor or psychotherapist is BACP accredited or equivalent.

What about you?

The questions below are intended to help you think about your approach to your own human fallibility and how you face up to it in your medical career. Think about your *instinctive* responses to these questions. How do they compare with the 'correct' responses you feel you are sometimes expected to give? Why not log onto the online CMF discussion forum and share your instinctive reactions to these questions with others?[6]

1. What do you do when you notice someone else making a mistake?

- ☐ Cover up for them
- ☐ Offer to discuss how to make amends
- ☐ Have nothing to do with it
- ☐ Feel angry as it might reflect on you
- ☐ Reprimand them
- ☐ Try to diminish its significance
- ☐ Ask them what went wrong
- ☐ Encourage them to say sorry

2. What do you do when you make a mistake?

- ☐ Try to hide it
- ☐ Feel guilty about letting others down
- ☐ Deny to yourself that it ever happened
- ☐ Talk to someone about what went wrong
- ☐ See if you can put it right
- ☐ Find a way to say sorry
- ☐ Beat yourself up
- ☐ Pretend it doesn't matter

3. How do you think medical mistakes should be acted on?

- ☐ Kept to a minimum
- ☐ Learned from
- ☐ Kept from the patient
- ☐ Ignored
- ☐ Apologised for
- ☐ Eliminated
- ☐ Blamed on someone
- ☐ Dealt with behind closed doors
- ☐ Appropriately acknowledged

4. What do you do when a patient can no longer be helped by medicine?

- ☐ Lose interest
- ☐ Look round for good palliative options
- ☐ Talk it over with the patient and loved ones
- ☐ Pray
- ☐ Feel it's a failure
- ☐ Feel you are a failure
- ☐ Turn away and leave it to others

5. How do you feel when disturbed by an incident such as a preventable death, child's incurable illness or a relative's distress?

- ☐ It doesn't impact on you
- ☐ That you mustn't let your feelings show
- ☐ Overwhelmed
- ☐ You will tell your feelings to someone who can understand them
- ☐ That it shouldn't affect you
- ☐ Sad
- ☐ Angry
- ☐ That you must take a brief time to compose yourself

6. What have been the worst and best times in your medical career so far?

further reading

- Doctors' Supportline 0870 765 0001 *www.doctorssupport.org*
- Cornerstone: Network of Christians Offering Professional Counselling and Psychotherapy *www.cornerstonetherapy.org.uk*
- British Association for Counselling and Psychotherapy (BACP) *www.bacp.co.uk*

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6. *www.cmf.org.uk/forum*

Rantimi Atijosan and **Eleanor Chiu** look at the current situation

Modernising MEDICAL CAREERS

The implementation of the Modernising Medical Careers (MMC) programme is in a mess. Thousands of SHOs, amongst them many CMF juniors, are facing major career disruption and ongoing uncertainty. How did things end up like this? What's happening now? And how can we as CMF members respond?

Reform

Back in 2002, Liam Donaldson, the Chief Medical Officer, considered the reform of the Senior House Officer (SHO) grade.[1] Everyone agreed with him that change was needed, but there was much debate over how to do it.[2] Eventually, MMC, with its two main parts, was born: firstly, a two-year Foundation programme to replace the Pre-

Interview with CMF junior, Eleanor Chiu

I'm frustrated at the government's lack of understanding and I'm struggling to trust God

Eley, in a nutshell, what's your career plan?
Surgery, but I don't want to become a consultant. I'd like to work overseas in a developing country context but I'm not sure if that will mean short term or long term trips.

How has MMC affected you?
Badly! I'm one of the old-style SHOs who is over qualified for the level I'm applying for. But, because I haven't completed my membership exams yet, I can't apply for ST3.

What happened in round one then?
I applied to specific deaneries because, for health-related reasons, I was really keen to stay in Southampton. Moreover, I'm just tired of constantly moving round the country and feeling so unsettled. I like my current church and have only just started to feel settled and as if I am experiencing genuine fellowship. That is one of the hardest things about being a junior doctor. Because I applied at ST2 level, I was very limited in choice, so I only applied for two jobs. Unfortunately though, I didn't get short-listed for either of them.

How do you feel about it all?
I'm frustrated at the government's lack of understanding and I'm struggling to trust God. This has been the biggest test of my faith so far. When I entered medical school, I never thought I would be facing unemployment ten years down the line.

What now then?
I'm praying and seeking support from others around me, trusting God that I won't be made destitute! I'm also going to go on an interview course in order to prepare for the new style ones.

Do you see any sign of God's hand in this situation?
To be honest it's hard to. And yet I know from my life experience that he is always faithful.

Registration House Officer (PRHO) year and the first year of SHO posts; and secondly, Specialty Training (ST), essentially a merging of the SHO and specialist registrar grades. Depending on the specialty, the ST training programme varies from six to eight years. More experienced juniors were invited to apply to skip the first one, two or three years of the programme (ie entering as ST 2, 3 or 4s respectively).

Foundations

In August 2005 the Foundation programmes launched around the country. With anticipated completion of the first batch of Foundation doctors in 2007, the focus for implementation moved to ST. In February last year the MMC team released information on what the new training would look like. As information unfolded about the process, anxiety built up. Goal posts changed and juniors scrambled for the last old-style Calman training numbers.

Applications

January this year saw the Medical Training Application Service (MTAS) inviting online applications to ST posts commencing in August.[3] Two rounds of applications were envisaged, with the best candidates being offered interview in the first round, and other applicants in the subsequent second round. Unfortunately though, the application forms did not seem to take account of previously important short-listing criteria (for example further degrees) and a whopping 75% of the short-listing scoring was based on a 150-word repartee to clinical and ethical scenarios and questions about commitment and probity.

The catalogue of disasters began with the crashing application website, the changing of eligibility criteria during the application process and the need for an extension of the deadline. There were reports of lost application forms and of people being considered for specialties they did not apply for! Nonetheless, 32,000 applications - by both UK and overseas graduates - were submitted. Yet, subsequently, MTAS seemed to indicate that there were only 18,518 ST posts available, not the 22-23,000 jobs promised by the government.

Distress

When MTAS revealed who would and wouldn't get a first round interview, there was widespread dismay: whilst highly experienced juniors failed to be granted even one interview, others got multiple offers. Such was the outcry that the MMC review panel have now agreed to give all eligible applicants one interview for their first choice of post. Still, the future remains very unclear, although the Health Secretary Patricia Hewitt has now apologised in Parliament for the distress caused to so many junior doctors.

Control

God is still sovereign and in control. MMC and MTAS have not taken God by surprise and so no child of his need fear that somehow they will be forgotten in this process.[4] However, truly acknowledging God's sovereignty means being willing to bring our lives into obedience to him. We have to resist the temptation to believe we have a *right* to practise medicine in the specialty and region of our choosing. God may give us the job we want in the place we want, or he may not. God may be calling us away from the direction we thought was ahead of us, even out of medicine altogether.

Prayer

Prayer affirms our dependence upon God, acknowledging his capacity and willingness to intervene. Pray for everything from wisdom for professional leaders, justice in the selection process to guidance in our own particular situations. Pray for those around us in difficult situations because of MMC. I would encourage senior CMF members to seek out local juniors who are in need of prayer support, particularly in June when the results of the first round will hopefully be available. The West Midlands CMF held a prayer meeting in March in response to this issue and those who attended were very encouraged.

Advice

During the application process, there were many who were happy to exploit people's fears by charging exorbitant amounts for advice on completing application forms and on interview technique. Here is an arena where seniors can really make a difference. There are some people who will be going through interviews as you read this article. Others will have another round of applications and potential interviews coming up. Offers of interview practice are often very welcome.

This system is going to have casualties. Juniors who fail to get posts in August are going to need further help and seniors could be on hand to help talk through tough decisions.

Justice

It has been suggested that the medical profession needs a 'new and stronger political voice'.[5] In a year when we are celebrating the great work and achievement of William Wilberforce, we should consider which battles we should be involved in, both as doctors and as Christians. What can be achieved when we prayerfully take up arms? Our God is concerned with justice.[6] Is it really just to the individual and to the nation as a whole to put thousands of competent doctors out of training? We should not ignore the plight of colleagues who are marginalised by the system around them.

When the Nazis came to get the Communists, I was silent because I was not a Communist…When they came to get me, there was no one left to speak for anyone. (Martin Niemoller)

Rantimi Atijosan *is a Specialist Registrar in Trauma and Orthopaedics in Oxford*

Photo: PA Photos

the future remains very unclear... God is still sovereign and in control

What are your experiences of MMC and MTAS? Tell us online at *www.cmf.org.uk/forum*

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6. Isaiah 58:6

Ruth Cureton considers the relationship between abuse and dissociation

Dissociative Identity DISORDER

key points

Severe trauma and abuse in childhood can lead to dissociative identity disorders in adult life. Unpleasant memories are parcelled away some distance from consciousness, but flashbacks to unrecognisable, terrifying episodes may disturb and overwhelm a survivor's awareness of self, time, place and person.

Suzie (name changed) went through such experiences, while managing to maintain a front as GP, wife, mother, and house group leader. Two different evangelical churches were unhelpful. The author describes best practice in healthcare and the church.

Case History

Suzie (name changed) is now a GP, and has given consent for this case history to be published. Her childhood was affected by neglect of her fundamental attachment needs because of physical and psychotic illness in both parents; by the trauma of witnessing domestic violence as her mother and brothers were subjected to chronic verbal and physical abuse; and by sexual abuse at the hands of her father. Without a protective attachment figure, she then fell victim to paedophiles within her small community.

Despite all this she attended medical school, became a Christian through CMF students, married a Christian, completed postgraduate training, and worked part time for 20 years, while bringing up a family.

During these years Suzie searched for support in an evangelical church context and was told:

- forgive all perpetrators lest you be judged
- honour your father and mother regardless
- the old has passed away and the new has come
- move on and live in the fullness of your new life

Having survived childhood by role-play and dissociation, she role-played good Christian wife, mother, doctor and house group leader. She pressed on through chronic anxiety, recurrent depressive episodes and various other symptoms.

She neglected her own needs, and allowed herself to be traumatised and spiritually abused as, by now in a charismatic church, her symptoms were attributed to demonic activity. Eventually family bereavement and church and work crises combined to cause major depressive breakdown and psychiatric admission. So began a long journey to recovery through appropriate medication and talking therapies.

Dissociative Identity Disorders (DID)
Diagnostic codes:
ICD 10: F44.9 Dissociative Disorder (unspecified)
DSM IV: 300.15 Dissociative Disorder NOS

The ongoing negative effects of neglect, trauma and abuse can impinge on us from all sides: from patients, staff, colleagues, family, friends and fellow church members. We are expected to understand, advise, support prayerfully, and treat, but our dearth of training and experience may leave us feeling inadequate.

Child abuse is sadly widespread. In one extensive survey of the childhood experiences of 2,869 18-24 year olds, 13% of the respondents assessed themselves as having been abused[1]. Elements of neglect, trauma and abuse frequently appear in the backgrounds of those suffering from psychotic

illnesses, bipolar and personality disorders, neuroses, phobias, obsessive-compulsive disorder, eating disorders, post-traumatic stress, and somatisation disorders.

Less familiar are the dissociative disorders. These are a series of, I believe, God-given coping mechanisms available in childhood whereby a combination of physiology, creativity and a child's innate spiritual awareness allows a child to tolerate the intolerable and survive the catastrophic.

For example, when rendered powerless and voiceless during sexual abuse some children are able to 'escape' in their imagination, perhaps to a sunny glade or other safe place, until the episode is over. The actual experience is then 'parcelled' away, at some distance from consciousness. Recent developments in neurobiological research are providing a physiological basis for these phenomena [2].

Where abuse is severe and repeated, and particularly if a primary attachment figure is either absent or is the cause of the trauma, then the areas of memory and narrative unavailable to normal consciousness may be widespread, with whole stages of normal childhood development being hindered in some cases [3]. The earlier in life that deprivation, trauma and abuse begin, the more widespread the consequences are likely to be. But the child survives and may function relatively normally at school and go on to achieve well, as the case history shows.

However, the unresolved trauma remains imprinted in both body and psyche and, as occurs in post traumatic stress disorder (PTSD), certain triggers such as a visual image, smell, symbol, word, phrase or situation can make a sudden, unexpected and often extremely unpleasant connection between the past trauma and present consciousness. Such traumatic flashbacks to a known occurrence in adulthood can be severe and disabling. Flashbacks to an unrecognisable, terrifying episode of child abuse may disturb a survivor's awareness of self, time, place and person to an overwhelming and destabilising degree. To the outside observer or confidante these episodes can appear or sound bizarre.

For both sufferer and significant others the boundary between sanity and madness may seem dangerously close, though not crossed. Although some degree of dissociative symptomatology may occur in many other psychiatric conditions, if DID is the primary underlying condition it can be treated very effectively. However, survivors with DID spend an average of 11.9 years in secondary care before being accurately diagnosed, and treatment is then complicated by the added traumas of the intervening years [4].

How can Christian doctors help?

I have had to recognise the limitations of both my medical and Christian training and accept that bizarre-sounding symptoms and behaviours may be neither factitious, nor signs of psychosis or personality disorder, nor indicate demonic activity. They may simply be outside my range of experience and understanding.

Many survivors of neglect, trauma and abuse are neither 'mad' nor 'bad', but just extremely 'sad' that, having been powerless and voiceless during their suffering, they have yet to be heard and offered appropriate help. They deserve thorough expert assessment, diagnosis and treatment, though NHS resources here are poor.

In healthcare

Investigate your local personnel and resources, statutory and voluntary, specifically targeted at PTSD, complex PTSD and DID. Sadly, due to the extent and nature of the help needed, short courses of practice-based counselling may only serve to emphasise the complexity of the survivor's problems without offering hope of a solution.

In the churches

Often looked to by survivors as a source of safety and comfort, churches need further guidance and training in a wide range of mental health issues. First, they must do no further harm. Second, they can input consistently, patiently, sensitively, and with appropriate boundaries to build the survivor's self-esteem. This will gradually allow them to form trusting relationships without placing undue demands and expectations on them, which they may try to meet to the detriment of their own faith, health and well-being.

Churches must be particularly sensitive when the abuse occurred in a religious context, and beware applying scriptural exhortations without considering the survivor's own journey and understanding. Many children abused by their own parents blame themselves. In a young child's developing psyche it is actually safer for them to see themselves as bad than to live with the knowledge that their 'God-like' protectors and providers are bad or unsafe. Many survivors need support to acknowledge both parental culpability, and the appropriate righteous anger that follows, before forgiveness can realistically be approached.

Conclusion

Listening, accepting, validating and arranging appropriate treatment for survivors, in an open-minded and non-judgmental way, can encourage them forward on their extremely challenging journey. Suzie, a real life case, is now moving towards full health and wholeness.

Dr Ruth Cureton *is a Trustee of the Trauma and Abuse Group, registered charity number 1108733, which arose from a working party of the Association of Christian Counsellors. www.tag-uk.net*

further reading

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Nigel Pocock pays tribute to a forgotten hero

Thomas Winterbottom
abolitionist physician

Thomas Masterman Winterbottom died in 1859. He was 94 years old – the oldest doctor in Europe. Shops shut. The local Corporation and thousands of citizens turned out to mourn him. In its obituary the *Newcastle Journal* noted that Winterbottom was 'as good a man as ever was born in the town of South Shields' [1]. What had he done to deserve so much love, respect, and affection?

Today few have heard of him. His *magnum opus*, two volumes published in 1803, was not republished until 1969. And who, even among specialists in tropical medicine who are familiar with Winterbottom's Sign (of sleeping sickness) know anything about the man himself?

This is a tribute to a great man in this bicentenary year of the abolition of slavery. He was a warm hearted and people-centred Christian, an excellent physician, a fine scientist, and a committed abolitionist who respected women and people of all races.

Sierra Leone

The Sierra Leone Company had been established by abolitionists, with the aim of facilitating trade and 'civilisation' and providing a home for Africans who had been imprisoned under the slave trade [2]. In 1792, having graduated MD from Edinburgh, Thomas Winterbottom sailed for Sierra Leone. He was a man who, unusually for this time, successfully pulled together the Anglican Revival, Enlightenment empiricism, and a burning desire to see the evils of slavery abolished forever.

Winterbottom laboured for four years in the fledgling colony, fighting against malaria (which he contracted several times himself), sleeping sickness, yaws, leprosy, filariasis, tuberculosis, scrofula, scurvy, dysentery, and many other diseases. These often occurred together, making diagnosis almost impossible by eighteenth-century standards. Yet improvements happened very quickly, for Winterbottom records reductions in the high death rate. It is unlikely that the cures of the day achieved very much, but he was not just interested in pathologies, but in what makes for health. He quickly realised that dirty water contained agents of disease and infection.

He observed that good morale was as important to health as the reverse, noting that 'health and [social] harmony' were closely related. He was totally committed to his patients. Even Anna Maria Falconbridge, the caustic and headstrong anti-abolitionist wife of a colleague, is grateful to him [3]. He was also a peacemaker, as his attempts to resolve an emerging quarrel between two of the leading forces in the colony showed. Zachary Macaulay, one of the parties to this disagreement, wrote 'There is so much warmth of affection in him, and the expression of it so often bursts from him involuntarily…' [4]. This was quite a confession, as Macaulay was not known for his spontaneous affection.

Women and polygyny

Winterbottom is notable for his extremely positive view of African women, for rejecting polygyny as belittling women in favour of male status, and for rejecting completely any idea that Africans are of a different race to Europeans. He writes that '…particularly the females, are said to be the handsomest people…The manners of [African women] are [graceful]…estimation of female beauty among the natives…is the same as in most [other countries]…[they] are remarkable for the beautiful contour of their limbs, and for an ingenuous open countenance…' [5].

Regrettably, '[African] women are regarded as beings of an inferior nature, and as born to be the slaves of man…Polygamy …tends still more to debase the female sex …[men rise] in the esteem of [their] neighbours in proportion to the numbers of [their] women [6].

Evidence based research

Winterbottom notes how alleged racial differences based on skin colour are absurd, especially when one realises how different skin colour can be within one group. Jewish people, for example, vary from white to black. There are huge variations within African populations.

In Africa he had been aware of what we would now call 'hermeneutical suspicion' and would not accept evidence on the basis of hearsay. On one occasion, he walked 44 miles to see a specific African chief. His interests embraced medicine in the widest sense and he saw it within its social and geographical context. Insects and other fauna interested him. He listed local remedies and cures, as well as noting aversion therapy for dirt-eating, and pioneered vocabularies of West African languages.

Much loved

When he died, Winterbottom had little money, having given much of it away. He never lost his concern for coal miners, sailors and the poor and continued to support charities looking after them. The people of Sierra Leone still remembered him nearly 60 years later. He was a much loved man, ahead of his time, whose writings are still of value to field workers today.

***Nigel Pocock** is a social psychologist and theologian, and Director of Vision Training and Research*

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Andrew Fergusson examines this Christian approach to antisocial behaviour and mental disorder

Mad, Bad or Sad?

At my medical school more than thirty years ago, psychiatry viewed religious faith as a sign of mental illness. William Sargent had just retired, but I once heard him lecture on his famous book, *Battle for the Mind*, and had to watch film of a Pentecostal service intercut with African voodoo ceremonies. The inference was obvious – belief was just brainwashing. Sargent was extreme, but that view largely prevailed in the early 1970s. Today there are probably more Christian doctors proportionally in psychiatry than in any other medical specialty. Christians working in mental health may well have spearheaded a rediscovery and revival of Christian values that could eventually influence all areas of health care.

The title is an old cliché – 'Is this patient mad, bad or sad?' Except for its relation to mild depression, 'sad' is barely mentioned. The subtitle: 'A Christian approach to antisocial behaviour and mental disorder' explains the agenda. The foreword and introductory chapter are by Professor Andrew Sims, a Past-President of the Royal College of Psychiatrists, and a spearheading pioneer.

Men behaving badly

In a well-researched and extensively referenced chapter, child and adolescent psychiatrist Elizabeth Guinness explains childhood influences on antisocial behaviour. This had an enormous effect on me. I realised that, despite my medical training, I am incredibly judgmental about 'men behaving badly'. Yet, 'of all male prisoners sentenced by the courts, 64% have ASPD' (Anti Social Personality Disorder). And where might that have come from? Aren't they just, well, bad?

But there is a 'genetic predisposition that interacts with harsh and inconsistent family life to produce vulnerability to ASPD' and 'poor impulse control means that stopping to think so as to learn from past errors is impaired; so also is postponing gratification. ..poor empathy hinders the ability to sense social disapproval or victim distress and therefore adjust behaviour'.

Each individual has been influenced by both nature and nurture. But, 'something's got to be done, doctor'. The two chapters on treatments, by Dominic Beer, a consultant psychiatrist in challenging behaviour, indicate what is available. He includes specifically Christian approaches, and challenges us all not to see anybody as beyond help.

Personal responsibility

He joins consultant forensic psychiatrist Janet Parrott in a chapter on responsibility and the mentally ill offender. The clearly biblical basis of British law on homicide is described, and as elsewhere case histories are both illuminating and encouraging.

This theme of personal responsibility is picked up again in the context of its relationship to substance abuse. Professor Christopher Cook is both an ordained Anglican minister and a researcher in the psychiatry of alcohol abuse. With a gentle tone, he asks us whether the person with an alcohol problem is really that different from us? Or is there some parallel between their temptations to drink and the struggle each Christian faces daily with temptations to sin?

Dr Roger Moss reviews the whole question of the demonic. Whatever each reader eventually concludes, we all need to take the cultural context very carefully into account, more than ever now in an increasingly multicultural Britain. Some may need to consider that the Western scientific worldview may not have all the answers. As someone who believes the occult is real but rare, I found this comprehensive chapter filled many gaps in my understanding.

> 'The hand that rocks the cradle rules the world'

Prevention is better than cure

If discovering I am judgmental was one outcome for me, then another has to be the importance of prevention. A few quotes from Elizabeth Guinness make this clear. She revisits recent research on imprinting upon the infant brain and concludes:

'This shows the vital importance of the first years of life when the brain is actually programmed and the foundations of the personality are laid. "The hand that rocks the cradle rules the world." Crime prevention needs to start in the cradle. The mother-infant relationship is the crucial factor...the role of the family, particularly the father, is to protect it...the integrity of family life is strongly influenced by the prevailing mores. Breakdown in the social fabric of society first affects the most vulnerable and thereby the mental health of the developing children.'

We have abandoned Christian ways. The social fabric of society is indeed breaking down. The evidence reviewed in this book, so capably edited by Dominic Beer and social psychologist and theologian Nigel Pocock, shows us the way ahead. There is hope, whether for the mad, the bad, or the sad.

Provenance. The *Church of England Newspaper* commissioned this review article from CMF, and it was published in the 23 February edition. We are grateful for their kind permission to reprint.

Andrew Fergusson *is now Head of Communications at CMF, but played no part in the production of the book.*

Mad, Bad or Sad?

A Christian approach to antisocial behaviour and mental disorder. Edited by M Dominic Beer and Nigel D Pocock. Paperback. 248 pp. Published 2006 by Christian Medical Fellowship. ISBNs 0 906747 35 X and 978 0 906747 35 3. Available on Amazon, and from CMF for £12 inclusive of postage and packing.

Faith, Spirituality, and Medicine

Toward the making of the healing practitioner
Dana E King

- Roundhouse Publishing 2000
- £10.57 Pb 126pp
- ISBN 0 78901 1158

Imagine working in a country where 77% of people want their physician to address their spiritual concerns, 61% say that faith is the most important influence in their lives and almost 50% want their physician to pray with them. That country is the United States of America.

Faith, Spirituality, and Medicine examines the degree to which we can and ought to involve spiritual matters in our work. It challenges us to re-connect spirituality and medicine. Although written by a Christian doctor, the author is restrained in promoting Christianity, and I did not find anything that would offend a believer in a non-Christian faith.

We may feel the silencing shadow of the GMC over us when discussing faith with patients. One chapter examined this issue but left many unanswered questions. Every chapter is brief, summarised, fully referenced and includes discussion questions.

I am grateful for the chance to read this book. We do need to talk more, research more, and publish more in the academic press in order to make headway in this area.

***John Holden** is a GP in St Helens, Lancashire*

Heresies

Against progress and other illusions
John Gray

- Granta 2004
- £8.99 Pb 224pp
- ISBN 1 86207 7185

Heresies comprises 24 essays, originally written for the *New Statesman*. The heresies discussed are intellectual and cultural ones and Gray himself does not profess any religion.

The essays fall into three groups: progress, terrorism, and political commentary. Gray adopts a worldviews approach in many of these essays, acknowledging similarities between belief systems of secular humanism and religion. He recognises the assumptions that lie behind secular humanism and exposes them as pale imitations of Christian doctrines.

Gray acknowledges that religion appears to be 'hard-wired in the human animal' and states that secularism is merely a substitute of one religion for another. Consequently, the militant evangelism of secular humanists is a mark of the unspoken contradictions and fragility of their beliefs.

The book does have its problems. By its nature, it is a little repetitive. One of the essays infuriated me in its advocacy of torture in combating terrorism. Nevertheless, this book will provide much food for thought, insight into the worldview that dominates our culture, and a significant analysis of the problems within secular humanism.

***Chris Knight** works for UCCF in Leicestershire*

For What It's Worth

A Call to 'No Holds Barred' Discipleship
Simon Guillebaud

- Monarch Books 2006
- £7.99 Pb 192pp
- ISBN 1 85424 7603

This book is an honest account from the heart of a man given over to God's service. Simon is not a doctor. He went to Burundi in 1998 as an inexperienced missionary and has since worked humbly with the local church. He has learned many lessons on cost, commitment and discipleship as he ministers in this small high tension African country. He has known the suffering and violent death of Christian colleagues as well as personal death threats.

Simon draws widely from the Bible to show the level of service God demands of us. He is honest about his own spiritual highs and lows, and about the realities of African life. There is a great mix of anecdotes about saints, both great and small - Tozer, Walt Disney's widow, Michael Green, C S Lewis and Desmond Tutu, to name but a few.

This book has changed my life. I read it when, after ten years in Malawi, I was spiritually weary and needed encouragement and challenge. I immediately went and bought ten copies to give away.

***Chris Lavy** worked in Malawi and is now Visiting Professor of Orthopaedics in Oxford*

Integrating Spirituality in Health and Social Care

Perspectives and practical approaches
Peter Speck and Wendy Greenstreet (ed)

- Radcliffe Publishing 2006
- £21.95 Pb 177pp
- ISBN 1 85775 6460

This book, comprising four sections, gives an excellent overview of what is understood by 'spirituality' and 'spiritual care' in the UK NHS.

The first section explores published literature to help us understand what is meant by 'spirituality' in the context of health care provision. I felt comfortable with the authors' interpretation of spiritual care as a part of multi-dimensional care. The second section is practice focused: Greenstreet suggests that spiritual care is largely delivered throughout a covenantal doctor-patient relationship. The third section attempts to make existentialist philosophy accessible to practising professionals. Care that is sensitive to religious and cultural diversity is acknowledged as important. Diet, physical examination and specific cultural and religious terminal care requirements are discussed. The final section illustrates innovative ways of supporting spiritual care, such as biographical techniques and art therapy.

This book prompts you to consider how you could identify spiritual needs and provide better spiritual support to your patients, which may of course give you opportunities to tell of your own faith and why you care as you do.

***Scott Murray** is Senior Lecturer in Palliative Care in Edinburgh*

Looking for Answers

A Christian in Medicine and Law

Tony Cole

- Memoir Club 2004
- £17.50 Hb 224pp
- ISBN 1 84104 0657

Looking for Answers is an intriguing autobiography of a Catholic paediatrician – awarded a papal knighthood for his work – who is also a magistrate, political activist and founder member of several charities.

The early chapters review his childhood, training and paediatric work. Cole has lived through major changes in healthcare and gives perceptive comments.

The later chapters describe Cole's work with the Guild of Catholic Doctors and the setting up of the Lejeune clinic for Down's syndrome children. The discussion about his work as a magistrate is most interesting for anyone wanting to learn about the legal system.

There is a brief section on English Catholic Church history. Some serious subjects are addressed but there are plenty of anecdotes to lighten the tone.

As some of Cole's work has been in ethical issues, this book would be a good introduction to those unfamiliar with medico-ethical history from 1984. It is valuable for its account of how one Christian has tried to bring faith and hard questions together. It also reminds us how much useful service can be crammed into one life.

***Greg Gardner** is a GP in Birmingham*

Pure

Sex and relationships God's way

Linda Marshall

- Inter-Varsity Press 2005
- £6.99 Hb 144pp
- ISBN 1 84474 0900

How often and how well does the church teach young people about sex and relationships? It is refreshing to see a book that uses a sensitive biblical approach.

This short and readable book is split into six chapters with excellent biblical referencing: Pure Perfection (Genesis 1 and 2), Pure Rebellion (Genesis 3), Pure Planets (Colossians 3), Pure Sex (1 Thessalonians 4), Pure Gifts (1 Corinthians 7) and Pure Forgiveness (Isaiah 53). The final chapter is vital for any book on this topic as, thankfully, God provides hope for all of us when we fail to live life his way.

The book was originally developed from a course offered to students in the Christian Union at Nottingham University. What sets it apart is that it has a website from which materials can be downloaded for running a *Pure* course. These include PowerPoint presentations, handouts and more. I hope and pray that many of our churches use *Pure* as a resource for their members. This should result in authentic Christian witness that no longer blends in with our prevailing culture but stands out from it.

***Richard Barr** is Director of Love for Life and a GP in Lurgan, Co Armagh*

Religions, Culture & Healthcare

A Practical Handbook for Use in Healthcare Environments

Susan Hollins

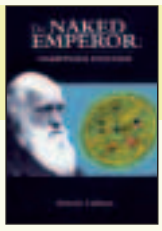
- Radcliffe 2006
- £19.95 Pb 116pp
- ISBN 1 85775 7556

This book aims to present an overview of religious groups to help deliver sensitive care to patients. The first three chapters provide a more theoretical justification as to why this should be necessary in contemporary Britain. The rest of the volume is a well-organised list of stereotypical attitudes and behaviour.

Each faith group is examined according to 17 reference points, for example background and beliefs, religious obligations, food and dress. The book thus aims to prevent insensitivity in dealing with individuals from particular backgrounds. This aim is laudable but the inevitable breadth of commitment within each religious group runs the risk of treating all adherents as if they were zealous. I am puzzled why Jehovah's Witnesses and Rastafarians are included within the 'other groups' section of the chapter concerning Christians, having been described as 'distinct from mainstream Christianity'.

Although I will not rush into buying a copy for my practice library, it could be helpful on a hospital ward.

***Paul Dakin** is a GP in London*



The Naked Emperor

Darwinism exposed

Anthony Latham

- Janus 2005
- £9.95 Pb 275pp
- ISBN 1 85756 635 1

This book chronicles the author's personal journey with Darwinism and is a fascinating summary of the main problems of standard Darwinian evolution. Latham is a GP in the Outer Hebrides and a CMF member. Accepting Darwinism at school and university, he 'enjoyed disputing with Christians about evolution…to me it was simply a knock-down argument against belief'. He became a Christian in 1982 and, from that point, began engaging seriously with Darwinism.

The origin of life, Cambrian explosion, fossil record gaps and irreducible complexity are discussed, as are the paucity of evidence for beneficial mutation and the impotence of natural selection to produce new body plans and structures. He distinguishes between observable micro-evolution and macro-evolution for which evidence is painfully absent. One chapter is given over to a detailed critique of Dawkins' classic, *The Blind Watchmaker*. Latham states: 'It reminded me of the story of the emperor's clothes...'

Although an interested amateur, Latham has read prodigiously on both sides of the debate and has skilfully and dispassionately pulled together the amassed learning of many eminent biologists.

***Mark Pickering** is CMF Head of Student Ministries and a London GP*

eutychus

Politics, faith and medicine

Julian Tudor Hart is a GP best known for his 1971 inverse care law (patients with the greatest need tend to receive the poorest healthcare). He reflects on the influence of his own beliefs: 'I was such a big public figure as a Communist and an Atheist, and this upset some of the strict chapel people, who virtually don't exist now, who in those days were a powerful force'. But he is even handed: 'Anybody who insists on high standards of care for poor communities – it doesn't matter what angle they come from, whether Christian or Conservative or whatever – all of them, as far as I am concerned, are involved in progressive politics, helping people to stand up for themselves'. (*New Generalist* 2007; 5.1: 62-65)

State funding for hospices?

An article on state funding for hospices revisits the formation of the country's earliest hospitals, commenting favourably on their Christian origins. St Thomas's was founded with 40 beds in the 12th century and run by nuns and monks to care for the 'sick and the merely needy' and Bible-seller and MP Thomas Guy opened his hospital in 1721 for 'incurables'. These had to wait up to 800 years for full state funding; hopefully hospices will do better. (*BMA News* 2007; 7 April: 14)

Medicine to ministry

Is it just Eutychus, or is there a lot more about spirituality in the journals these days? A careers piece considers Rainer Verborg who trained as a surgeon in trauma and orthopaedics in the West Midlands before becoming a monk in 1998; vicar Steven Benford, ordained for six years and an associate specialist in anaesthetics; and Margaret Jacobi, a respiratory physiologist who became a part time GP and is now a rabbi at the Birmingham Progressive Synagogue. (*BMJ Careers* 2007; 7 April: GP134)

Suburban shaman

However, the spirituality in question isn't always positive. Opting out of out-of-hours care freed time for Enfield GP Ian Rubenstein to join a 'psychic development circle' and his occult-sounding experiences there have continued into his consultations. He does have a sense of humour though. Describing himself: 'He plans to become a medium by starting off as a large and going on a diet'. (*New Generalist* 2007; 5.1: 73-74)

Reincarnation researcher

Hopefully similar factors were not at work in the career development of Ian Stevenson, a 'psychiatrist who researched reincarnation with scientific rigour'. According to his whole page *BMJ* obituary, the vice president of the Rockefeller Foundation told him: 'The most important question is, "Is there a life hereafter?"' Stevenson devoted the next 50 years to parapsychology and an associate concluded 'He believed the evidence was sufficient to permit a reasonable person to believe in reincarnation'. Eutychus thinks Hebrews 9:27: 'Man is destined to die once, and after that to face judgment' answers the question. (*BMJ* 2007; 334: 700)

Judaism and the sanctity of life

Rounding off this review of spiritual coverage in the journals, the *British Journal of General Practice* devoted almost two pages to a religious consideration of the sanctity of life, with 'Judaism, a religion that delights in encapsulating everything possible in codes and laws' as its context. Eutychus couldn't agree with everything in the article, but was pleased to see it. (*BJGP* 2007; April: 332-333)

GPs and gambling

With the supercasino coming, health concerns associated with gambling are being reviewed. A *BJGP Viewpoint* tells us: 'Pathological gambling is a known diagnostic category. Problem gambling is enmeshed in other addictive behaviours, most notably drinking and smoking. There are a variety of other mental health concerns of varying severity, from stress and depression through to increased risk of suicide among people with more serious gambling concerns.' The authors go on to ask whether all this is to become the responsibility of GPs, and if so, predict that 'may well be uncomfortable for the majority'. (*BJGP* 2007; April: 327)

Circumcision to prevent HIV

Championed for years by the *Lancet*, some doctors have long been recommending routine male circumcision to prevent the transmission of HIV. Two recent randomised trials from Kenya and Uganda suggest male circumcision cuts the risk of HIV by half. The *BMJ* countered that 'unhygienic circumcisions may increase risk of HIV in Africa' but the debate seems to have been settled by WHO and UNAIDS jointly recommending circumcision as an additional intervention. Director of HIV/AIDS at WHO, Kevin De Cock, said: 'The recommendations represent a significant step forward in HIV prevention'. (*Lancet* 2007; 369: 643-56, 657-66, 617-9, 615, 708-13. *BMJ* 2007; 334: 498. *http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/6502855.stm*)

Alert on MedicAlert

To accompany the enactment of the Mental Capacity Act, Dignity in Dying (the former Voluntary Euthanasia Society) is running a campaign to petition Lord Hunt to establish an online database for advance refusals of food and fluids, and then to get all its supporters to sign up and wear MedicAlert bracelets advertising the fact. Eutychus finds such bracelets helpful clinically, but this scenario seemed to echo the words of Jesus to Peter in John 21: 18: 'When you were younger you dressed yourself and went where you wanted; but when you are old you will stretch out your hands, and someone else will dress you and lead you where you do not want to go'.
(See *www.livingwillscampaign.org.uk/* Click on 'Your questions answered' and scroll down to find the link to MedicAlert.)

letters

NICE guidance

***Jeffrey Stephenson**, a consultant in palliative medicine in Devon, qualifies Adrian Treloar's challenge to NICE guidance about prescribing for Alzheimer's.*

I agree with Adrian Treloar *(Triple Helix* 2007; Winter: 5) that, when faced with difficult decisions, we must remember our vocation and that the patient is our first concern. However, the patient before us cannot be our *only* concern, since we have responsibilities to other patients and to society. After all, that is a major argument we use against assisted dying in a society that increasingly rejects Christian values.

We cannot escape the fact that the treatment or care we provide for a given patient carries with it an opportunity cost, in that those resources are no longer available to other patients with different needs. We operate within a healthcare system with finite resources, and we simply can't go on expecting that every new and ever-increasingly expensive treatment can be made available to everyone who could possibly benefit. Some sort of cost benefit analysis has to be made if we are to preserve the essence of the NHS philosophy of care for everyone that is 'free' at the point of access. The alternative is that patients receive only those treatments that they or their insurance can pay for – which is surely a much more inequitable system.

As individual practitioners, of course we will be vocal advocates for our own patients, but the harder we push for our share of the 'pot' the less there will be for other specialties. Cost benefit analyses are very difficult to perform, but someone has to make assessments to guide decision making, and NICE has been charged with that task. It is an imperfect body, and will make mistakes, but it should be supported and respected in the difficult job it does.

Sometimes the best care or treatment option available may not be feasible for our patients for any number of reasons, including economics. I face such issues every week in decisions over the transfer of terminally ill patients from hospice to nursing homes in order to release beds for other patients who need our specialist services.

I have little experience in looking after those with dementia, and none in the use of anti-dementia drugs, and I would not presume to pass judgement on NICE's decisions in this area. I simply want to draw attention to other important principles.

God is our supreme authority, and clearly we must submit everything we do to him. Compassion, love and a concern for the weak and vulnerable are undoubtedly marks of Christian discipleship, but so also are good stewardship and submission under God to those in authority over us, even if we disagree with them (Romans 13: 1-2).

*As Medical Superintendent of the International Nepal Fellowship's Green Pastures Leprosy and Rehabilitation Hospital, **Iain Craighead** agrees.*

I want to respond to Adrian Treloar's article 'A nasty challenge from NICE'. I don't agree with his assertion that 'Effective treatment should be prescribed, even if a guideline … has told us not to'. It presupposes that managers make arbitrary decisions based on a whim, without thought to a patient's welfare, when in fact many health service managers are men and women of integrity who make decisions they believe to be correct based on the limited resources at their disposal.

If Dr Treloar had budgetary and managerial responsibility for a hospital I wonder if his attitude would change? I have managerial responsibility for a 73 bed leprosy and rehabilitation hospital. If I were to run the hospital on the basis described in his article, I could consume my annual budget within a few weeks, after which the hospital would have to close down.

Our Lord wants us to heal but he also wants us to be good stewards of the precious resources he has given us.

HPV vaccine

***Andrew Tomkins**, Professor at the Centre for International Health and Development at the Institute of Child Health, University College, London, argues the case for harm reduction.*

Chris Richards (*Triple Helix* 2007; Winter: 21) brands HPV vaccine, condom promotion and clean needles as unethical. Having worked in child health in Africa for many years, I present an alternative view, based on painful awareness that we all live in a world where consensual decisions about when and where to have sex are frequently overcome by male demands.

Yet health professionals have a range of opportunities to prevent illness in women and children. 'Harm reduction' is a pragmatic term describing interventions that recognise, rather than ignore, the social and economic constraints that many people, especially the poor, live in. It is not a replacement for abstinence from extramarital sex or a denial of the need for behaviour change in a dug addict. It is not a perfect means of preventing transmission of HIV from a father to his innocent infant. 'Harm reduction' does however recognise the compassion that Jesus had on those suffering from their own behaviour or the behaviour of others.

In the description of Jesus meeting with the woman who was about to be stoned for adultery (John chapter 8), the crowd could have followed traditional ways of judging but they dropped their stones one by one as they were challenged to save rather than kill. In seeking a Scriptural way forward we need a considered theology of 'harm reduction' to guide us.

We have commissioned an article on the theology of harm reduction. In the meantime the print correspondence is closed, but members are encouraged to resume the debate in the Forum: www.cmf.org.uk/forum

news from abroad

Paul writes in his letters (eg 2 Corinthians 11) of his sufferings for the gospel. Our members working overseas sometimes speak of their difficulties. Like Paul, several have recently faced violence, storms, floods, loneliness and isolation. Do continue to remember them and constantly uphold them in your prayers.

Storms and floods in Madagascar

David Mann writes:

Madagascar recently suffered a severe tropical cyclone. Here in Mandritsara we had 250 millimetres' rain in two days and the main river that runs on the edge of town burst its banks for the first time since 1959. The smaller river that separates our hospital from the main part of town flooded and cut us off completely for a while. We received an urgent phone call from our colleagues living in town to say they had been called to the government hospital, where there are no surgical facilities, to see a lady in labour, bleeding with a probable placenta praevia. She needed an urgent Caesarean section - but there was absolutely nothing any of us could do except pray.

The next morning an enterprising man had set up a ferry service. He had tied two thick planks of wood together, made a small paddle, and was offering to carry people across the flood for the equivalent of 25p, two hours' wages for a labourer. He paddled while his passengers sat on the planks, between one centimetre above and one centimetre below the water level. The patient and her family were among his first passengers! By 8 am we had done the Caesarean section and she had a bouncing baby boy, to whom they gave the name 'Tafitalakana' which means 'crossed over in a little boat'!

Isolation in Papua New Guinea

Andy Boorne writes from Kikori Hospital:

My family and I live in the southern delta swamplands of Papua New Guinea. There are no roads and it would take several days of tough walking to get out of here. Alternatively you could take a canoe or motorised dinghy through the stunning delta and out into the open sea and away. Otherwise a fairly expensive flight in a Twin Otter is the only easy way to go, though the airstrip has once been closed for 3 months. The phone is working at the moment, but can be out of action for several months at a time - even when it works it can't cope with even a plain text email.

I qualified as a GP in the UK. Now I am the only doctor in an 80-bed rural district hospital, mission run but government owned, with some 41,000 patient episodes a year. Over 90% of the patients are dealt with by the nursing staff, who are mainly excellent. We have some 250-300 deliveries a year and deal with whatever comes in.

We serve an amazing God. I've seen him answer prayer: while desperately trying to stop heavy bleeding ... as some find the Lord; or watching severe injuries heal; or the infrequent overt miracle where someone at death's door revives with prayer and walks home. One time about 200 relatives came with a man who had been brought in with his last cyanosed gasps, with a tension haemopneumothorax, having been shot in the chest. They demanded an unwise medical evacuation that I refused, and so the crowd waited in angry silence. You could hear the chest drain bubble in the packed ward. His brother sat with his axe across his knees swearing revenge if he should die, and he let it be known that part of that anger would be directed at me. When the patient got better and was discharged home, the brother looked at me and said: 'You serve a great God'.

Violence in Pakistan

The staff at a Christian hospital in the North West Frontier of Pakistan recently had several terrifying sleepless nights while the surrounding town came under heavy fire from Mujadeen fighters. Fortunately a heavy paramilitary presence around the hospital prevented loss of life but the hospital has had to close until the security situation improves, which will place a further heavy burden on the hospital's finances.

Mission hospital closure in Thailand

OMF recently announced the closure of Manorom Hospital after 50 years of faithful service. Staffing levels had fallen to a point where it was impossible to continue.

But now for some good news!

For those working overseas or thinking of so doing:

- Missionary personnel are now eligible for free treatment on the NHS
- The value of time spent overseas may soon be more widely recognised and appraisal and re-entry procedures to the NHS made easier. The full document can be found at www.dfid.gov.uk/pubs/files/ghp.pdf

See *CMF News* for more details.

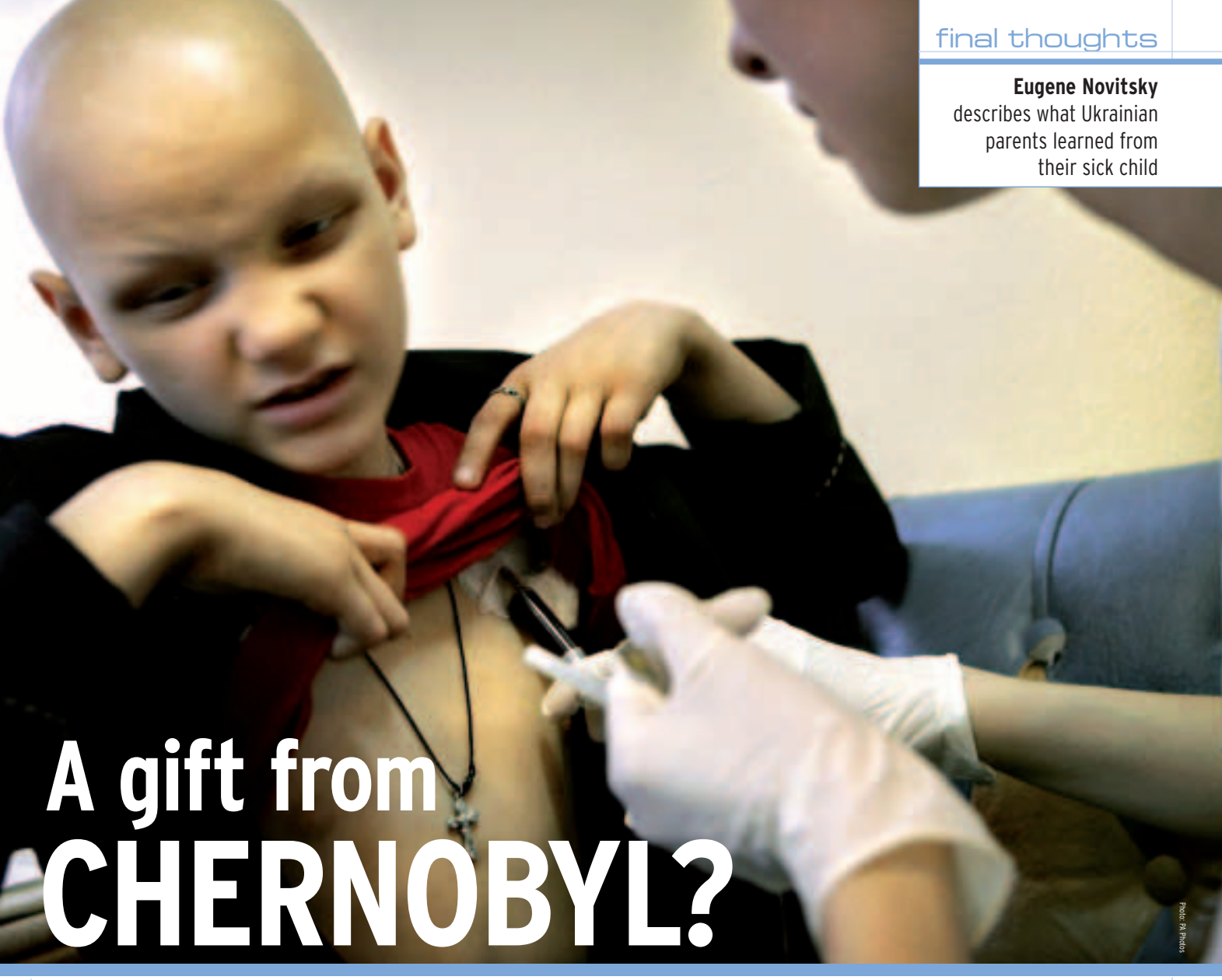
Doctors are needed by:

- United Christian Hospital, Lahore, Pakistan
- Kikori Hospital, Papua New Guinea - see Andy Boorne's comment above
- Leprosy Mission International - in Bangladesh, and a surgeon in Nepal
- Mildmay International - with HIV/AIDS experience, in Africa, India and Eastern Europe
- Medair - with experience in public health in DR Congo, and an anaesthetist in Nepal

See *www.healthserve.org/overseas_opportunities* for further details.

Peter Armon *is CMF Head of Overseas Ministries*

Eugene Novitsky describes what Ukrainian parents learned from their sick child



A gift from CHERNOBYL?

Photo: PA Photos

We listen to the oncologist's verdict. 'Blood cancer - leukaemia.' Immediately we grasp the implications. Eight to nine months' treatment…mother to stay in hospital, too…chemotherapy …radiation…75% survival. Why, Lord, why *our* child? Is this punishment? And if so, do we deserve it? Yet we believe the statement of Jesus (Luke 13:1-5) that suffering and death are not necessarily forms of punishment. So what is the origin of this sickness?

The simple answer is that it has come from the Chernobyl isotopes spread around the Ukraine, from the sin of a carelessly designed power station, from the 'progress' that is destroying the world. Yet surely it would not have been a problem for the Almighty to spare *our* child from this horror? Then we recall that God shares the pain with us, that Christ's death answers the question 'Why?' and that his cross and resurrection lead us to salvation and newness of life. It was our eight-year-old son who, bald and exhausted after two months of chemotherapy, said that perhaps his illness was not a punishment, but a *gift*.

In our motherland, where atheism was god for so long, a dying person is not told the truth. As Christian parents, we wanted to be truthful. Honesty, being the pledge of love, will bring trustful security. Hope and faith never grow from a lie, yet here was our child exercising both as he shared with us the amazing truth that, despite appearances, God still had something good to give us. There was no more room for doubt as we received this insight. By our staying close together, through pain and victory alike, we would mirror God's own unfailing love, even in the darkness of the abyss.

On this hospital ward, our eyes can see God more clearly than in the busyness of everyday life, but here he is not so much on a heavenly throne as on the cross. We are isolated, fighting cancer of the blood, and we are left facing our Saviour. Even despairing parents who do not know Christ have suddenly sensed his presence. For the first time, some are overwhelmed with the need to cleanse their hearts before him.

Young children do not see death as final, but often view it as a door into another world. On a cancer ward, more of them are familiar with blood than the rest of us and some can grasp that Christ's blood was shed to give us life. As we trust him he saves us from eternal death and keeps us safe forever. Some are able to speak to their families about this assurance. Thus, eleven-year-old Natasha was first in her family to find Christ, her mother then finding him whilst staying with her daughter in the hospital. The young girl's initial dreams of recovery changed to awareness that she was dying, so she told her mother to stand firm and to pray for her father. He came to faith after Natasha's death.

Help us, Lord, to learn from our children. Through their sickness, their fragile lives and even through their dying, they teach us, support us, comfort us and bring us to Christ, through whom the gift of God is eternal life (Romans 6:23). What a priceless love-gift to find, hidden on a cancer ward. Our little boy was right.

*Adapted from a paper by **Eugene Novitsky** who heads a support agency for children with cancer in Simferopol, Ukraine*

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