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for today's Christian doctor

triple helix

STAT

- Short Term Able to Travel

Eureka moments, NHS cuts, biblical counselling, Burrswood, any willing provider, a curious cure, testimony, reviews

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contents

Policy decisions in medicine

Driven by evidence or ideology?

The risk of developing [lung cancer] increases in proportion to the amount smoked. It may be 50 times as great among those who smoke 25 or more cigarettes a day as among non-smokers. Thus concluded Richard Doll's 1950 *British Medical Journal* 'citation classic' which reviewed lung cancer rates in 20 London hospitals, and first revealed a link with smoking. Four years later, the British doctors study[1] of some 40,000 doctors over 20 years confirmed the findings. As a result the government issued advice that smoking and lung cancer rates were related and the rest, as they say, is history. Sir Richard Doll[2] is now recognised as the foremost 20th century epidemiologist, and is credited for making the subject a rigorous science.

But it is easy for us to forget that the now well-accepted link between smoking and lung cancer has not always been known or acknowledged. The tobacco industry, because of its powerful financial vested interests, provided a major obstacle to the publication of incriminating research, and the matter was not really finally resolved until the $206 billion settlement with 46 US states which the industry made in 1998 to pay for the costs of smoking-related health care.[3]

Financial or ideological vested interests can be used to stifle the truth when medical issues become highly politicised. This edition of *Triple Helix* (p5) reports on the case of a Christian doctor sacked from the Advisory Committee on the Misuse of Drugs (ACMD) for claiming a link between homosexuality and paedophilia.[4] Ironically his claims were based on peer-reviewed articles including one quoted in previous Home Office documents. But it is not acceptable to hold such views in the current political climate.

We further comment (p5) on the bias of Lord Falconer's 'Commission on Assisted Dying'. There is a political agenda driving this investigation and it is being financed, chaired and manned by people sympathetic to a change in the law to allow assisted suicide or euthanasia.[5] We need therefore to treat any conclusions with an appropriate index of suspicion.

The Royal College of Obstetricians and Gynaecologists has also recently come under fire for producing updated abortion guidance which appears to underplay the evidence linking abortion with mental illness and pre-term delivery.[6] This followed a February 2011 article by a senior (pro-choice) neonatologist accusing the RCOG of misrepresenting the evidence for fetal pain sensation in fetuses under 24 weeks. He likened their 2009 report on the matter to 'the Emperor's new clothes'.[7]

Other instances of a liberal establishment cherry-picking scientific studies to back prior prejudice, while ignoring others, have been highlighted in *Triple Helix* before. Are animal human hybrids likely to yield patient-specific embryonic stem cells which will be of value in developing new treatments? Does abstinence-based sex education work? Is there a link between abortion and breast cancer? Will legalised abortion reduce maternal mortality rates in the developing world? Is homosexuality genetically determined? What is the mechanism of action of post-coital contraception? Does cannabis cause psychosis? Do readily available condoms alone reduce levels of sexually transmitted disease? Do harm reduction strategies work?

The answers to such questions are important and profoundly shape government public policy and medical practice. Real people take the consequences when the underlying assumptions are wrong. It is therefore essential that our conclusions about them are based on sound evidence rather than ideological conviction.

Christians are of course not immune to reading into scientific research answers that might not actually be there, in order to confirm a Christian worldview. We need therefore to be rigorously self-critical in our analyses, not falsely claiming results that the evidence does not support. But we also need to be willing to challenge conclusions based on inadequate evidence, or on evidence that has been specially selected because it better serves the prevailing secular consensus.

Challenging politically correct scientific views, especially those expressed in peer-reviewed journals, involves investment of time and effort and risks to reputation and career. Writing on such issues will generally not be good for one's CV and may result in ostracism by colleagues or even in lost appointments. There may be long waits on editors and frequent rejections of manuscripts. But such challenges need to come from people who have both the credibility and the standing to make them, and also the courage to stick their heads above the parapet.

CMF members have an important role to play in critiquing scientific conclusions that do not ring true. Scientific reports which support the current liberal agenda are often lapped up uncritically by the media. Critiquing them properly, especially after the media hype has resolved, can be a painstaking task with few rewards. But it is essential that we do it.

Peter Saunders *is CMF Chief Executive*

references

1. Doll R, Hill AB. The mortality of doctors in relation to their smoking habits. A preliminary report. *British Medical Journal* 1954;1(4877):1451-55 (26 June) *PMID 13160495*
2. *en.wikipedia.org/wiki/Richard_Doll*
3. Tobacco Industry Worked to Thwart Lung Cancer Link: Report *news.healingwell.com/index.php?p=news1&id=523415*
4. Fergusson A. Christian GP removed from drug advisory committee. *Triple Helix* 2011; Easter: 5
5. Saunders P. The Commission on Assisted Dying. *Triple Helix* 2011; Easter: 5
6. Saunders P. RCOG draft guideline on abortion. *tinyurl.com/5rhfs7y*
7. Ward Platt M. Fetal awareness and fetal pain: the Emperor's new clothes. *Arch Dis Child Fetal Neonatal Ed 2011*; 3 February

news reviews

End of Life Assistance (Scotland) Bill

Heavily defeated as Scots count cost and reappraise 'dignity'

Review by **Calum MacKellar**
Director of Research, Scottish Council on Human Bioethics

On 1 December 2010, the End of Life Assistance (Scotland) Bill, which would have legalised both euthanasia and assisted suicide, was heavily defeated in the Scottish Parliament by 85 votes to 16 with 2 abstentions.[1] The final vote was the result of near unanimous opposition from Scottish healthcare professionals and faith groups including the Christian church. It also reflected a strong resistance to the Bill from the umbrella organisation Care Not Killing (Scotland) which campaigned against any change in the law.

The reasons for this opposition were manifold. The main ones were the danger the Bill represented about protecting the most vulnerable people in society, who may have begun to see themselves as a burden; and the manner in which it would have undermined the relationship of trust between the patient and the physician.

But the opposition was also successful in confronting the human dignity argument from those in favour of euthanasia and assisted suicide, and their often used 'dignity in dying' slogan. Indeed, it was repeatedly made clear, inside and outside Parliament, that the concept of human dignity could not be reduced to a private matter that can vary between persons and to different degrees.[2,3] Instead, human dignity is inherent – it is an irreducible, immeasurable and necessary quality that belongs equally to all members of humanity and can never be lost. Thus, any attempt to end the life of a person through euthanasia and assisted suicide would be a denial and violation of this kind of inherent dignity which is the basis of all civilised societies. It would also mean that there is such a thing as a life unworthy of life.

This realisation by MSPs that ending the life of an individual had profound consequences for relatives, friends, neighbours and the whole of society was one of the reasons for their opposition. As John Donne reminds us, no man or woman is an island. A civilised society is an interdependent one. Every person's signal of hope or despair has a profound impact on the lives of others.

The Scottish parliamentarians were very thorough in gathering evidence about the different arguments. In opposing the Bill by 83%, the MSPs demonstrated that when time, effort and wisdom are invested into the careful examination of all the different issues, the only possible outcome becomes a strong opposition to euthanasia and assisted suicide.

references

1. Margo MacDonald's End of Life Assistance Bill rejected. BBC News, 1 December 2010. *www.bbc.co.uk/news/uk-scotland-11876821*
2. End of Life Assistance (Scotland) Bill Committee Report. The Scottish Parliament, November 2010. *www.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm*
3. Jeremy Balfour. Dignity of life trumps the choice of the ill to end their suffering. *The Scotsman*, Friday 5 March 2010

Cuts in US overseas aid

But the church could have a significant impact on global inequalities

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

At the time of writing, the United States government and legislature are in the midst of a huge wrangle about how far and how deep they will cut expenditure over the next two years.[1] This situation is familiar to us in the UK as we stare at fiscal austerity measures that see many essential services facing severe cuts in a drive to reduce the budget deficit.

An interesting difference between the US and the UK is that spending on overseas aid has been largely protected here in Britain, but across The Pond it is likely there will be massive cuts to overseas aid.[2] Whatever the eventual outcome, US spending on the world's poor will probably decrease. And while US overseas aid makes up less than 0.2% of their gross national income, the size of the US economy still makes them the largest national aid donor in the world.

This could have a significant impact on Christian organisations, which tend to be funded more favourably by the US than by other donors, and inevitably services to those most in need will suffer. This is particularly so as, where the US leads, other donors tend to follow. Christians have a responsibility towards the poor, whether on our own doorstep or further afield, and it is certainly true that in Africa and South Asia alone, Christian hospitals, clinics and churches provide a disproportionate amount of healthcare to the poorest communities. Sadly, this happens with relatively little support from Christians in the West.

At the Lausanne Conference on World Mission in Cape Town last October, Richard Stearns, author of *The Hole in Our Gospel*,[3] challenged the church, particularly in the rich nations, about engaging with global justice issues.[4] If we reoriented our lives in giving – our time, our money, our skills – to serve the poor in the name of Christ, and gave it not to expensive buildings and comfortable lifestyles, but in a radical commitment to justice, the church could have a significant impact on global inequalities and injustices. This would happen whether or not our governments get engaged.

And with that commitment to the poor, we gain a prophetic voice that challenges the political will of governments to act justly.[5] The Apostles remind us that faith leads to action, and a care for those in need is integral to the outworking of our faith.[6]

references

1. Rucker P. House GOP spares no pet projects in trimming budget. *Washington Post*, 21 February 2011. *tinyurl.com/4dt87qd*
2. Rogin J. Obama cuts foreign assistance to several countries in new budget request. *The Cable, Foreign Policy Magazine*, 14 February 2011. *tinyurl.com/4h4zloc*
3. Stearns R. *The Hole in Our Gospel*. Thomas Nelson, 2010
4. Stearns R. Wealth, Poverty and Power - The Hole in Our Gospel. 24 October 2010. *tinyurl.com/654r6c8*
5. Isaiah 1:17
6. James 2:13-14

Christian GP removed from drug advisory committee

Hired then fired for being 'controversial'

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

As a GP working with patients with drug problems, CMF member Hans-Christian Raabe was appointed in January to the Advisory Council on the Misuse of Drugs (ACMD). On 7 February, before he had attended any meetings in the unpaid 3-year post, the Home Office announced he had been dismissed after it emerged he had previously co-written a study linking homosexuality to paedophilia.[1]

There are two separate issues of major concern. First, the ACMD is already controversial, some of its scientist members having unwisely crossed the line into pronouncements on public policy. Its chairman, Professor David Nutt, resigned two years ago over the government's decision to reclassify cannabis from a class C drug to class B, and was followed by other members. He chose to re-enter the policy arena to criticise Dr Raabe's appointment, saying it was 'deeply worrying' that he could support total abstinence when there was 'a vast body of evidence in favour of harm reduction'.[2] Surely a committee which merely advises government should be allowed a range of views, and would benefit from a member who actually treats patients?

However, more serious than an abstinence/harm reduction spat is that sources said the sacking was for not 'disclosing' during interviews a paper he had co-written, which had linked homosexuality to child sex offences. The campaign to remove him gained momentum after former Liberal Democrat MP Evan Harris blogged[3] about his past publications, BBC home editor Mark Easton highlighted the case[4] and the *British Medical Journal* published 'New appointment of evangelical Christian to advisory body sparks controversy',[5] provoking some interesting responses.[6] Dr Raabe himself commented that his dismissal resulted from views which were 'completely unrelated to drug policy', adding 'I have been discriminated against because of my opinions and beliefs, which are in keeping with the teaching of the major churches'.[7]

Perhaps most ironic of all, in a medical world where both clinical and public policy decisions are supposed to be evidence based, the data Dr Raabe and colleagues gave for linking homosexuality and paedophilia were actually derived from peer-reviewed scientific journal articles, including one quoted approvingly by the Home Office itself.[8]

references

1. Gay row government drugs adviser GP Raabe sacked. BBC News 7 February 2011. *www.bbc.co.uk/news/uk-12384693*
2. *Ibid*
3. Harris E. What is happening to our expert advisory committees? *Guardian blog. tinyurl.com/6gv4o2t*
4. Easton M. Another ACMD member threatens to quit. BBC News 20 January 2011. *tinyurl.com/66d6knq*
5. Dyer C. *BMJ* 31 January 2011;342:doi:10.1136/bmj.d624
6. *tinyurl.com/5vng2tq*
7. Saunders P. In sacking Dr Raabe, the Home Office has demonstrated intolerance, cowardice, and ignorance. *CMF blog. tinyurl.com/5v8so9r*
8. *Ibid*

Lord Falconer's Commission on Assisted Dying

Unnecessary, unbalanced, and lacking in transparency

Review by **Peter Saunders**
CMF Chief Executive

On 30 November 2010, just a day before the overwhelming defeat of Margo MacDonald's Bill, the pro-euthanasia lobby launched its latest strategy to change hearts, minds (and ultimately laws) with respect to euthanasia and assisted suicide. The aims of Lord Falconer's 'Commission on Assisted Dying',[1] set up under the auspices of left-leaning think tank 'Demos',[2] are to consider 'what system, if any, should exist to allow people to be helped to die and whether changes in the law should be introduced'. The commission will take oral and written 'evidence' throughout the year and produce a report in the autumn.

Lord Falconer has been adamant about wanting to hear 'from all sides' and that his inquiry will be 'an objective, dispassionate and authoritative analysis of the issues'. However, six out of the eleven initial invitees (including myself) actually refused to give evidence. Why?

First, Falconer's commission is unnecessary. There has already been a comprehensive recent examination of 'assisted dying' by a House of Lords Committee along with three parliamentary votes in the last six years (two in the House of Lords and one in the Scottish Parliament), all strongly rejecting a change in the law.

Next, it is unbalanced. The commission was 'suggested' by the pressure group 'Dignity in Dying' and is being part-funded by Terry Pratchett, one of their patrons. Nine of the twelve members, handpicked by Falconer, are already known to favour a change in the law, including all five parliamentarians and all four doctors. It is furthermore to be chaired by Falconer himself, who led a failed bid to decriminalise assisted suicide in the House of Lords in 2009.[3]

Finally, it is lacking in transparency as none of its members' conflicting interests have been openly declared. Why is it, when the five major disability rights organisations in the UK (RADAR, UKDPC, NCIL, SCOPE, Not Dead Yet) all oppose a change in the law, that Falconer has chosen a disabled person who represents none of them and takes a contrary position? Why, when 95% of palliative medicine specialists and 65% of doctors support the *status quo*, has he picked four doctors who hold the minority view?

Lord Falconer, of course, is perfectly free to set up an *ad hoc* committee to take evidence and make recommendations to Parliament. It is a free country and he has every right to try and influence public policy. But it is somewhat disingenuous of him to pretend that a group with such clearly settled prior convictions might bring any impartiality or objectivity to bear on these important issues.

references

1. *commissiononassisteddying.co.uk*
2. *www.demos.co.uk*
3. *tinyurl.com/69rpnz8*

The cholera crisis in Haiti launched CMF's new rapid mobilisation programme, says **Vicky Lavy**

Photo: Samaritan's Purse/Photographer Matthew Powell

STAT
Short Term Able to Travel

key points

The turn-of-the-year cholera crisis in Haiti that followed the earthquake saw ten CMF doctors travel there to provide treatment, effectively launching the new 'STAT list' of members able to meet short term needs overseas.

Vivid accounts describing the short term situation include a new clinical sign – the 'Nokia sign' means that once they are back on their mobiles the patients are no longer dehydrated.

But Haiti has well documented long term woes too, and health training may be set back a generation. CMF opportunities for overseas service are described.

One year after its catastrophic earthquake, Haiti suffered a further devastating blow – a cholera outbreak which saw over 200,000 cases and claimed over 4,000 lives. Samaritan's Purse, an international agency which has been working in Haiti since the earthquake, asked CMF in November to find some doctors to help in their cholera treatment centres, where the numbers of patients were overwhelming. At one point they were receiving 30 patients per hour, brought in by wheelbarrow or slumped on the back of a motorbike.

We used our newly created *STAT* list – a database of doctors willing to help short term – to send out an email alert. Ten CMF members took up the challenge and went out to help during December and January, mostly for two week stretches. **Alex Bunn** was among them, and says it was one of the best things he has ever done. While there, he wrote a blog for the CMF website: [1]

21.1.2011

'We're up at 5am each day in order to arrive before sunrise at the cholera camp, and not back until 7:30pm. We avoid the roads in daylight hours partly for security, as there has been rioting and unrest since the failed elections in November. It was quite unnerving on the first day to see a couple of guys on motorbikes speed past our Land Cruiser brandishing shotguns, until we realised they were our armed escort, recruited from local slum gangs.'

The 'Nokia sign'

'So what is it like to treat cholera? I had only read about it before in textbooks – a devastating diarrhoeal illness which can render a person semi-conscious within hours through dehydration. We use the infamous cholera beds, with a hole in the middle to allow the passing of 'waterfall stools' without the patient having to mobilise – dangerous when they are so fluid depleted.'

'One patient required 90 bags of Ringer's Lactate in just over two days – he was losing his whole body weight in diarrhoea each day. I had never before seen sunken eyes in an adult, dough belly skin, nor jaw dislocation secondary to vomiting. But cholera is very satisfying to treat, as 99.5% recover if they get help, even those who present without a palpable pulse. Another sign that seems quite useful is the Nokia sign: even the poorest appear to carry phones, and once they are on their mobiles, they are home and…not so life-threateningly dry!'

'One abiding memory of the camp will be the ubiquitous bleach. We have to splash through a soggy tray of bleach on leaving every ward – my trainers have never shone so white! And there is a tank of 0.2% bleach stationed at every gateway, where an attendant shouts 'Wash! Wash!' at all who pass – perhaps the NHS has something to learn here!'

I know who holds the future

'I am also impressed by the chaplains who welcome us each night armed with bleach brushes, to decontaminate our shoes. A very necessary take on washing one another's feet, I suppose. It is just one illustration of the integrated role of the pastors in every aspect of the work.'

'At the clinic, the pastors lead a rousing worship time in the courtyard waiting area, as the medics scout out the sickest who can't stand up to sing, and bring them to the front of the queue. A surprising number take up the offer of pastoral support after seeing the doctor. Despite their circumstances, their requests for prayer are not usually desperate, but a quiet reflection on the obvious fact that none of us has total control of events. 'I don't know what the future holds, but I know who holds the future' seems less trite in a context where the ground might literally open up sometime, but where faith makes some sense of the bigger story. And it's a rebuke to me to hear the conviction and joy of the worship on the cholera wards. If Haitians can remain thankful despite post-colonial destitution, earthquakes and cholera, what's my excuse in the UK?'


Alex Bunn

Supporting local people

Jill Wilson was another CMF volunteer who was pleased she had joined the team:

'I am so grateful that God gave me this opportunity to serve. Although our time there was short, I think we did make a difference in an acute situation – most of the people we saw would have died without our intervention but they made complete recoveries. The Haitians didn't have enough staff to manage the centre by themselves and they didn't have the experience to manage such acutely unwell patients, especially the children. We gave as much training and support as we could, because when patient numbers decline, the ex-pat team will be reduced and they will be in charge.'

Abi Boys returned home after her two week stint with hope, despite the enormous problems facing Haiti:

'The chaos and corruption in the first election, the grinding poverty and the piles of rubble across the country make you think progress is still decades away. But when I see aid organisations empowering a community; when I look at an individual or a family collecting safe water, finding shelter, kids going to school – there's a feeling that the grassroots people may just be the ones to turn things around.'

Just the latest fire

Sadly though, cholera is just the latest fire that needed putting out. The chronic woes of the country are well documented. Seventy per cent of the economy has been wiped out. Only about a tenth of the rubble has been cleared. The university was literally flattened, and its clearance has been hampered by the difficulty in identifying corpses that rats have disfigured. Health training may be set back a generation. Haiti will be needing external support for a while to come. Do pray for those who remain there to do the slow and less rewarding work of reconstruction.

STAT – Short Term Able to Travel

How can we help overseas if we live in UK? Our survey showed that many CMF members are involved, in a variety of ways.[2,3] Some 350 signed up to the newly created *STAT* list for those who might be able to fill a short term gap abroad. Those on the list will receive email alerts of specific needs relevant to their specialty, which might be urgent, like the crisis in Haiti, or might be for a planned trip a few months away. Opportunities might include:

- Specialist help for a teaching trip
- Locum cover for a long-termer
- Extra help in an emergency
- Extra support where staffing levels are low


Photo: Samaritan's Purse/Photographer: Matthew Powell

Abi has been on several short term trips as a junior doctor. She says

'People often think you have to be a consultant to be able to help but you don't. My role in each of the trips I've done has been different – and the learning curve often huge! But as long as I remember that it's God's job to save the world – not mine – and that I just have to be faithful in doing the bits he calls me to, it's not overwhelming. My skills, management and prayer life have all grown each time. My eventual aim is to be abroad long term and involved in international health, but I would encourage everyone for whom it's possible to go on a short-term trip: Just do it. Stat!'

If you would like to be on the STAT list, email *vicky.lavy@cmf.org.uk*. Short and long term needs are advertised on the international job opportunities page of the CMF website *www.cmf.org.uk*.

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

Abi Boys

most of the people we saw would have died without our intervention but they made complete recoveries

references

1. *www.cmfblog.org.uk/2011/02/02/552*
2. *admin.cmf.org.uk/pdf/international/international_survey.pdf*
3. Lavy V. Working from home – across the world. *Triple Helix* 2010; Summer:14

Glynn Harrison on the Bible and counselling

THE NEW BIBLICAL COUNSELLING:

a challenge to 'Christian' psychiatrists

key points

Abbreviating a talk given at the CMF psychiatrists' day conference in 2010, the author reflects on his own development as a Christian wanting to relate his faith to his practice.

In the 'levels of explanation' model, psychiatry approaches human suffering at one level of explanation and the pastor approaches it from another. The 'new biblical counselling' approaches are then introduced and criticised because biblical counsellors fail to integrate bio-psycho-social perspectives.

However, biblical counselling presents psychiatrists working in secular settings with a potent challenge. As the old certainties continue to break down, psychiatrists are more ready to acknowledge their beliefs and the different ways these interface with their practice.

Back in 1975, when I started my psychiatry training, it wasn't long before I met my first patient requesting to see 'a Christian psychiatrist'. At first I sympathised: suspicion of atheistic Freudianism had led me to commence my training with a 'Christian' consultant too. But with experience I began to realise that, for many patients, wanting to see 'a Christian psychiatrist' meant not really wanting to see a psychiatrist at all. Some used a spiritual smoke screen to camouflage difficult family and personal dynamics while others adopted a conspiratorial tone of 'special' relationship that expected privilege and personal treatment.

As these experiences accumulated, I found myself beginning to challenge the very idea of the 'Christian' psychiatrist. What people needed, surely, was a 'good' psychiatrist rather than one who shared their faith or, more pointedly, their particular churchgoing habits. A 'good' psychiatrist, Christian or not, would respect the spiritual beliefs of a patient and where necessary refer them for appropriate 'spiritual' help elsewhere. There was nothing to fear from the 'good' psychiatrist because they, too, shared many of the common values that had shaped our western (Christian) culture.

A 'levels of explanation' model

I adopted what might be termed a 'levels of explanation' model. Here, psychiatry approaches human suffering at one level of explanation and the pastor approaches it from another. The two perspectives reflect different dimensions of human experience: psychiatry seeks to understand how the brain functions and how we, as responsive agents, react to our different experiences and environments. Faith, on the other hand, deals with our experience of God and how we seek to relate to him. Working at these different, but complementary, levels was all part of a day's work for the 'good' psychiatrist, as opposed to the explicitly 'Christian' one. Or so I believed.

It was never a very satisfactory approach. The 'levels of explanation' model works reasonably well for reconciling the discoveries of laboratory based neuroscience and some experimental psychology with Christian faith.[1] When applied to counselling or psychotherapy, though, it runs up against the philosophical challenge of how we understand the *telos*, or end-point of human experience.[2] As soon as we enter a therapeutic arena and invite a client to consider how they might change, or what they 'ought' to do in response to life experiences, we find ourselves reaching for some concept of overarching *purpose*. And the 'levels of explanation' model just doesn't address that central issue.

Think about the question: 'Is this a good screwdriver?' It is possible to analyse the screwdriver's physical composition, its shape and its weight etc, but we are floundering to know whether it is a 'good' screwdriver until we know what a screwdriver is actually *for*. It's the same in therapy. As soon as we invite the client to consider what he 'ought' to do, or think, or feel, we run into the larger philosophical problem of what we are actually here *for*. What is our purpose? And psychology as a science, and particularly psychotherapy as an art, cannot engage with our *telos* without reference to larger questions that are essentially philosophical and, indeed, 'spiritual'.

While these questions have received renewed attention with the recent interest in 'spirituality' among psychiatrists generally, they have been addressed most cogently by the 'biblical counselling' movement. And because 'biblical counselling' – currently attracting growing interest in the UK – polarises the issues quite interestingly, I am going to examine the movement and its history in more detail.

Origins of the 'new biblical counselling'

The 'new biblical counselling', as I've called it, grows

out of the earlier work of Jay Adams. His name does not elicit a great deal of affection from older UK psychiatrists who recall early assertions such as 'depression comes as a result of failure of self control and self discipline'.[3]

Adams coined the term 'nouthetic counselling' in his influential book *Competent to counsel* first published in 1970.[4] A prolific author, he pioneered the view that modern psychological theories depend essentially on quasi-religious narratives of human nature. Echoing the teleological challenge to therapeutic psychology, Adams argued that you can't work out what a person ought to do, until you have some overarching concept of what a person is for. Christians have been created for worship of the one true God, and all human malaise ultimately stems from our idolatrous rejection of that *telos*. Adams therefore dismisses modern psychologies that promise psychological 'wholeness' as futile attempts to replace biblical categories of creation, fall, redemption and holiness with secular categories of health and illness.

Adams believes that the Bible contains *all* that we need to know about how human beings can flourish in line with God's purpose. His emphasis is strongly behavioural: we may bring all kinds of past experience into the consulting room, but ultimately we need to take responsibility for how we respond to that psychological inheritance. So the nouthetic counsellor, having helped us tease out sinful (and self-destructive) responses to the 'sin done to us', needs to challenge us to change our behaviour and thinking in line with biblical teaching.

Take the example of a 66-year-old man who presents with depression in the setting of his recent retirement from a lifetime of work in industry and management. The 'nouthetic counsellor' might acknowledge vulnerability factors in early life experience but they would move deftly to refocus the client toward the 'idols of his heart'. How much has he idolised the status and security provided by his role and his standing in his company? Will he embrace biblical wholeness by re-imagining his identity and purpose around worship of the one true God? In Adams' view, antidepressants and secular counsellors tinker around the edges of the heart, but they don't deliver real heart 'change'.

The next generation

After founding the Christian Counselling and Education Foundation (CCEF), linked with Westminster theological seminary in the States, Adams eventually left in the mid 1970s. Since then a new generation of thinkers has arisen. Authors such as David Powlison and Paul Tripp moved CCEF in the direction of increased sensitivity to suffering, and a more nuanced understanding of how sin blights the human condition. But while the next generation are more willing to 'look behind' presenting issues, they continue to insist that biblical counselling is a distinctively biblical 'psychology', offering a particular understanding of people, problems, influences, suffering, motives and change processes.[5]

The fundamental critique of modern psychology remains: only the Bible provides a view of man that shows us why we should change and how we should live. And if we are to change in line with God's purposes for us, we must address the sinful idolatry of the human heart and seek to grow in a spirit of repentance and obedience. Biblical counsellors also continue to insist, with Adams, that we can't 'sector off' any sphere of human mental experience as the province of 'the theories, practices, and professions of modern psychologies'. And, although they recognise that God's providential 'common grace' brings many goods to humankind, including the provision of insights about the workings of the human psyche, they argue that when torn from their biblical foundations these insights can only provide a deficient, false theology of human nature. Hence, where modern psychotherapies claim to bring 'wholeness', they are in effect 'competing with Christ'.

Is biblical counselling 'biblical'?

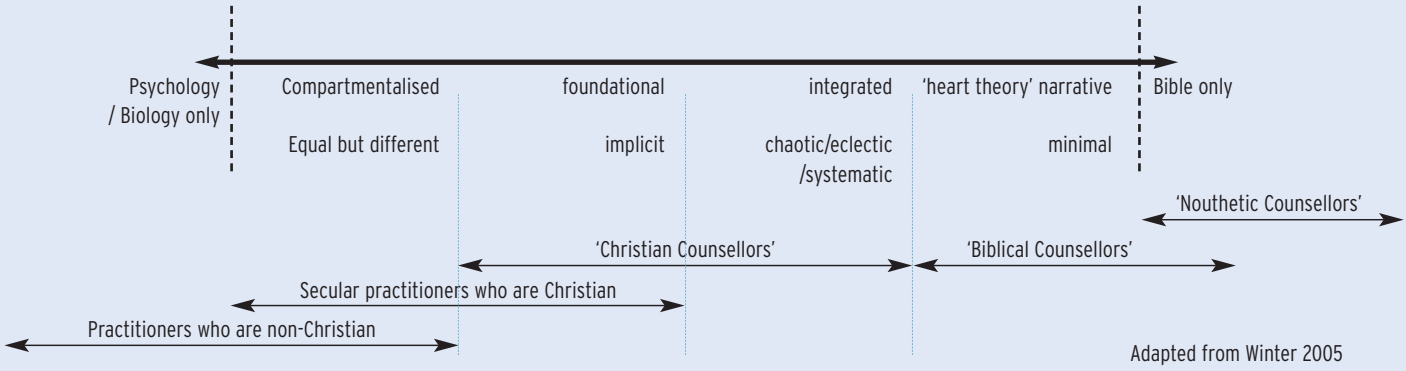
Biblical counsellors make some hard-hitting points and challenge us to think again about the models that underpin our day-to-day practice. But their approach has some potentially serious weaknesses.

First, despite paying lip-service to the gifts of 'common grace', biblical counselling continues to create an impression of being at best grudging and at worst dismissive of modern psychological insights. Take again the example of our 66-year-old depressed retiree. It would be reckless to neglect the potential importance of a positive family history of major depression, early life 'loss experiences' that may have shaped biological vulnerability, and the role of synaptic neuro-regulation in the genesis of his disorder. And to speak prematurely of 'responsibility' and 'sin' seriously risks accentuating a depressive mindset that is already biased toward self blame and despair.

Biblical counselling can become crudely dualistic, too. For example, while research has shown that optimal brain development depends upon a positive psychological and social environment, including relational stimulation and affection in early life, biblical counselling too readily partitions off emotional responses as being all a problem of the 'heart', as if the 'heart' stands aside from the brain. The human 'heart', in the biblical sense of the embodied seat of character and will, may be rendered *biologically* vulnerable to disorder by a whole range of genetic and experiential factors. Statements such as 'even those who suffer mentally disabling medical problems need godly counselling'[6] imply there is a clear recognisable demarcation line between 'medical problems' and 'conditions of the heart', but such a distinction is not sustainable. Human 'heart' experience overwhelmingly results from complex interaction between biological, social and psychological mechanisms that remain incredibly hard to unravel.

In my view, the zeal of biblical counsellors for a robust biblically based model of human suffering fails to integrate modern biological perspectives, and risks depriving clients of some of the important 'gifts' of

Human 'heart' experience overwhelmingly results from complex interaction between biological, social and psychological mechanisms that remain incredibly hard to unravel



God's common grace, especially the gift of discovering his 'ways' through human inquiry and observation. They pay lip service to common grace, but one senses a grudging reluctance, rather than wholehearted celebration and integration of the vital fact that *all* truth belongs to God. In this crucial sense I would argue 'biblical counselling' is not fully 'biblical'.

But the challenge remains

But this does not mean biblical counselling presents those of us working in secular settings with anything less than a potent challenge. Take our depressed 66-year-old retiree once again. Let's suppose we have carefully taken our histories and prescribed our anti-depressants. Now what? We might decide to enhance our treatment by adopting a cognitive therapy approach to some of the unrealistic beliefs that are fuelling his low mood. But what is the *realistic* perspective for a man deprived of his sense of identity and sphere of competence, who faces an uncertain short term future and longer term certain death?

And what if, despite being a Christian, he had in fact been over-absorbed in his work, to the detriment of his wife and family whom he now barely knows? What if he has made an idol of his work? Is it good enough simply to refer him to the hospital chaplain for prayer and 'reflection'? How many pastors are competent to address the sort of heart issues that biblical counsellors are willing to raise or even inclined to do so? And, while for some an antidepressant may help him achieve 'recovery', what will he have 'recovered'? Should we as psychiatrists forego the opportunity to explore how this period of suffering could be a catalyst for more fundamental 'heart' change and spiritual growth? Any psychiatrist who wishes to grasp the teleological nettle will be forced to think hard about these issues.

Also, in recent years interest in notions of 'spirituality' has developed among psychiatrists generally. The Spirituality Interest Group of the UK Royal College of Psychiatrists has grown in numbers and influence, and the College has acknowledged the concept of incorporating a 'spiritual history' into patient assessments.[7] A range of spiritual philosophies is being drawn more explicitly into therapy, for example via Buddhist concepts related to 'mindfulness', and New Age 'spirituality' models. So by various means we are being challenged to re-examine how we relate our faith to our practice. And for me, the old concept of the 'good' psychiatrist will simply no longer do.

How many pastors are competent to address the sort of heart issues that biblical counsellors are willing to raise or even inclined to do so?

Re-visiting our models: from foundational to integrated

Drawing on the work of Richard Winter and others,[8] the figure above illustrates four possible models that lie between the extremes of 'psychology only' and 'Bible only'. First we have the 'levels of explanation' model outlined above. Despite its flaws, both Christians and non-Christians may continue to feel more comfortable within this kind of framework. But most Christians in secular practice probably work with the second model termed 'foundational'.

Here, to a greater or lesser degree, what we do in routine practice is viewed as being rooted in an essentially Christian view of the world, but at an implicit rather than explicit level. The client's 'spirituality' may be explored as an important part of an assessment, but the emphasis is upon encouraging reflection rather than direct engagement with the issues that emerge. The ethical obligation to respect the views of the client and avoid the abuse of power remains paramount, and the counsellor works carefully with the grain of his client's beliefs, drawing on the complementary skills of pastors and chaplains. The third model – 'integrative' – attempts a more explicit engagement with spiritual issues, but is harder to pin down. It includes a variety of approaches ranging from *ad hoc* eclectic blending of perspectives to more systematic integration of biblical precepts with cognitive or dynamic orientations.

'Biblical counselling' is our fourth model. It would clearly be unethical to pursue this approach in a secular setting where the client does not share the therapist's biblical worldview – integrated and explicitly 'biblical' models are more likely to be used in private settings. But does the 'free market' NHS offer new opportunities for developments in this area?

Conclusion

In the final analysis the models we adopt must be constrained by fully informed choices of the client and relevant guidance from the General Medical Council. But I hope I have illustrated why I am no longer content simply to offer those who want to see a 'Christian' psychiatrist the simplistic alternative of the 'good psychiatrist'. As the old certainties of counselling and therapy models continue to break down, psychiatrists are more ready to acknowledge their beliefs and the different ways they interface with their practice. And that is something I for one now welcome.

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references

1. As advocated so clearly by the Christian psychologist Malcolm Jeeves
2. A challenge posed to modern psychology by the philosopher Alasdair MacIntyre in *After Virtue: A Study in Moral Theory*. London: Gerald Duckworth & Co Ltd; 2007
3. *www.peacemakers.net/unity/adepressed.htm*
4. Adams Jay E. *Competent to Counsel*. Phillipsburg, NJ, USA: Presbyterian and Reformed Publishing Company; 1970
5. *www.ccef.org/ccef-history-theological-foundations-and-counseling-model*
6. *Ibid*
7. *www.rcpsych.ac.uk/mentalhealthinfo/treatments/spirituality.aspx*
8. Adapted from Winter R. The Search for Truth in Psychology and Counselling. *Presbyterion* 2005; 31/1: 18-36

In the face of NHS cuts, **Andrew Flatt** advocates political action

NHS CUTS: HOW CAN WE RESPOND?

Juniors, you will staff the NHS of the future. In a time of change, what sort of NHS do you want to work in? We must all recognise the country's financial situation, and seek to follow the Christian mandate to be good stewards of resources. So, how can we respond to the planned cuts?

It is still a privilege to be a doctor. Amid frequent tiredness and frustration we have the honour and the adventure of the challenge to follow in the footsteps of the Great Physician, as we encounter so many people and pathogeneses. We face many kinds of battles: against intensive rotas, diagnostic enigmas, difficult examinations, and apathy to the Gospel. It is a point of pride to work for an organisation, and under a regulator, which have great sympathy for biblical mandates – notably the NHS' provision of healthcare regardless of means, and the GMC's directives to value integrity and avoid prejudice.

In this financial recession, we know so many face difficulties with resources and face difficult decisions. As with any important issue we must be thorough in prayer and study to ascertain how to face these challenges, and petition God for the courage to do so.

The spotlight of Scripture

The richness of the Scriptures holds wisdom for every circumstance.[1] It is often forgotten which topic Christ spoke about most – it was not sex or doctrinal harmony, but management of money. Christ's use of the word 'Mammon' (as translated in the King James Version[2]) equates money and avarice with a demonic force, not to be underestimated. This goes hand in hand with God's concern for the poor. Isaiah 58 describes both sharply and eloquently false and true worship, calling us to the 'fast' of breaking yokes such that 'your light will break forth like the dawn'.[3]

The book of Amos has much to say on God's intolerance of social injustice. A repeated theme is the condemnation of nations selling others to slavery: 'because she took captive whole communities'.[4] Soberingly for the message's recipients at the time, the accused included Israel, God's people. Specific concern for the oppressed echoes across the Old Testament; through the books of the Law and the Prophets, through the Psalms and Proverbs. Proverbs 22: 22 states 'Do not exploit the poor because they are poor and do not crush the needy in court'. Memorable, considering the use of '2222' in many Trusts!

The threat is real

No one in the UK can be unaware of the budget cuts prompted by the recession. All the media are now thoroughly engaged in argument, both at local and national level, debating specific cases and ideologies. The threat to many services for the vulnerable is real, both in terms of lost services, reduced funds, and future consequences. We know, for example, that clinical depression occurs in proportion to urban deprivation and perceived helplessness. We must ask ourselves what we can do.

A danger is to demonise politicians and apportion blame. Arguably the most famous politician in history, with his name appearing in the Nicene Creed, is Pontius Pilate. There is much controversy over the reasons for his action of handing Christ to the Jews for execution. Some historians cite that he himself was under threat of execution from Caesar to avoid a further riot in Jerusalem. The truth of why he acted as he did may never be known this side of heaven, but the possibility does add another perspective to the character synonymous with 'washing his hands of the matter' and 'passing the buck'.

Lobbying appointed representatives

With regards to our own MPs, we have a right, and a duty, to voice our opinions and concerns. Their profession is to convey our representation to government, just as patient care is our profession. Until recently I didn't know the name of my local MP. Having learnt it, I can now pray for him and have been inspired to write, and I would encourage others to do the same.

An organisation I have been proud to contribute to is Amnesty International. The mainstay of its petition, the expression of concern in the context of held beliefs, is a powerful one. Politics, of course, is a large and complex field and to give significant time to politics amid on call, family and local church duties will be literally impossible for many. But my resounding hope is that MPs will receive letters from those proudly stating they are Christian doctors, and petitioning for the support of the oppressed. We should maintain hope and continue to pray for justice, not becoming dismayed and disheartened by any perceived apathy.

As an analogy, in the parable of the Sower, the 'scattering' of God's Word is a given; the results, due to the nature of the ground, are not under the sower's control. Likewise we should be quick to declare our faith, and patient to its effect; in all things letting God work in us to 'to will and to act according to his good purpose'.[5]

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resources & references

- Contact your Councillors, MP, MEPs, MSPs, or Northern Ireland, Welsh and London Assembly Members for free: *www.writetothem.com*
- Join the British Medical Association, if you haven't done so already, and become active: *www.bma.org.uk/_top/join_bma/index.jsp*

1. 2 Timothy 3:16-17
2. Matthew 6:24
3. Isaiah 58:8
4. Amos 1:6
5. Philippians 2:13

Steve Fouch looks at opportunities with 'The Big Society' and NHS reform

Photo: PA

Any willing PROVIDER?

key points

With a new government and an austere economic climate, the author considers the opportunities the 'Big Society' and the NHS reforms offer to Christians. He recalls the 18th and 19th century Evangelical social reformers and briefly reviews the state of a largely secular NHS.

An entrepreneurial contemporary example is given of a Christian social company seizing the opportunity by delivering healthcare in north Manchester which is 'faith based but not faith biased'.

Acknowledging the dangers of strings attached to funding that limit work from a Christian ethos, and of colluding with an agenda to provide public services on the cheap by outsourcing to the 'voluntary sector', the author calls for a clear vision of a biblical, transformational mission that does not separate witness from service.

As we settle into a new decade, a new government, and a new and austere economic climate we face potentially radical change to society in general and to national healthcare provision in particular. The NHS reform bill [1,2] is creating much heat (and maybe limited light at present [3]), while the government's 'Big Society' strategy, emphasising the role of voluntary and local community groups in addressing social needs, is gaining much attention. [4]

In addition, last year's Papal visit re-ignited the debate about the role of faith in society, with the government proclaiming that it *did* 'do faith'. All these factors suggest a sea-change, not only in how healthcare will be delivered in the UK, but in the attitude to Christians being involved overtly in delivering it.

Precedents

In times of change I always find it good to hark back to the wisdom of *The Philosopher* who counselled that 'there is nothing new under the sun'. [5] We have walked a similar path in the past. In the 18th and 19th centuries there was no national healthcare system; life for the poor and marginalised in society was 'nasty, cruel and short'. Into that environment stepped a series of Evangelical social reformers – Wilberforce, Shaftesbury, Barnardo, Booth, and Nightingale, among others. These men and women were inspired and profoundly influenced by Scripture and their Christian faith, and did a huge amount to change the society around them. They paved the way for the reforms that led to the founding of our modern educational, welfare and healthcare systems.

The 1948 advent of the NHS changed many things, moving church hospitals into state control, secularising healthcare and making it universally available. It is worth noting that at the time many Christians opposed this, just as many today would be the first to stand up and defend the NHS.

> It would seem that we are at a *kairos* moment – a time in which God is opening doorways for his people to respond. But in what ways can we engage with these opportunities?

After 60 years the NHS has become an embedded part of our national life and culture. Love it or hate it, we cannot be indifferent to it. The NHS is where most of us work; most of us were born in it and had our own children under its care. We will have seen our elderly relatives cared for at their lives' end, and indeed it will be by the NHS that most of us will be cared for in our last days. It touches the lives of our nation in a way no other institution does. But as Christians we have largely been excluded from its essentially secular structures. Yes, we have Christian GP practices and chaplains, but our voice and input are mainly kept at the edges.

Christian service in the 'Big Society'?

That looks likely to change however, if the 'Big Society' thrust of the coalition government becomes a reality. The government says it is seeking to engage local communities, churches and small, self-organised collectives of health professionals with the running and provision of essential services. At the same time the Health and Social Care Bill is looking at a radical restructuring of the NHS to devolve more power to GPs, and create more space for private and voluntary sector organisations to be involved in providing services and supporting GPs in their new commissioning role.

Following the Papal visit which brought to the fore a long marginalised debate about the role of faith in the public square, the government has gone on record acknowledging the important role of faith in the life of our nation, and they say they are keen to involve churches and Christian organisations in the Big Society.[6]

It would seem that we are at a *kairos* moment – a time in which God is opening doorways for his people to respond. But in what ways can we engage with these opportunities?

An example

In north Manchester CMF member Tim Lyttle, along with several other Christian leaders and health professionals, responded to Lord Darzi's NHS review by setting up a social company to tender for contracts for new primary care practices. They were awarded four contracts, in some of the most socially deprived communities in the area.

The company, now called *Hope Citadel Healthcare*,[7] has grown from five founders to over 70 staff, including 14 GPs and six nurses. There is a team of healthcare assistants who also have a role in health promotion and education. They have strong links with two local Christian charities – *EDEN*[8] and *Inspire Middleton*[9] – involved in social transformation work in the north of greater Manchester, with the aim of responding 'holistically' to the considerable needs of these communities through more than just traditional GP services.

While the basis of Hope Citadel is firmly Christian, they do not exclusively employ Christian staff at any level, nor do they only work with Christian charities and community groups. However, it is from the churches of north Manchester that they have drawn many of their staff and volunteers, although getting Christian GPs involved has been a big struggle.

Tim is very up front about it being a Christian company: 'We are faith *based*, but in no way faith *biased* – we have been criticised for being a Christian organisation and many people have come to us expecting prejudice, but in terms of patients and staff we show no partiality. We do want to give Christian doctors and health professionals a chance to work out their faith in a supportive, Christian environment. Our main aim is not evangelism or praying with patients, but more to work with the church for transformation in local communities, investing in the wider Christian witness, not just in personal witness.' As such Tim says he sees this work as a form of transformational mission, giving the local church an opportunity to engage meaningfully with the NHS.

As Hope Citadel seeks to consolidate and build local networks after rapid growth in just three years, they are looking to the long term and at the opportunities to partner with other groups doing similar work in other parts of the UK.

Christian social enterprise

This is one example of Christian social enterprise, delivering whole person healthcare in response to a specific opportunity. But many more such opportunities are likely to open up in the next few years. Are we already thinking about new and creative ways to engage with our churches, denominations and other Christian organisations to have a positive influence?

Should we be finding ways of tackling many of the spiritual and social roots of the health problems in our society, such as obesity, diabetes, mental and sexual health, and not just dealing with their consequences? New ideas such as Parish Nursing[10] – developing a community health programme within churches – and new grassroots social enterprise models could engage Christian business people and managers in reshaping healthcare. The NHS Bill also creates the opportunity to form new collectives of Christian health professionals providing services in local communities. These are just some of the options to consider and explore.

Caveats

There are many factors to weigh in the balance before we jump in. First is the danger of having to compromise by 'accepting the King's shilling' – being constrained by strings attached to funding that limit our room to work from a Christian ethos. Also, are we in danger of colluding with an agenda that seeks to provide public services on the cheap by outsourcing to the 'voluntary sector'?

There is a further danger that some Christians become so caught up in social service provision that we lose sight of our call to make disciples. But at the same time, have we caught a clear vision of a biblical, transformational mission that does not separate witness from service?

We need to weigh these questions seriously, but if we ignore this *kairos* moment, we run the risk of missing a real opportunity that God seems to be providing for us to be real salt and light[11] in our society. Let's bring God's people back into a real engagement with the NHS.

Formerly a nurse working in HIV/AIDS, ***Steve Fouch*** *is CMF Head of Allied Professions Ministries*

Photo: PA

We are faith *based*, but in no way faith *biased* – in terms of patients and staff we show no partiality

references

1. Health and Social Care Bill 2011. *tinyurl.com/4kqzuhd*
2. *Equity and excellence: Liberating the NHS*. Department of Health White Paper, 12 July 2010. ISBN 978 0 10178 812 0
3. Thousands voice concern over Government's NHS reform bill. *Daily Telegraph* 19 January 2011. *tinyurl.com/65obnbx*
4. Building the Big Society. Cabinet Office. *www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf*
5. Ecclesiastes 1:9
6. Evangelical Alliance welcomes Government's commitment to people of faith. *Christian Today*, 20 September 2010. *tinyurl.com/2v6n9qw*
7. *hchealthcare.org*
8. *www.eden-network.org*
9. *www.inspiremiddleton.org.uk*
10. Eveleigh J. What is parish nursing? *Triple Helix* 2008; Spring:15
11. Matthew 5:13-16

Gareth Tuckwell describes a hospital that continues overtly Christian ministry

BURRSWOOD

Christian hospital and place of healing

Dr Paul Worthley with a patient

key points

Burrswood has always been a place of healing, founded in response to a vision Dorothy Kerin received almost 100 years ago shortly after being completely restored to health: 'to heal the sick, comfort the sorrowing and give faith to the faithless'.

Burrswood is now a hospital licensed by the Care Quality Commission with 40 beds, a busy outpatients wing, a refurbished church and a guest house. 'We never impose our Christian faith but believe in living out gospel values at the bedside.'

The staff and volunteers would like Burrswood to be better known and dream that one day they would be able to offer treatment and care irrespective of people's ability to contribute to the cost. They invite visits and prayer.

There is still an overtly Christian hospital in the UK that is alive and well. Burrswood, in Kent, is an international resource for the Christian church that demonstrates a practical outworking of Christ's call to heal, with a marriage of orthodox medical treatment and care alongside Christian ministry and an expectation that Jesus heals today.

Burrswood is a place of healing. We believe we offer excellence in interdisciplinary healthcare, where hurting and broken people discover the love of Christ in action. As staff and volunteers, we aim for Burrswood to be a prophetic outworking of Christ's call to heal that looks at people and relationships and the impact of illness, rather than just focusing on disease processes and polypharmacy. This is a work of God born out of obedience to God's call.

The vision

That call was given to Dorothy Kerin nearly 100 years ago. She describes in her book *The Living Touch*[1] how during the days following her healing, when she had been for the most part in a coma and with her family gathered around her bed, she received a vision from God. In this vision she was brought back to life 'to heal the sick, comfort the sorrowing and give faith to the faithless'. These concepts have been at the centre of Burrswood's developing vision ever since it was founded in 1948.

Over recent years Burrswood has obtained hospital registration and is therefore licensed by the Care Quality Commission. In the last decade we have raised over £5 million for major refurbishment and now have an amazing 40-bed hospital, a busy outpatients wing, a church, and a guest house. The focus of the hospital is on treatment and care of the whole person and the team has developed particular areas of expertise, all of which are undergirded by prayer.

Areas of expertise

- Immediate post-operative recovery supported 24/7 by a medical team
- Intensive rehabilitation with treatments such as hydrotherapy to maximise recovery
- Complex respite care during which patients receive individual treatment plans to help them live more fully despite their difficulties
- Chronic fatigue syndrome (CFS/ME): the team has seen many lives transformed through individualised programmes of treatment and care
- Certain acute illnesses where an integrated whole person approach is offered with intravenous therapies, transfusions and interventions as required
- Counselling is offered for a range of psychological and emotional problems which are amenable to short term intensive work in a supportive environment; we also offer a week of treatment specifically designed to help manage stress and anxiety
- Palliative and end of life care with expert symptom control and spiritual care, with a bed for as long as required

Is a place like Burrswood still needed?

Why do we need a place like Burrswood in the 21st century? I believe that all Burrswood has to offer has never been more relevant or more needed. Acute healthcare today is seen in terms of specialties, subspecialties and procedures, rather than being centred round individuals and the totality of their need; a need that often springs from illness and isolation. As doctors we barely have time to think outside the box. Scans, biochemistry and a good examination mean that it seems less necessary that we really listen to the patient.

At Burrswood we have the luxury of being able to spend up to 90 minutes admitting a patient. It is then we so often find that the patient's story has not been heard in depth. Tuning in to language and emotion can be so helpful, and lead to the real cause of malaise and dysfunction coming to light. At last we begin to see the person in the patient.

As far as spiritual care goes, with NHS Trusts driven to balance the books at all costs and only spending on 'best value', there is growing evidence that employing chaplains is seen as low priority. Yet, whatever our faith or lack of it, within us all there is a search for meaning. We need opportunities to make sense of what comes our way and to derive meaning from it. Although Burrswood is an Anglican foundation with three Anglican chaplains, there are also Free Church and Roman Catholic lay chaplains within the large volunteer team. People of all faiths or none are made to feel very welcome. We never impose our Christian faith but believe in living out gospel values at the bedside.

Falling through the gaps

While I wholeheartedly believe in the NHS, Burrswood must be there to bring hope to the increasing number of people who fall through the gaps in healthcare provision.

We have a passion for something better, particularly for those who have lost hope, meaning and purpose; for those whose illness has taken them over and sometimes become their identity. Such people come to Burrswood and hopefully find a love at the heart of care that centres on them, accepts them as they are and believes in them as individuals.

We aim to offer excellence in whole person healthcare. Sometimes a diagnosis that has eluded others is made. Sometimes fuller recovery is achieved. Sometimes faith is found or renewed.

We are committed to person centred, quality care that is not afraid to work in difficult areas of life if that is what is needed. Because none of us is going to live forever, sometimes that also means helping people to pack their bags with what matters most for them as death draws closer.

Making Burrswood better known

We would like Burrswood to be better known. The demand for beds is often strong but we long for everyone in the UK to know of Burrswood and to realise it is delivering cutting edge care. The Chair of a nearby PCT says we undersell ourselves. The PCT have no concerns about our 'Christian' label; they go for our values, our added value, and our ability to offer complex care. What opportunities the 'Big Society' will bring, and how we will best interface with GP Commissioning Consortia and care pathways is yet to be seen.

It costs £4 million a year to run Burrswood. All-inclusive hospital charges are in the region of £300 a day and last year we helped 37% of patients receive financial support with the cost of their care. The demands on our bursary fund (Access to Care) will probably reach £500,000 this year but in reality we can only give out in bursary support the profits of our trading arm (£60,000) and donations specifically given.

How can you help? Do look at our website, read about the CFS research programme, check out the same day admission process, and remember we take people from across the UK and beyond. We'd like to make connections with people who may be able to help, including people or companies who might sponsor events for us. Like everybody else, we need funds to see us through this critical time in our development. But truly, above all, we would value prayer – see specific needs at *www.burrswood.org.uk*

What is our dream? That one day we are able to offer treatment and care irrespective of people's ability to contribute to the cost of their clinical care. Please pray with us that our dream might become reality!

PS

One 40-year-old patient wrote about what she had found at Burrswood after two admissions largely paid for by our Access to Care Fund:

'If it were not for Burrswood I'm not sure that I would have survived. This statement may seem dramatic, but I know at a very deep level that in my case it's not. I cannot imagine there is anywhere else that provides a person in their entirety with such a level of total care. I am a living testament to the fact that God's 'work' that is done at Burrswood doesn't diminish as you leave, but is so embedded into your soul that it becomes part of your new healed or healing self. Burrswood will always be 'in' me and I will always be able to factually recount the healing that is ongoing in me because of my time spent there.'

Gareth Tuckwell *was Medical Director of Burrswood from 1986 to 1999 and was reappointed as CEO in 2007. He invites visits:*
gareth.tuckwell@burrswood.org.uk

We never impose our Christian faith but believe in living out gospel values at the bedside

reference

1. Kerin D. *The Living Touch*. The Dorothy Kerin Trust, 4th Edition 2008

Peter Ravenscroft on life-changing times in his career

MY EUREKA MOMENTS

key points

As the outgoing Chairman of the International Christian Medical and Dental Association, the author gave the opening address at the 2010 World Congress in Uruguay: *Balancing priorities: integrating faith and science.* He concentrated on personal Eureka! moments.

On a student elective in Papua New Guinea, a pioneering missionary surgeon had great faith as well as skill and was a lifelong encouragement. A visit to Switzerland confirmed that Francis Schaeffer was a man who lived a life that matched his inspirational rhetoric.

Crying in the shower gave relief as his first wife was dying, and an interest in palliative care culminated in a Chair. As Christians, we need both technical expertise in science to practise our chosen profession, and the meaning and purpose for life which comes through faith.

I would like to take the first step in this Congress[1] of helping us to get to know each other better, and to tell you some of the '*eureka* moments' of my own story, which illustrate the interaction and priorities of faith and medicine.

I like to talk of these experiences as '*eureka* moments' for this reason. You will remember that Archimedes, while bathing, discovered that any object floating upon, or submerged in, a fluid is buoyed upward by a force equal to the weight of the displaced fluid. He realised that principle would allow him to measure the disputed composition of a crown and is then said to have taken to the streets, so excited by his discovery that he had forgotten to get dressed. He shouted *Eureka*! (meaning 'I have found it!') as he went. There are moments in life when we realise we have found something very meaningful, and they often come after hard and testing times. For me, these moments have been ones of personal discovery, and some of intense emotion.

Encouraged by Theo in Papua New Guinea

For my elective as a medical student, I applied to the Papua New Guinea (PNG) government to work as a medical assistant. The Health Department assigned me to Yagaum Lutheran Mission Hospital, just inland from Madang, a town on the north coast of PNG. My job was to assist Dr Theo Braun, a missionary surgeon, who had arrived in PNG at the age of 26. Mornings were spent in surgery; in the afternoons my job was to manage the medical wards. Theo said he didn't know much medicine, so he was leaving it to me! That was real faith!

My three months with Theo were a formative experience. Theo was a surgeon, a great technical surgeon as far as I could see. He was also a man of faith and vision. At the end of World War II, he asked General McArthur if he could have the equipment from the American field hospital at Finschhafen, further down the north coast of Papua New Guinea. Upon getting a positive answer, he arranged to raft the hospital contents up to Yagaum. In 1950, he set up a surgical facility in a series of huts in the jungle that had been used as barracks for Japanese soldiers, at whose hands he had suffered much. Theo had the ability, facilities and equipment to do most types of surgery. I have never seen his like since.

In Theo, I saw a man who had thoroughly integrated his faith and his practice of medicine. I worshipped with him in the little mission church and helped with surgery. I am truly grateful to him for this time we spent together. As I left the mission hospital, he said to me, 'Peter, I have no doubt you will become a great physician'. Whether I deserved these comments or not, I have looked back to them many times since, when things have been very difficult, and I have been encouraged to keep going. That memory has been helpful too in reminding me to encourage younger people in their own journeys. My *eureka* moment came as I reflected on the example Theo had set for me.

Inspired by Francis Schaeffer

In the mid-1970s, I was in the United States doing postdoctoral research at the University of California, San Francisco. Heather, my first wife, and I began to notice there were a number of books by Francis and Edith Schaeffer circulating at our church. As we read them and got hold of Schaeffer's tapes, we became quite excited with their contents. Francis Schaeffer was an important Protestant theological figure in post-war times. He addressed, among other things, the loss of hope and reason in post-war society.

Francis Schaeffer[2] encouraged us all to take our faith and explore it consistently in all areas of human endeavour – in medicine, science, the arts, family relationships. It was that integration of all these factors that captured my attention. His work impressed us so much that at the end of my Fellowship, Heather and I flew to Switzerland from the USA to see if this fellow 'was real', that is, whether he could live a life that matched his rhetoric. He was able to demonstrate that and more, and that experience formed a *eureka* moment that I have found to be true as I have lived on in life.

Dealing with my wife's death

Heather developed breast cancer at age 35 and died in April 1986 aged 39. She had surgery, chemotherapy, radiotherapy and palliative care and was managed at home except for acute hospital admissions. It was a very hard time for our children, the whole family and me. One morning, I was having a shower and found myself crying. I have found in my experience in palliative care that it is not uncommon for men to cry in the shower. It is the one place where we men can be alone with our thoughts, experience deep emotion, and express it in privacy.

At that time I was grappling with the sorrow of why God was not healing Heather. If anyone deserved healing, I thought, Heather did. There was much love and prayer for her from all of us. My *eureka* moment came when I realised that I must continue to pray for Heather's healing, yet at the same time understand that she may not be healed – that was my paradox. Understanding this situation was beyond me, but it seemed I needed to acknowledge my own humanity before God. I fell into line with Job, who having been through all his suffering was able to say:

> *I know that you [God] can do all things;*
> *No plan of yours can be thwarted*[3]

To understand that I had to live with that tension was actually very liberating for me, both during Heather's terminal illness and after her death. We continued to pray and to care for Heather at home until the time she died. Why some die young and why others live longer is a mystery to me. I know I will only understand when I too have gone to be with Christ – and what a *eureka* moment that will be!

Led to a Chair in palliative care

While at Princess Alexandra Hospital, we decided to apply for a major grant to consolidate the research programme and the clinical work at the hospital and hospice. It was our dream, but the grant was not funded. After a struggle and much prayer, I realised I should be prepared to move, if necessary.

I began looking around Australia. While doing this, I received a phone call from a friend who was working at a palliative care service in Newcastle (about 800 km to the south). He was a Christian, but had developed leukaemia. He had helped raise funds to build a new hospice, his dream, but he needed to go back to Western Australia to be near his family during treatment. Was this the opportunity that was being given to me?

I subsequently applied for and accepted in 1992 the position of Hospice Director and Foundation Professor of Palliative Care in Newcastle. Within a year, my friend and research colleague and the head of my research laboratory both moved from Brisbane to Newcastle to work with me. We developed palliative care services in Newcastle and re-established the research programme, fulfilling our Brisbane dream. I felt God led us, my second wife Beth and I, to Newcastle and into palliative care there.

My *eureka* moment came when I realised this was where God wanted me to be and I was amazed that the staff and facilities available would make our dream possible. I always say to my trainees that they should keep their minds open to a calling. Even if it means a change in direction and location, God may lead you into a wonderful work. I am for ever grateful for that opportunity in my life.

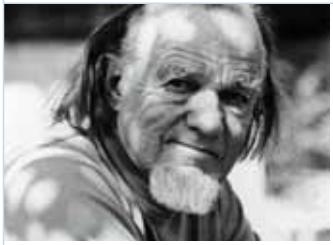
Faith is our *raison d'être*

Faith gives our lives and our medicine and dentistry meaning and purpose. It is our *raison d'être*. It is in the context of faith that we, as Christians, practise our medicine and dentistry. As Christians, we need both technical expertise in science to practise our chosen profession, and the meaning and purpose for life which comes through faith. For all of us life will bring challenges, but for me, the *eureka* moments have helped to fashion my life of faith and therefore my practice of medicine.

Paul gives us this advice that is still as relevant for us each day as we practise medical science as it was for the first century church:

> *See to it that no one takes you captive*
> *through hollow and deceptive philosophy,*
> *which depends on human tradition*
> *and the basic principles of this world*
> *rather than on Christ.*[4]

Peter Ravenscroft *is Professor of Palliative Medicine, University of Newcastle, Australia and was Chairman of ICMDA from 2002-2010*



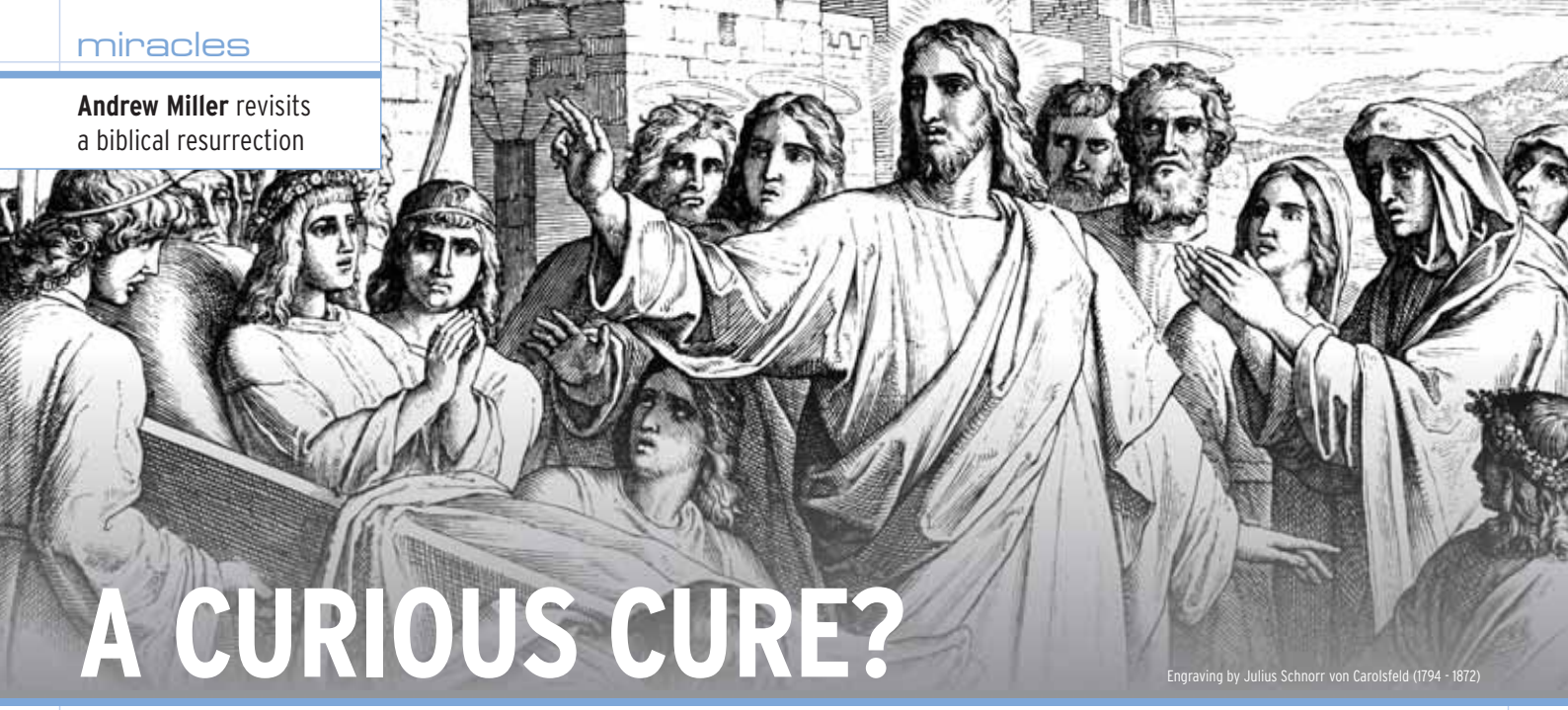
Francis Schaeffer

I have found in my experience in palliative care that it is not uncommon for men to cry in the shower

references

1. Extract from the Opening Address, given at the XIV World Congress of ICMDA, Uruguay, 2010: *Balancing priorities: integrating faith and science*
2. Schaeffer F. *Complete Works of Francis A Schaeffer. A Christian World View*. Crossways 1982; Vol 1: p 9,10
3. Job 42:1
4. Colossians 2:8

Andrew Miller revisits a biblical resurrection



A CURIOUS CURE?

Engraving by Julius Schnorr von Carolsfeld (1794 - 1872)

…Jesus went to a town called Nain, and his disciples and a large crowd went along with him. As he approached the town gate, a dead person was being carried out – the only son of his mother, and she was a widow. And a large crowd from the town was with her. When the Lord saw her, his heart went out to her and he said, "Don't cry."

Then he went up and touched the coffin, and those carrying it stood still. He said, "Young man, I say to you, get up!" The dead man sat up and began to talk, and Jesus gave him back to his mother.

They were all filled with awe and praised God. "A great prophet has appeared among us," they said. "God has come to help his people." This news about Jesus spread throughout Judea and the surrounding country.
(Luke 7:11-17)

The Galilean village of Nain is nine miles south of Nazareth and is still occupied today. It is aptly named (*Hebrew*: pleasant) because it is half way up a hill with a spectacular view over the Jezreel valley below to snow-capped mountains beyond. The nearby hills are studded with caves.

As Jesus walked down to the entrance to the village, he saw and heard a funeral procession. A body was being carried by four men on an open coffin, as still happens in parts of the Middle East today. He learnt this was a young man, the only son of his widowed mother. But what prompted Jesus to do what he did? After all, he would have been familiar with death and must have attended several funerals of relatives and local people.

There are only two other occasions when he intervened in this way. In one this was only necessary because the patient died while Jesus was side-tracked by another case,[1] and the other was deliberate because, for special reasons, he waited until the sick person had died before taking any action.[2] So why this time? Why risk the inevitable publicity which he otherwise strongly discouraged?

His heart went out

The clue to this is in the word translated here as 'his heart went out' to her (elsewhere 'he had compassion'). The Greek root is the word for intestines (as in *splanchnic*), and here Luke is saying that this scene caused Jesus' 'guts to be churned up'. Indeed, this word is used almost exclusively of Jesus and by him. It is a deep emotional response, and so it differs from the equally important and uniquely Christian concept known as *agape* love (which is fundamentally a decision of our will).

It was Jesus' compassion for the crowds that made him yearn for their spiritual needs, heal their sick, and feed their hungry.[3] It was his compassion that led him to heal the blind, those with leprosy and those affected by demons.[4] It was his compassion that is the foundation of his two most sublime parables, known as the Good Samaritan[5] and the Prodigal Son.[6] In both these stories this gut-wrenching was at complete odds with the attitudes of everyone else.

Churned up inside?

So what prompted this deep gut reaction in Jesus? Was it his discovery that the widow was now truly alone, defenceless, and without any support other than charity? Or could it be that it brought back painful memories of another widow? – his own mother grieving the loss of her husband Joseph? At that time, Jesus would have been right in the middle of the home where Mary experienced her own devastation, and he would have been deeply involved in her pain as she gradually rebuilt her shattered life.

> are we still encountering some cases that deeply churn us up inside?

Perhaps, when he saw this widow at Nain, he relived his own feelings when he knew that Joseph would never come back. And perhaps too on that day at Nain, he was reminded that the day would come when the widow Mary would have to bury her Son.

From time to time we need to recognise that, with the relentless pressure of demanding patients, we may be continuing to offer good competent medicine but somehow drifting away from this depth of compassion. Or, instead, are we still encountering some cases that deeply churn us up inside?

Andrew Miller *is a retired general physician who divides his time between medico-legal work, medical education at a Christian hospital in Egypt, and being a Street Pastor*

references

1. Mark 5:22-34
2. John 11:1-15
3. Matthew 9:36, 14:14, 15:32
4. Matthew 20:34; Mark 1:41, 9:22
5. Luke 10:33
6. Luke 15:20

eutychus

Adverse maternal outcomes from IVF

UK maternal mortality has been creeping up for two decades. The first published case report (1991) related to in vitro fertilisation predicted increasing maternal morbidity and mortality associated with assisted reproductive technologies, due to pregnancies at an older age, multiple pregnancies and pre-eclampsia. A 2010 Dutch study showed that overall maternal mortality in IVF pregnancies was higher than in the general Netherlands population. *BMJ* editorial authors reviewing this and other data call for systematic reporting so lessons can be learnt and action taken.
(*BMJ* 2011;342:d436 doi: 10.1136/bmj.d436)

French Senate rejects assisted suicide & euthanasia

On 25/26 January the French Senate rejected proposals to legalise assisted suicide and euthanasia, by 170 votes to 142. Francois Fillon, the French prime minister, had spoken out strongly against the proposals. This relatively clear rejection in a very secular state should encourage us in the UK that we have the arguments, and that when they are heard we will continue to reject all such unnecessary and unethical proposals.
(*Le Figaro* 26 January 2011, accessed at *tinyurl.com/4byjr2g*)

Silent night

Before Christmas, a *BMJ* article began with a hospital notice: 'Noise disturbs sick people. Quietness assists recovery.' Palliative care consultant Paul Keeley continued: 'I spent some of my otherwise misspent youth in the great Benedictine monasteries of England. There I learnt of the great silence that falls across such monasteries from the last office that completes the day until after dawn, when the monks raise their voices in praise and thanks... Is it too fanciful to believe that, to facilitate the healing of patients, such a great silence may be allowed to fall across hospital wards?'
(*BMJ* 2010;341:c6989)

10 best & worst developments for the family in 2010

The US-based World Congress of Families released its 'awards' in January. Although very much North America oriented, CMF was pleased to claim some credit for best developments 6 and 8: 'UK plans to block children's access to Internet porn' and 'Regarding abortion, Europe preserves right of conscience for medical professionals'; and sorry to agree with worst development 9: 'Growing anti-Christian bigotry in Europe'.
(*World Congress of Families Newsletter*, January 2011 Vol 5:1, p3. Accessed at *tinyurl.com/64pu8ha*)

'The ways we say goodbye'

UK funeral customs are changing. Over half of today's funerals are celebrations of life, and a Co-operative Funeralcare report explains: 'High profile funerals, such as that of Princess Diana and, more recently, of Jade Goody, have encouraged people to adopt a fresh approach...Religious music is declining with contemporary music, from love songs to favourite TV programme themes increasing in popularity.' The most popular songs are *My Way*, *Wind Beneath My Wings*, and *Time To Say Goodbye*. (*Co-operative funeralcare news*, 24 January 2011. Accessed at *tinyurl.com/6yv5y2m*)

Satisfied with the NHS?

At the end of the first decade of the new millennium, there are lots of surveys out. According to the 2009 British Social Attitudes survey, satisfaction with the NHS is at an all time high. When New Labour came to power in 1997, only 34% were satisfied; by 2009 64% were. The greatest increases were among those with traditionally low levels – 18-34 year olds and better-off households. Satisfaction with GPs was at 80%, and with outpatients at 67%.
(Quoted in *Quadrant*, January 2011: 2)

What British people believe

In late 2010 Populus polled 1,037 British adults. Only 19% accept the biblical account that God created the earth in six days and rested the seventh; 55% thought it was untrue and 25% were undecided. 67% think humans have evolved from apes. Only 37% believe in life after death; 26% refute the possibility of an afterlife and 37% are unclear. 31% think UFOs have visited the earth from other planets, though 31% think not and 38% are unsure. In all of these findings, Christian Research report encouragingly on the large proportions who are undecided.
(Quoted in *Quadrant*, November 2010: 4)

What British evangelicals believe: 1. Abortion

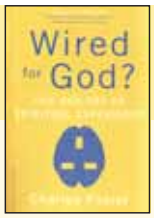
21st Century Evangelicals is a new Evangelical Alliance and Christian Research publication. Throughout 2010 over 17,000 questionnaires were completed at festivals popular among evangelical Christians all over the UK, and at 35 randomly selected EA member churches. To the statement 'Abortion can never be justified', 20% agreed a lot, 17% a little, 18% were unsure, 28% disagreed a little, and 17% disagreed a lot. Younger evangelicals were more likely to think abortion could never be justified.
(*21st Century Evangelicals*: 8. *www.eauk.org/snapshot/read.cfm*)

What British evangelicals believe: 2. Assisted suicide

To the statement 'Assisted suicide is always wrong', 42% agreed a lot, 18% a little, 24% were unsure, 10% disagreed a little, and 6% disagreed a lot. CMF clearly has a lot of work to do in engaging with the churches, explaining the Sixth Commandment and providing an evidence base. Assisted suicide is merely euthanasia one step back (and therefore prohibited by the Commandment), is unethical, and is always unnecessary.
(*21st Century Evangelicals*: 9. *www.eauk.org/snapshot/read.cfm*)

What British evangelicals believe: 3. Homosexuality

Because most evangelicals distinguish between homosexual 'feelings' and 'actions', two questions were asked. Regarding 'It is wrong to have homosexual feelings', 13% agreed a lot, 11% a little, 21% were unsure, 25% disagreed a little, and 30% disagreed a lot. When considering 'Homosexual actions are always wrong', 59% agreed a lot, 14% a little, 11% were unsure, 8% disagreed a little, and 8% disagreed a lot.
(*21st Century Evangelicals*: 9. *www.eauk.org/snapshot/read.cfm*)



Wired for God?

The Biology of Spiritual Experience
Charles Foster

- Hodder and Stoughton 2010
- £12.99 Pb 331pp
- ISBN 978 0 34096 442 2

I doubt many CMF members will have read a book quite like this. If, like me, you haven't read other works by Charles Foster, this will be an eye opener. The author is a Christian polymath – barrister, vet, scientist, explorer and writer.

It is one of the most learned yet lively looks on the nature of religious experience that I have read. Vast arrays of scientific papers are made accessible and woven together into a coherent set of themes. Chapters include: 'Religious experience and the origin of religion', 'An introduction to other states of consciousness', 'How psychoactive substances can throw open the doors of perception', 'Near-death and other out-of-body experiences', 'The holy helix: genetically predestined to believe?' and 'Wholly mad or holy madness?'

Many fascinating case examples of religious experience are examined. Foster takes on top scientists, such as Professor Susan Blackmore, and disputes her dismissal of the self and individual consciousness. The writing style is energetic and full of punchy one-liners. Because of this, the author uses turns of phrase which might occasionally jar with some readers. You might not agree with all in the book but it is a thoroughly good read, and there are some good pictures too.

***Dominic Beer** is a consultant psychiatrist in London*

Empty Arms

A mother's journey through grief to hope
Keren Baker

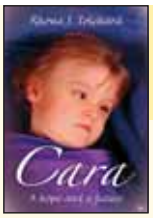
- Evangelical Press 2009
- £6.69 Hb 125pp
- ISBN 978 0 85234 704 9

The Bible reminds us to 'comfort those in any trouble with the comfort we ourselves have received from God'. Keren Baker does this beautifully through this book, which she wrote during the year following the death of her two-year-old daughter Natalie from septicaemia.

While not minimising the heart-wrenching agony of a grieving mother, it is clear that she knows and trusts a good and loving God. Scriptural truth is woven throughout the narrative. She describes frankly the emotional, physical and spiritual effects of Natalie's death, particularly on her other children, and provides sensible and practical advice on how to navigate the turbulent waters following.

It is short, easy to read, and ideal to offer to somebody struggling with the raw pain and distress that Keren and her family experienced. When my daughter Eva died in 2008, I searched for such a resource. Since its publication, I have given copies to many friends and relatives. All have wept, but all have been helped to understand the goodness of God through such trials and have been greatly encouraged. I highly recommend this book for the bereaved.

***Catriona Waitt** is a physician in Liverpool who described her own loss in* Triple Helix *Summer 2010: 9*



Cara

A hope and a future
Rhona J Tolchard

- IVP 2010
- £7.99 Pb 184pp
- ISBN 978 1 84474 430 5

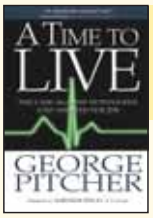
This is the story of a mother's spiritual journey, interwoven with the practical challenges of parenting and accessing support for a severely disabled daughter. It is an honest and painful account of one family's struggles but also a clear testimony of God's grace and care, even in the bleakest times.

I found myself challenged by the justified anger directed at both individuals and systems that stood in the way of Cara reaching her potential, and with which her family had to battle day after day. Our society's attitudes and actions are laid bare in an account where no profession – medicine, education or social services – comes across in a universally good light.

The key messages include choosing our words carefully as even throwaway lines can have a profound effect. We are encouraged to offer time and understanding when we have no cure, to avoid imposing our own views of disability, to offer practical support rather than platitudes, and to be advocates for the needs of the vulnerable.

As Christian health professionals we will all, either personally or professionally, look after disabled people and their families. I highly recommend this book for all who would like to do better in standing alongside them.

***Kirsty Saunders** is an associate specialist in community paediatrics*



A Time to Live

The case against euthanasia and assisted suicide
George Pitcher

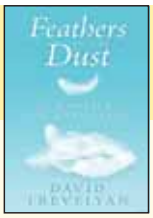
- Monarch Books 2010
- £8.99 Pb 158pp
- ISBN 978 1 85424 987 6

The author makes a very strong case against euthanasia and against 'assisted dying' as a route to its legalisation. He starts with his experience of his mother's death and uses accounts of others' experiences effectively. Pitcher tackles social, medical, legal and theological arguments thoughtfully, but so as to make the book interesting and readable. As an Anglican minister and Religious Editor and columnist at the *Daily Telegraph* he writes authoritatively, and is up to date with recent developments such as the UK Director of Public Prosecutions' guidelines.

His central and longest section is concerned with current practice in Oregon, Holland and Switzerland. He shows clearly the dangers for vulnerable and disabled people, as well as the effect that introducing euthanasia has had on the development of palliative care in these places, compared with that available in the UK.

In his final two chapters Pitcher discusses a theological viewpoint new to me, that of 'open theism'. I found it interesting, but suspect that many may not be able to agree with it. With this proviso, I would recommend the book as a valuable and persuasive addition to the literature against assisted dying and euthanasia.

***Anthony Smith** is a retired palliative care physician and surgeon, and a tutor with PRIME*



Feathers in the dust

A hospice doctor's tale
David Trevelyan

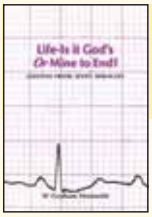
- Authorhouse 2010
- £7.99 Pb 266pp
- ISBN 978 1 45204 387 6

David Trevelyan is the pen name of a hospice doctor who wrote this novel because 'for too many, what happens in a hospice is cloaked in mystery and misunderstanding'. He tells the story of a young surgeon who takes a temporary post at the local hospice. He is given a lot of information about the hospice movement and is introduced to some newer challenges such as clinical governance and care plan protocols.

Once the scene has been set, the pace quickens. David is challenged by the different ways of working that he encounters, and is increasingly impressed by the behaviour of the staff. He grows in maturity and empathy for his patients. A large part of the book is taken up with descriptions of a burgeoning love affair and, finally, David has to decide whether or not to return to surgery.

This book's strength lies in the way the author brings to life complex ethical dilemmas surrounding treatment decisions in a simple and engaging style. There are some intriguing insights into the necessity for good communication and the nature and management of pain beyond mere medication. This simple book could help those seeking a brief introduction to the uniqueness of palliative care.

***Rosie Knowles** is a part time GP locum in Sheffield*



Life – Is it God's or Mine to End?

Lessons from Seven Miracles
W Graham Monteith

- Grosvenor House 2010
- £8.00 Pb 124pp
- ISBN 978 1 90765 237 0

The major aim of this short book is to examine the 'value of life' in the light of all the resurrection miracles in the Bible, such as the story of Lazarus, and to ask why they took place. The author concludes these miracles reflect the extremely high value and meaning that God gives to human life.

In the last two chapters, the book addresses the value of human life in the 21st century, where a rise of individualism and control are emphasised. It also examines the question of euthanasia and assisted suicide, where boredom (French *ennui*) and existential suffering (German *angst*) seem to become an excuse for some to end their lives.

One of the final questions discussed is whether the West is fast becoming a post-biological-family society where only the Christian church can address the important needs of real unconditional love and meaning given by God. The author, who sometimes reflects in his style his long experience as a minister of the Church of Scotland, challenges the churches to continue in their battle of love for God and others – with the help of God. Overall, this is a very readable and topical book.

***Calum MacKellar** is Director of Research of the Scottish Council on Human Bioethics*

Audacity to Love

The story of Hospice Africa
Anne Merriman

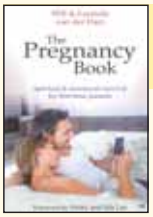
- The Irish Hospice Foundation 2010
- £11.99 Pb 296pp
- ISBN 978 0 95348 809 4

After years as a missionary in Nigeria and then as a geriatrician in Merseyside, Anne Merriman developed an understanding of palliative and terminal care and took it to relieve cancer sufferers, first in Singapore then in Uganda. The 'audacity' of the title describes her struggles with officialdom before winning approval, first for recognition of this different form of care, and then so that trained hospice team members could prescribe oral morphine in the home.

Hospice Africa was born, modelled on Ugandan practice. A highly respected local physician helped Anne take the concept to other African countries, the ongoing struggle being for adequate funding. The 'love' linked with 'audacity' is other-centred and self-sacrificial, often wounded, yet always valued by the sufferers it embraces. This reflects the love of Christ that has motivated Anne from childhood and, encouraged always by the hospice team, has shaped her major life work.

Mixing analysis and anecdote, her book should inspire any finding it hard to blend idealism with realism. To establish good relations within and beyond a team, with audacity and love energised by the Spirit of God, is evidently to find a prescription for more than we could ask or think.

***Janet Goodall** is a retired paediatrician from Stoke on Trent*



The Pregnancy Book

Will and Lucinda van der Hart

- IVP 2010
- £7.99 Pb 189pp
- ISBN 978 1 84474 440 4

Will van der Hart is an Anglican minister and national speaker of rising repute, and his wife a key partner in this work. The book spans conception to the first year of a first child's life. The van der Harts contextualise each time period biblically, give some practical pointers and vignettes from interviews with Christian parents of very young children, and pose challenging questions to be worked through as a couple. It was somehow written while their daughter was very young, so the issues were fresh in their minds, and there is little waffle.

They are clear that reading this book will not prepare a couple to become parents, only give a blueprint for working through issues with God. The section on creative use of time with God, rather than expecting regular quiet times to proceed as normal, was very helpful. I would highly recommend this gem to all Christians hoping to become parents, going through pregnancy, or who have an infant already. It would make an ideal gift, even to non-Christians, as this can be a time of surprising spiritual openness.

***Anna Reynolds** is a young doctor in Winchester, and she and Mike have recently become parents*

Palliative care consultant **Nicholas Herodotou** recounts his search for the 'One True God'

Nicholas and his wife, Zvart

From the occult to assurance

I come from a Greek Orthodox background although this personally meant nothing to me, as within the Greek community you cannot separate culture and religion. From the age of 15, I had a great desire to know truth and if there was that 'One True God', I wanted to find him. I often thought about the reason for living. Was it merely to get married, have children, then to get old and die? Was there a life after death and if so, where would I go – to heaven or to hell?

Unfortunately, I met a lady who introduced me to the occult. I started attending spiritualist meetings where a medium would relay messages from the 'dead'. It all seemed so realistic and true. I thought this was real Christianity as it demonstrated a spiritual dimension I had not experienced before in church. She taught me the philosophy of Eastern Mysticism which is a belief that we can all become one with God – in essence we can become God. This can only be achieved through countless reincarnations and this progress to perfection can be accelerated by acquiring hidden (occult) knowledge.

I started to delve deeper into the occult. I read countless books on the subject including titles on mediumship, spiritualism and tarot cards. I had my palm read, practised meditation, and even experimented with hallucinogenic drugs.

Empty spiritually and increasingly immoral

As I continued in these practices, I became empty spiritually. I realise now there is an evil power in the occult that keeps you in spiritual bondage. I had also become increasingly immoral in my lifestyle. There was such loneliness in my heart, coupled with guilt for the things I had done wrong. There was also a great fear of death. I certainly was aware of my sinfulness, and I instinctively knew that my lifestyle was going to lead to my destruction.

I continued to take on board every aspect of 'open belief' (believing all things and accepting all things without questioning) but grew more and more frustrated with all these different teachings. God seemed so far away and impossible to reach. I felt imperfect and the thought of never being able to reach God made me despair. Suicide was an option I considered but I was too fearful of pain.

I used to read the Bible but regarded Jesus Christ as no more than a great man. I accepted some of his teachings but rejected those I had difficultly believing. In the end, it was Jesus' authority and the great signs and power he demonstrated that left me with a conviction he was God. I was, however, unable at first to acknowledge him as God and allow him to change my life. His promise that he would return to save those who trust in him but would also judge the world in righteousness frightened me immensely. I was truly frightened at the thought of an eternity in hell and yet at the same time constantly drawn back into the pages of the Bible.

My only answer

The more I started to question Jesus, the more I realised he was my only answer. Many times before I had called on his name to help me but experienced nothing but silence. I prayed often but my prayers seemed unanswered. I now know this was because I was not prepared to repent of my old life and to trust and follow Christ.

It got to the point where I was questioning Christianity more seriously and I started to attend a local evangelical church. I began to realise that God loved me and showed his love by sending his Son into the world to die for me. This would save me from God's judgment and I would receive Christ's righteousness by faith and have everlasting life. This revelation of God to me was something quite wonderful – I could know this holy personal God and have peace with him.

I do not remember the exact date when I became a Christian. I said a prayer in church and asked Jesus to forgive me for all of my sins. It was not a dramatic conversion with thunder and lightning but a simple reassurance that all my sin was removed and forgiven forever! I was totally free from my past and my guilt and fear had disappeared. It was, and still is, the most wonderful experience of true freedom, hope and peace.

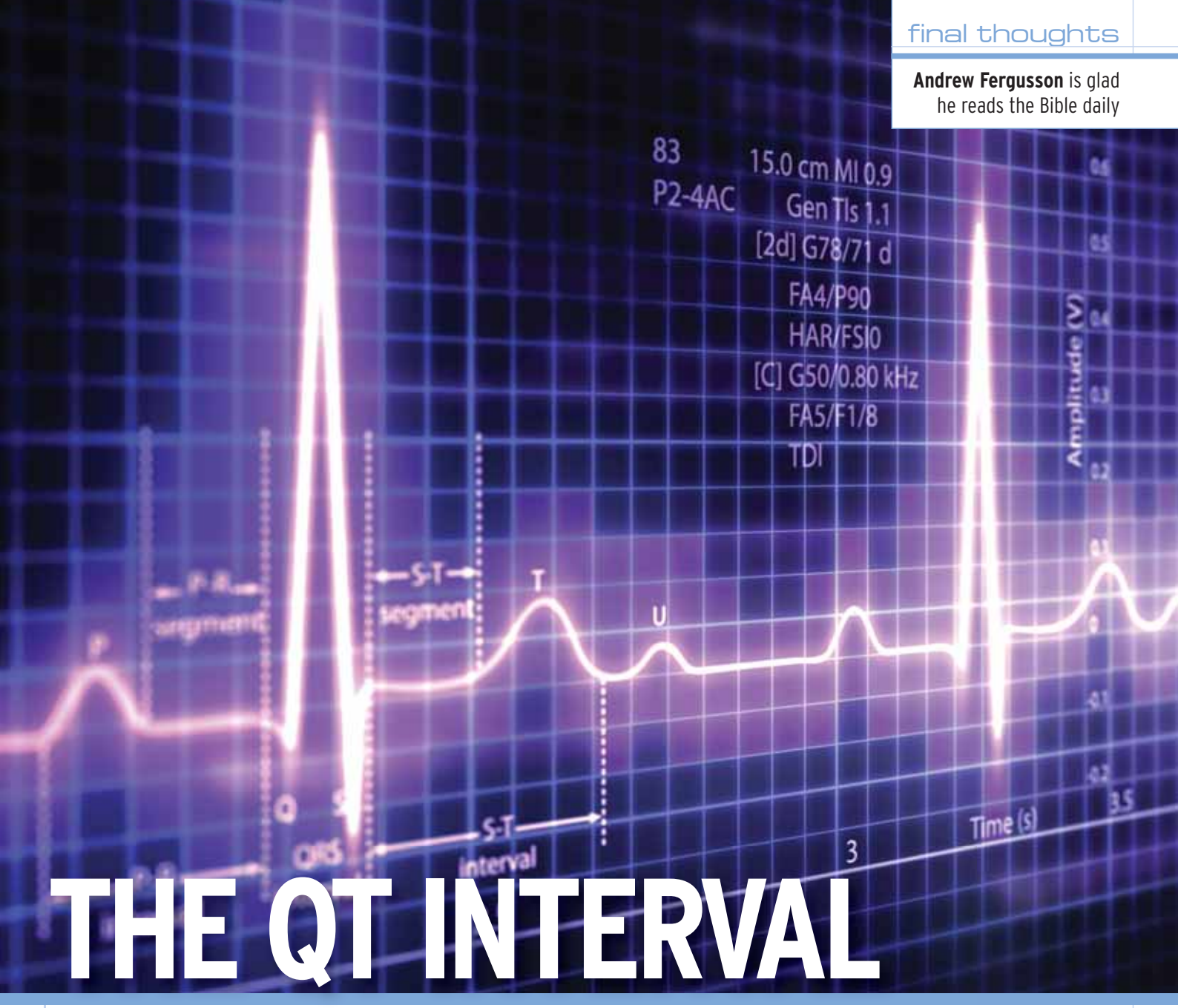
Being a Christian is having an eternal assurance, hope and joy. This is not for the things that this world offers, as these are all temporary. I live for the promise of Christ's return and our freedom from death, pain, suffering and sorrow. Jesus' kingdom is a perfect and everlasting place.

Starting medicine as a new Christian

I had always had a desire to be a doctor, but left school with no suitable qualifications. After a few months as a nurse and several other short term jobs, I returned to night school at 21 to resume my O Levels and then went to college full time to obtain A Levels. After three years I eventually succeeded in obtaining a place at St Andrew's University in Scotland, and followed that by doing my clinical training at St Bartholomew's Hospital.

Nicholas Herodotou *is now Macmillan Consultant in Palliative Medicine for Luton Community Services*

Andrew Fergusson is glad he reads the Bible daily



THE QT INTERVAL

More than 30 years ago I was, briefly, a registrar in cardiology. I became familiar with interpreting ECG traces, and therefore studied the QT interval. As a relatively new Christian, who has always enjoyed playing (badly) with words, I could relate the QT interval to a habit I had been inducted into in those far off days of muscular evangelicalism – the daily *Quiet Time*.

The early morning was recommended: 'those early morning quiet times begin the night before'. I was not, am not, and probably never will be, an early morning person. I soon learned to pick the time of day that was best for me; initially evenings, it became home most lunchtimes in my GP years (general practice was much gentler then). With a daily commute into the CMF office I am now back to the early morning.

But it isn't the time of day that matters; it is the discipline of reading God's word every day. In house jobs it might just have been the evening selection from *Daily Light*. I was a GP when I first read the whole Bible in a year – using one of the many versions which arrange scripture by date, or by 'Day 1, Day 2…etc'. Sometimes I would pick a theme – the 'I am…' passages in John, or I might use a little devotional book. I have used both editions of *The Doctor's Life Support* which you can now read daily on the CMF homepage.[1] I've always been resistant to Bible reading notes and study guides, but that's my problem – not liking being told what to do.

The point is that read day in, day out, with prayer before and after, 30 something years on I now have a reasonable grasp of the breadth and depth of Scripture. I've sometimes used whole verses in live broadcasts (though not usually obviously so – more 'None of us lives to himself alone and none of us dies to himself alone'[2]). Even though there are some Bible books I have only read six or seven times, perhaps any wordsmith skills I might have relate to reading so much really well written material, so often, for so many years.

In this 400th anniversary year of the publication of the *King James Bible*,[3] when we recall the transformation wrought in the English speaking world by putting the words of Scripture into the hands of ordinary people, let's get back to the Bible. Reading it regularly if not daily, in whatever way and with whatever aids work for you, is a huge blessing. And maybe on Sundays you could indulge in a 'prolonged QT interval'.

***Andrew Fergusson** is Managing Editor of* Triple Helix

references

1. *www.cmf.org.uk/doctors/devotion.asp*
2. Romans 14:7
3. *www.biblesociety.org.uk*

Photo: Samaritan's Purse/Photographer Matthew Powell

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