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for today's Christian doctor

triple helix

mind and soul

Organ donation, existential anxiety, building CMF networks, destitution, the wider horizon, dementia: a glorious opportunity, reviews

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Why not legalise same-sex marriage?

Britain is coming under increasing pressure to legalise same-sex marriage and Prime Minister David Cameron is determined to drive it through. A consultation on same-sex marriage closed in Scotland in December 2011 and a new consultation has been launched in Westminster to consider how legalisation should proceed in England and Wales.

Marriage is a divine invention. It was God who first said that it was 'not good for man to be alone' and who created the unique complementarity of the marriage relationship for companionship, pleasure, procreation and the raising of children; one man, one woman, united for life (Genesis 2:24).

Marriage is also in this way illustrative of Christ's own self-giving abandonment to his bride the Church (Ephesians 5:31, 32) and points to a greater richness of human relationships beyond the grave of which the very best on earth are but a pale shadow (1 Corinthians 2:9,10).

But Christians should also have confidence that there are many strong arguments for not redefining marriage that make sense to those who do not share our faith. [1] Here are seven:

1. **Marriage is the union of one man and one woman**. Marriage has existed in virtually all cultures for thousands of years and has been recognised in our own laws as the 'voluntary union of one man and one woman to the exclusion of all others for life' (Hyde v Hyde 1866). It is not up to governments to redefine marriage – but simply to recognise it for what it is, and to promote and protect it as a unique institution. Same-sex marriage is an oxymoron, like a four wheeled bicycle or a two storey bungalow.

2. **Same sex couples already have civil partnerships**. All the legal rights of marriage are already available to same-sex couples through civil partnerships so there is no need to redefine marriage to include them. The President of the Family Division of the High Court in England and Wales has described civil partnerships as conferring 'the benefits of marriage in all but name'. Marriage and civil partnerships have been designed for two very different types of relationship and should be kept distinct.

3. **Redefining marriage without consultation is undemocratic**. None of the political leaders who are supporting the legalisation of same-sex marriage announced it as a priority in their election manifestos. There is already a huge amount of opposition to the move and pressing ahead with legalisation will lead to considerable dissension and division. Legalising same-sex marriage to appease a small minority is wrong and it should not be foisted on the British people without proper consultation about *whether* rather than *how* it should be done.

4. **Protecting traditional marriage is good for children and society**. Stable marriages and families headed by a mother and a father are the bedrock of society and the state has a duty to protect the uniqueness of these key institutions. There is considerable evidence [2] to show that marriage leads to better family relationships, less economic dependence, better physical health and longevity, improved mental health and emotional well-being, and reduced crime and domestic violence. Same-sex marriage, in comparison with marriage, is an unproven and experimental social model.

5. **Marriage is a unique biologically complementary relationship**. Marriage is the only legal union which can naturally lead to children. The fact that there is a natural link between sexual intimacy and procreation is what makes marriage distinctive and different. Redefining marriage will undermine this distinctness and difference and risks normalising technological intervention in reproduction.

6. **Redefining marriage will be complex and expensive**. Redefining marriage could cost billions and involve amending hundreds of pieces of government legislation. The word 'marriage' appears 3,258 times in UK legislation, which underlines the central role the institution plays in national law. Introducing same-sex marriage is a legal can of worms [3] which cannot be achieved without changing the common and legal definition of the word marriage and other words which define it (eg. 'husband and wife', 'consummation' and 'adultery'). These changes will inevitably change the definition and nature of marriage for opposite sex couples by trying to accommodate these two very different kinds of relationship under one legal umbrella.

7. **Redefining marriage will lead to faith-based discrimination**. We have already seen a rising tide of discrimination against people who support traditional marriage as a result of the legalisation of civil partnerships coupled with new equality legislation. If same-sex marriage is legalised it would inevitably impact on other areas of law, such as health, education, adoption and employment, and place people from faith groups at risk of marginalisation, exclusion and litigation.

__Peter Saunders__ is CMF Chief Executive

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Another GMC consultation: doctors 'assisting' suicide

Upholds law and ethics, but needs input from the consulting room

Review by **Andrew Fergusson**
Chairman, Advisory Group, Care Not Killing Alliance

The General Medical Council has launched a consultation ending 4 May, on 'Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide'.[1] The definitive version will primarily be for the GMC's own purposes, to decide whether to proceed against doctors whose fitness to practise is apparently questioned.

Why the need? In July 2009, the Law Lords (now Supreme Court) ruled on the case brought by multiple sclerosis sufferer Debbie Purdy. She wanted assurances that if her husband assisted her suicide, he would know what criteria the Director of Public Prosecutions would use in deciding whether to prosecute. Ordered to publish criteria, the DPP's final guidance included among the 16 public interest factors listed in favour of prosecution: 'The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional… and the victim was in his or her care'.[2] Subsequently, the Medical Defence Union[3] and the Medical Protection Society[4] issued advice that doctors should not involve themselves at all, and the Royal College of Nursing guidance[5] is cautionary.

Health professionals are at risk both of criminal prosecution and of action by their regulator. The GMC's guidance, which will affect all registered doctors, is brief and commendably clear. It sets out the current law, and makes no ethical comment, but the detail is incredibly significant as it is against those final words that the GMC will judge any doctor's conduct.

Like the DPP, the GMC effectively lists 'more likely to prosecute' and 'less likely' factors. These are ethically conservative and show common sense, though questions remain. Most likely to affect doctors is: 'She wants records and a medical report for Dignitas – what am I allowed to do?' While 'providing access to a patient's records in compliance with a valid subject access request under the Data Protection Act 1998' (22b) is listed as less likely, 'assessing a person's physical health or mental capacity and/or writing reports knowing, or having reason to suspect, that the assessments and/or reports would be used to enable the person to obtain encouragement or assistance in committing suicide' (19c) is rated more likely.

This example suggests a potential minefield in practice. Individual doctors should respond to uphold law and ethics, and to comment on details in this consultation from the perspective of their consulting rooms.

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Changing views about sexual orientation

'A more fluid approach'

Review by **Peter Saunders**
CMF Chief Executive

Many people believe that homosexual and heterosexual are distinct biological categories like race – unchangeable, biologically fixed and genetically determined. It is on the basis of this view that the gay rights lobby and sections of the media argue that 'homophobia' is a form of discrimination akin to racism.

But this view is being increasingly challenged, not least by gay rights activists themselves. In a recent Huffington Post article that has generated a huge amount of attention, 'Future Sex: Beyond Gay and Straight',[1] Peter Tatchell affirms both the spectrum and also the fluidity of sexual attraction.

Regarding bisexuality he says: '*We already know, thanks to a host of sex surveys, that bisexuality is a fact of life and that even in narrow-minded, homophobic cultures, many people have a sexuality that is, to varying degrees, capable of both heterosexual and homosexual attraction.*'

Then he challenges the traditional view that gay and straight are distinct categories: '*Research by Dr Alfred Kinsey in the USA during the 1940s was the first major statistical evidence that gay and straight are not watertight, irreconcilable and mutually exclusive sexual orientations. He found that human sexuality is, in fact, a continuum of desires and behaviours, ranging from exclusive heterosexuality to exclusive homosexuality. A substantial proportion of the population shares an amalgam of same-sex and opposite-sex feelings - even if they do not act on them.*'

Tatchell, however, grossly inflates the true incidence of exclusive homosexuality. The best evidence[2,3,4] suggests that only a very small percentage of men (1-2%) and women (0.5-1.5%) experience exclusive same-sex attraction throughout their life course. But bisexuality appears to be more prevalent than exclusive homosexuality.

What is the relative ratio of bisexuality to exclusive homosexuality? For each man who is 'completely homosexual' (Kinsey score 6) there are three with varying shades of bisexuality; but for women the ratio is 1:16.[5]

Sexual attractions are therefore best understood as lying on a spectrum rather than in terms of a simple dichotomous binary categorisation, and mixed patterns of sexual desire, including attraction to both sexes at the same time, appear to be more common than exclusive same sex attraction, especially among women.

But the concept of a spectrum of sexuality–known for decades, but often ignored–also calls into question simplistic analogies between sexual orientation and race. Conflating sexual orientation and race is not really comparing like with like. It is what is called a 'category error'.

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Social care funding

Archbishop adds to pressure on government

Review by **Helen Barratt**
Speciality registrar in public health

The Archbishop of York, Dr John Sentamu, has called on the Prime Minister to address the current 'crisis' in the elderly care system. The Archbishop said it is 'widely acknowledged' that the existing funding arrangements are 'unfit for purpose' as pressure grows on the government to reform the social care system. [1]

Social care includes the support services that help frail and disabled people remain independent, active and safe. Such services are funded in a separate and more localised way than the NHS. Whilst the NHS was established as a centrally directed service, largely free at the point of use, personal social services remain the responsibility of local councils and subject to means-testing. [2]

Despite an ageing population, there has been little increase in gross spending on social care for older people in recent years. Consequently, councils are having to restrict help to smaller numbers of older people with the most intensive needs. Individuals with assets totalling more than £23,250 are liable for their full care costs: a quarter of those aged 65 today can expect to spend over £50,000 on care in their lifetime. [3]

Following the General Election in May 2010, the coalition government acknowledged the urgency of reforming the social care system to ease the cost burden many individuals face. [4]

A commission, chaired by the economist Andrew Dilnot, reported in July 2011. In his report to the government, Dilnot recommended that individuals should not have to pay more than the first £35,000 of their care costs. Additionally, individuals with assets, including their homes, totalling less than £100,000 should not have to pay for care. [5] The cost of the Dilnot proposals is estimated to be around £1.7 billion.

The Commons' Health Select Committee has recently called for the government to implement the findings of the Dilnot Commission, noting that older people are being let down by a social care system in which they are 'passed like a parcel' between services. The government has however yet to accept the recommendations, and Health Secretary, Andrew Lansley has referred to them as merely 'a basis for engagement.' [6]

However, in his open letter to the Prime Minister, Dr Sentamu described the Dilnot report as 'a call to action which our country cannot, must not ignore'. Quoting Proverbs, the Archbishop called for a new social covenant that 'assures the weak and vulnerable of proper protection,' stressing the valuable contribution that older people make to a society which increasingly considers them 'an irrelevant burden'. [1] The government has pledged to set out its approach to reform in a White Paper to be published 'in spring 2012'. [7]

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Four steps forward, five steps back

Continuing challenges in global health

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

The last year has seen some significant changes relating to global major health problems. We saw that maternal mortality in the developing world was less than had been previously reported, [1] there were improvements in child health [2] and the global community came together over strategies to invest in treatment and prevention of non-communicable diseases (NCDs) [3] and neglected tropical diseases (NTDs). [4]

But we have also seen a crisis of confidence in the Global Fund to fight TB, HIV and malaria, partly over corruption allegations (mostly untrue) [5] but largely due to the Eurozone crisis. [6] Most major donors used the allegations as an excuse to renege on funding pledges as they struggled with mounting sovereign debt crises.

During the year Bill Gates has poured more money than most governments into tackling global health issues, and the UK government has kept its status as the second largest bilateral donor to health development. However it is sobering to reflect that the annual funding to eliminate NTDs and NCDs and the three major infectious killers (TB, malaria and HIV) come to little over 1% of the money the UK alone put into bailing out the banks. And this as we languish under a national debt of £1 trillion, fuelled by self-interest and cheap credit. [7]

More recently we learnt that the global malaria situation may be far worse than we thought, [8] that cancer is a bigger killer in the developing world than AIDS [9] and the crisis in midwifery recruitment globally may set back the modest gains in reducing maternal and infant mortality of the last decade. [10]

We know *how* to tackle these health problems, and many (including our own government, to their credit) are putting in the money and resources to make this happen, but in the face of a worsening global economy, many are pulling out of funding initiatives that could save lives for a fraction of what is being spent to bailout the failing economies of Europe.

God's judgement of Sodom was simply that, 'She and her daughters were arrogant, overfed and unconcerned; they did not help the poor and needy. They were haughty and did detestable things before me. Therefore I did away with them as you have seen.' [11] Let's be careful the West does not fall into the same judgement.

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Philippa Taylor considers the complexities of presumed consent

ORGAN DONATION

Plans are well underway in Wales to introduce legislation for an 'opt-out system' (otherwise known as 'presumed consent') for organ donation. This would permit doctors to remove organs from any dead patient, unless they had specifically registered a formal objection to it.

Currently an 'opt-in' consent system operates across the UK. Individuals can authorise organ removal after death by joining the Organ Donor Register (ODR), or making their wishes known to their family. Families can also consent to donation of organs from a deceased relative, if that person has not made a known decision either way.

It is well known that there is a shortage of organs for transplant. The Welsh Government believes that a 'soft opt-out' scheme could increase rates of organ donation on death by 25%-30%. A soft opt-out scheme would authorise doctors to remove organs and tissue from any patient declared dead, unless the deceased had formally registered their objection. Families would 'be involved' in the decision-making process around donation.[1] A public consultation, seeking views on how best to implement the legislation, has taken place. The next step will be draft legislation for Welsh Assembly scrutiny.

At the same time, campaigns to introduce similar legislation in Scotland and England are gathering support. A new BMA report proposes options to increase the number of donors including a system of mandated choice, a regulated market, or paying the funeral expenses of those who sign up to the ODR and subsequently donate organs. The BMA advocates a soft opt-out system as their preferred option for the UK.[2]

So would an opt-out system increase organ donation rates? With prescient timing, new articles in *Transplantation* and the *BMJ* suggest otherwise. Research published in Transplantation found that donation rates in countries with opt-out laws do not differ dramatically from countries requiring explicit (opt-in) consent. Instead:

'*…countries with the highest rates of deceased donation have national and local initiatives, independent of PC, designed to attenuate the organ shortage*'.[3]

Another Transplantation paper notes that in the UK deceased organ donation has increased 25% in three years through implementation of measures that have transformed the infrastructure of donation,[4] not through introducing an opt-out system.

Advocates of presumed consent often cite Spain as a legislation success story. Yet a BMJ article reports that:

'*In fact, what Spain has shown is that the highest levels of organ donation can be obtained while respecting the autonomy of the individual and family, and **without** presumed consent.*'[5] (emphasis added).

Another *BMJ* article, reviewing countries with 'presumed consent' systems, concluded that various factors (such as the transplantation system, public attitudes and awareness) contribute to variation between countries and 'presumed consent alone is unlikely to explain the variation in organ donation rates between different countries'.[6]

It could nevertheless be argued that it is worth proceeding with an opt-out system in case it might make a difference, and it would increase public awareness of the need for more organ donors on death.

This is where ethics come to the fore. Organ donation is a generous gift and an example of altruism. However consent to donation should always be voluntary (un-coerced), informed and autonomous. 'Presumed consent' is a misnomer, involving neither donation nor consent from the individual. Silence does not amount to consent. When organ donation becomes 'presumed', it is no longer a voluntary gift, nor a 'donation', but an obligation. It is about taking, not giving organs. Further concerns have been expressed about the body effectively belonging to 'the State' at death, and about controversies with the definition and diagnosis of death.[7]

Introducing a system that relies on presumed authority, based solely on people registering their decision to opt out, has to ensure that *everyone* is fully informed and understanding of the situation, knows their options and can easily and simply opt-out. Otherwise it cannot be ensured that every removal of human organs is appropriately authorised. The groups least likely to express their views, if they hold views on this, will include those who are disorganised, apathetic, disabled, less well educated or informed, lacking full capacity, of different languages and race, suffering from mental illness, dependent, those who have less ready access to information and those changing their minds. Silence in many of these cases should not amount to consent to donation under an opt-out system.

The primary factors influencing donor rates are the numbers of potential donors, provision of intensive care facilities, end of life care, use of transplant coordinators, trust in the donation system and trust in the medical profession (particularly those treating dying patients). This is surely where policy, and the money that follows it, should be directed, rather than towards ethically tricky, and unnecessary, presumed consent legislation.

***Philippa Taylor** is CMF Head of Public Policy*

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Pablo Martinez on anxiety and faith in Jesus Christ

EXISTENTIAL ANXIETY:
BETWEEN FAITH AND DESPAIR

'As the deer pants for streams of water, so my soul pants for you, O God. My soul thirsts for God, for the living God' [1]

Anxiety is one of the most common medical conditions today affecting about 20% of the population. Almost half of the patients seen by a family doctor have some kind of anxiety related disorder. Many symptoms are caused by anxiety: headaches, lack of breath, dizziness, muscle pains, sexual and gynaecological dysfunctions, etc. One of the most neglected causes of anxiety is the lack of meaning and purpose in life. This is what we call existential anxiety.

Certain schools of psychotherapy, the so-called existential schools, maintain that man's central problem lies in his lack of meaning in life. Authors such as Victor Frankl [2] and Binswanger identify a person's basic problem as the absence of vital meaning with its inevitable results: desperation, the sense of cosmic disorientation, the nausea of which Sartre speaks. [3] This disturbing inner unrest goes far beyond the symptoms of clinical anxiety (panic attacks, free floating anxiety, phobias etc). What is the origin of such a deep rooted condition that is not relieved by anti-anxiety drugs nor by psychotherapy? According to existential therapists, the solution lies in finding significant and enriching relationships. The therapeutic key is to be found in encounters with others: a genuine relationship is the main healing instrument.

This viewpoint partially coincides with the biblical diagnosis of human nature. God created humans with their greatest need being the need for relationship. '*It is not good for the man to be alone. I will make a helper suitable for him.*', [4] said God. This ought not to surprise us since humans were made in the image and likeness of their creator who, from eternity, enjoys a harmonious and intimate relationship among the persons of the Trinity. This helps us understand that human beings are born with that profound need of having contact with a 'you'.

Nevertheless many people seem to have satisfactory relationships, and yet they do not have peace, that inner harmony or *shalom*. Why? These relationships need to be two-dimensional: with our fellow human beings, but also with our creator. Such was man's original situation indeed the most vital relationship is the relationship with our creator. In Genesis 1 and 2, human beings did not have emotional problems: there was no fear, no shame, no pain, because there was a perfect relationship between God and man, and that gave total fulfilment. But, as soon as man drifts away from God, this harmony is broken and conflicts arise both within himself, fear and shame occur for the first time, [5] as well as with his neighbour: '*Cain attacked his brother Abel and killed him.*' [6] Separation from God is therefore the ultimate source of anxiety because our deepest need is not being met. Jung himself, said: 'I have never seen a single case of neurosis that ultimately did not have an existential origin.'

Existential anxiety is sometimes terrible to experience. Jesus' words on the cross: '*My God, my God, why have you forsaken me?*' [7] remind us of the intense pain of this reality. How right was the Spanish mystic author St John of the Cross, when he wrote about 'the dark night of the soul without God'. [8] Being away from God is probably the most disturbing experience any human being can ever face. This is Hell – banishment from relationship with God.

Seen in this light, Christian faith becomes the antidote that reaches the deepest cause of anxiety. Ultimately the problem of anxiety requires a firm hope, a hope that is not Utopia, but based on the person and work of our Lord Jesus Christ. It is a hope that provides certainty and meaning to our existence - both present and future - because it does not arise primarily from subjective feelings, 'a religious experience,' but from objective facts. Whenever the apostle Paul refers to God´s promises and to future life, he uses the verb '*we know*'; he does not say we imagine or we feel. [9] A solid hope, described as '*an anchor for the soul…firm and secure*' [10] is a soothing balm to our deep restlessness and anxiety.

The Christian faith also relieves existential anxiety through the therapeutic tools of prayer and Bible meditation. Inasmuch as they provide us with personal contact with God, they return us to the first relationship (with the obvious limitations imposed upon us by our fallen nature) and enable us to rediscover the true purpose of life: relationship with God. As they restore free and constant dialogue with our creator, prayer and meditation allow us to meet our deepest longing, our thirst for God. They contain the most therapeutic element to relieve existential anxiety for which there is no substitute.

As a practising psychiatrist I am convinced that the Christian message provides the supreme antidote against existential anxiety because Christ alone, the image of the invisible God, is the only one fully able to fill that 'God shaped void that only God can fill.' [11]

***Pablo Martinez** is a psychiatrist, author and Bible teacher*

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Rob Waller shares his experiences of working with Christians struggling with mental health issues

MIND & SOUL

key points

As a trainee psychiatrist the author became increasingly frustrated with the failure of the Church to deal sensitively with issues of mental health and began to blog about his learning and questions.

Through networking with others, stories of stigma towards mental-health problems within Christian circles began to emerge showing that many Christians were suffering in silence, unsure if psychological solutions were appropriate. This was highlighted further when a close friend experienced post-traumatic depression and found himself completely unprepared for the experience.

Through the Mind & Soul initiative much good has been done to bring mental health issues onto the agenda for churches and to encourage mental health friendly churches. In conclusion the mental health benefits of Christianity are affirmed.

The division between sacred and secular is felt keenly in our understanding of the mind and the soul. Until a few hundred years ago mental illness was in the domain of the Church, then Carl Gustav Jung proclaimed that 'psychiatrists were the new priests'.[1] However this is not a role that many of my colleagues desire, and the Church is still heavily involved in the care of souls.[2]

Over the last five years, I have been exploring this division as both a Christian and a psychiatrist; I don't think one comes first, as both have different values. Networks have been invaluable, made up of professionals, pastors, people with their own illness and those who are just interested.

Torn in two

As a higher trainee in psychiatry, increasingly I was finding my Sunday and Monday did not join up: the two worlds were separated as if the other did not exist. Clearly, this could not continue and (as it was the '90s) I started a blog to share my learning and questions. More people than I expected read it and many who were struggling with mental health issues came out of the woodwork in Leeds where I was living.

At the same time an old university friend, Will Van Der Hart, had trained for the Anglican ministry and was a curate in Marylebone; the London bombings of 2005 impacted him greatly:

> 'I heard a noise like a bomb... I donned my largely unworn dog collar and proceeded under the cordon, as if this outfit of black and white were some sort of superhero licence to action that would protect me from danger... "Would your officers like to base themselves in our hall, use the loo and have some refreshments?"... I had little comprehension of how powerfully I would be affected by this encounter... Looking back, I'm not surprised by my panic attacks, although I was surprised at the time. I was refusing to give credence to my feelings...[3]

Will found that his journey into depression and taking antidepressants was not something that his training had prepared him for. The Church was focused on reaching the 'lost' and this was not meant to happen to the 'found' – instead the 'found' were supposed to be prayed for, keep calm and carry on!

Both of us had started informal groups which we later found were forming across the country – a coming together of professionals, pastors and others who wanted to understand how their faith and mental health related; who were not content with the standard answers of either the sacred or the secular camp; people who wanted to have the best of psychology as well as the full expression of faith.

Stories of stigma also emerged. We have all read of the challenges of faith in the NHS but, to its credit, the NHS knows this is an issue and has

a commitment (on paper at least) to change. However, this also seems to be a huge issue in the Church: people who take antidepressants in silence, people with schizophrenia who are patronised and seen as scary, people who are painfully thin yet no-one seems to care enough to ask…

> 'As a very keen Christian, I felt very guilty about being depressed as it appeared to me as a great spiritual failure... I went to see my minister, told him that I was being treated for depression. I had become quite distant from things... so I hoped he might be able to help me get more involved again. Instead of this, he told me that I must have no contact with anyone else in the church in case they caught the depression from me... We must not consider people to be 'backsliders' if they can't regularly attend services. They may be uneasy being in large groups, which always made me feel very lonely and vulnerable.' [4]

Building a bridge

As we began to write about this area, many people expressed an interest, including Premier Christian Radio, which asked us to help their phone-in and email service. [5] They were getting many requests for help with mental health problems and they wanted a resource to recommend. The result was a website (see box) where information was available freely and comments and 'service-user' perspectives were encouraged.

People have engaged with amazing honesty and a willingness to encourage others. We have also run a handful of major conferences, working alongside organisations like the Association of Christian Counsellors, the British Association of Christians in Psychology and, of course, CMF. Amazingly, 500-1000 people have come to each of these. We have been very blessed to partner with some of the better-known churches in the UK, and celebrate the fact that those who shape much of current Christian thinking are also willing to host an event about mental health. It is such an encouragement to those who attend.

We involve the local NHS bodies where we can and have included some multi-faith seminars that were of great interest. One aim is not only to put the issue of mental health firmly on the Christian map, but to interest secular care providers too. Being fully compliant with NHS policies on spirituality, yet remaining distinctively Christian, is quite a challenge, but one I believe is achievable with grace and mutually respectful relationships.

The last few months have seen a move into print media, starting with *The Worry Book*, reviewed in this issue of *Triple Helix* (see p21). We have also tried to move beyond the 'old chestnuts' (such as whether demons cause schizophrenia, whether Jeremiah was depressed, whether the mind is part of the body or the soul – the website covers all of these) and instead project a strong message of 'both and' when it comes to faith and mental health.

We have encouraged churches to go beyond a vague awareness of mental health issues to being genuinely 'mental health friendly', in the same way that putting in an access ramp does not mean you are inclusive to those in wheelchairs. This is about encouraging belonging, having a variety of environments, being locally informed and seeing all as on a journey. [6]

We believe it is possible to be full of faith, struggling with illness, finding joy in the Lord, taking time out and serving out of suffering all at the same time! Of course, this applies to the professionals as well – not just those we call patients…

Fully linked together?

Many people ask whether Christianity is good for your mental health, and I typically reply that there are thousands of scientific papers that suggest this is the case. This link has been reviewed for health in general in a recent *CMF File*, [7] and also more specifically for mental health by Harold Koenig. [8]

A more subtle reply is to ask people to think in three levels, and this works well with secular colleagues for all these have scientific proof. Behaviourally, there is a benefit to getting out of the house to church once a week. Cognitively, there are Christian beliefs that increase self-esteem (though there can also be excessive guilt). Existentially, there is a benefit to an externalizing faith where we are not alone and not powerless to influence change. [9]

But behaviours, beliefs and a general spirituality are not the same as Christianity and I pray that we can be both compassionate citizens and also distinctive disciples. As people are more open about their mental health (both in society and in church) there is a huge opportunity for Christians to shine hope where none can be seen and offer helpful answers to questions people are asking every day. The Good News can be shared naturally, relevantly and powerfully.

Rob Waller *is a consultant psychiatrist working for the NHS in Scotland and a Director of Mind and Soul*
www.mindandsoul.info

Premier Mind and Soul

This is a growing website containing hundreds of articles from experts, a growing set of book reviews, a podcast, forums and a directory of helpful organisations around the UK and online. It also contains lots of audio from events we have run, all freely available to download.
www.mindandsoul.info

I pray that we can be both compassionate citizens and also distinctive disciples

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Mark Pickering suggests ways to strengthen CMF's local and regional support networks

BUILDING CMF NETWORKS

key points

Local networks are essential. Although membership of the local church is vital, doctors often need to talk and pray with others who understand the challenges of medicine.

Building closer links is not easy. Doctors are busy with family, church and work responsibilities. Churches don't always understand why medics need the support of Christian peers. Often it is difficult to identify fellow Christians in the workplace.

Networks build on relationships. Prayer triplets and topical meetings can help if there is also space to develop friendships. Events which include students, graduates, other healthcare professionals and Christian medics who are not CMF members can be mutually beneficial.

The Christian Medical Fellowship's goal is to unite and equip Christian doctors. Much can be done through conferences, literature and public policy work, but there is a real need to strengthen and support the grassroots networks and relationships between ordinary Christian doctors at a local and regional level. If we are able to do this better, then the resources and events provided by CMF staff and the national office will be more effective.

In the last 18 months I've led three seminars at CMF conferences on the subject of building local and regional support networks amongst Christian doctors. In preparing and leading these I've spoken to regional secretaries, those leading local groups and others who are keen to see networks develop in their local areas. All these conversations could be summarised in two short phrases:

1. It's really important
2. It's jolly hard

Why is it important?

CMF produces great literature and runs excellent conferences, as well as standing up for Christian values in the media and with government. But the individual Christian doctor can still feel isolated, struggling to work out the crucial 'What Would Jesus Do?' question in their daily life and work.

I find CMF conferences incredibly stimulating and encouraging, but the challenge of applying Christian principles to Monday morning is still difficult. We are much more likely to be equipped and effective if we have a local network of Christian colleagues with whom we can pray and discuss how to be salt and light in our daily practice. Whilst our local church is vital, we also need some around us who understand the nuances and challenges of medicine.

Why is it hard?

In preparation for the seminars above I emailed all the CMF regional secretaries and asked them about the challenges they are facing in developing functioning local support networks. Four themes emerged repeatedly:

i) ***Busyness*** – Christian medics are busy! Work, family, church and other outside interests can mean that any discussion of 'getting involved with another organisation' can quickly lead to the furrowed brow and hasty retreat. Unless we are offering something that is seen as 'really relevant,' efforts to build CMF locally are unlikely to draw many people in.

ii) ***Church commitments*** – Many Christian medics are already committed to worthy responsibilities in their local churches. It can be difficult for non-medics to see that Christian medics have needs that are not well catered for by churches, and that these need working out in partnership with others who understand them.

iii) ***Geography*** – Being spread out over a rural region, or across a city, can produce an extra challenge in getting people together for meaningful contact.

iv) ***Lack of network*** – Often we simply don't know who the other Christian medics are in our area. I am often surprised to discover keen Christian

medics in unexpected places. Whilst frustrating at one level, it is a constant reminder to be on the lookout, to be praying for contacts, and to be flying the 'faith flags' that make it easy for others to identify us as a Christian at work.

What sort of things tend to work?

- ***Relationships are key***. Social events that give Christian medics opportunities to get to know each other better will develop friendships that spin off in other ways.
- ***Prayer is valued***. We all have things that need praying for, and many will be willing to pray for others. Some can be encouraged to meet in twos and threes for prayer. I have been greatly encouraged by meeting periodically to pray with two other young Christian GPs, and separately with a local psychiatrist. It's been a great chance to share struggles in life and at work, to pray for God's will in our priorities and career decisions, and wisdom in our witness to staff and patients.
- ***Meetings*** on relevant topics can be very helpful. CMF is able to provide ready-made roadshows such as Saline Solution or Who Is My Neighbour? Promoting social interaction at these events is very important.

It's important to tailor things to your local area, to scratch where people itch, and this may mean taking some time to build individual relationships to find out what people would want to commit to.

Using students

Christian doctors and medical students need each other! Students need the wisdom and experience of both junior and senior doctors to help them work out what being salt and light in their careers looks like in practice. Equally, contact with the freshness and enthusiasm of students can restore life to many a tired and disillusioned doctor.

Relevant events can be opened to both students and graduates to encourage the synergy. At a recent family Open House for local doctors and students, a number of local graduates who had had little contact with CMF commented on how much they had enjoyed chatting with the students. Conversely, one very useful way of bringing local doctors into the local CMF network is to ask them to speak at a student meeting on a topic they know well.

Partnership with the student reps and CMF medical school secretary at your local medical school is a great way of helping each other. In our local Hull York Medical School the CMF student team have developed an excellent network of monthly Open House meetings in the homes of local doctors for students on each of the five clinical placement sites (search for 'CMF HYMS' on Facebook to see what they get up to). These have been incredibly valuable in supporting the students. It's good to remember that, in order to encourage our local students, we don't need to be perfect - just available and willing to share some of the lessons we're learning as we walk the same road, just a little further ahead of them.

Non-doctor health carers

One perennial question asked by leaders of local CMF groups is, 'should we allow/invite other Christian healthcare workers?' My answer would always be yes. Even if the main focus is on doctors, other disciplines face many of the same issues as us and also need encouragement and support. The staff prayer meeting at our local hospital would never function without the commitment of a core group of administrators and nurses; we should promote partnership wherever possible. It can be a powerful demonstration of God's kingdom in action to break down some of the hierarchy and have supportive friendships between multidisciplinary team members.

CMF membership

Another thorny issue is why more Christian doctors don't join CMF. There are many keen Christian doctors who are involved in their churches and keen to use their careers for God's kingdom, but they haven't seen a reason to join CMF. There may be myths we can dispel of what CMF is or isn't about. There may be fears about what 'getting involved' might mean in terms of time commitment. CMF is a mixture of 'membership' where my involvement produces benefits to me, and 'mission', where my involvement and giving produces benefits for others. Communicating this dual purpose may sometimes help.

Certainly if we have more local support available, then the 'what does CMF do for me?' question is easier to answer. But there will always be those who don't want to join, so it is important to keep activities open to them, and to have a means of communicating with them, eg keeping an email list of local non-members to inform them of events.

What can I do?

A great question for us all to ask is, 'what do the combination of my gifts, opportunities and life circumstances particularly fit me to be doing?' The answer will be different for each of us, but I would love to see more CMF members giving time to building their local CMF support networks. After all, there are often others who can get involved in much of what is needed in the local church, but supporting Christian medics is more specialised and we are often best placed to do this.

Traditionally CMF has used a system of regional secretaries, but the regions can often be quite large and there is certainly a need for people to concentrate more on their local area, such as one town or city. If you feel God might be prompting you to give some time to this, get in touch with your existing regional secretary or graduate staffworker if there is one (visit the 'contacts in your area' pages on the doctors, juniors or students pages at *www.cmf.org.uk*. If not, then contact Pablo Fernandez, Head of Graduate Ministries, to chat about what you might be able to offer.

Mark Pickering *is CMF North Yorkshire regional secretary*

'I believe that as Christians who are doctors, it is important for us to unite with one another, sharing fellowship, education and serving God together, be that in the UK or elsewhere in the world. CMF helps me to do this through fellowship with a network of Christian doctors both locally and nationally, through petitioning and highlighting the Christian viewpoint on topical medical ethical and legal issues, and through its many invaluable educational resources and publications.'

Victoria Parsonson,
a missionary doctor working in Madagascar

'CMF is invaluable in helping groups of junior doctors meet together to support each other in our faith and then put it into practice.'

Clare Mason,
GP Trainee, Leicester

Closer online connections

During 2012 CMF is developing the website to provide better links between members. When the changes are complete, a secure, personal log-in will give access to personalised pages and online links with other members in your locality, specialty, workplace, church or medical school.

Becky Macfarlane on the plight of failed asylum seekers

DESTITUTION

A STATE OF UTTER POVERTY

key points

The author explains that destitution among failed asylum seekers in the UK is a growing problem due to widely-criticised legislation designed to discourage asylum seekers from coming to the UK and to bring down the volume of asylum claims.

The reality for those who are refused asylum is bleak: many already-traumatised people go on to suffer hunger, despair and exploitation while their immigration status and homelessness disadvantage them in accessing healthcare.

The author concludes that the destitute matter to God and provide an opportunity for Christian healthcare professionals to get involved; one such is CMF Member Gillian Webster who reports on her volunteer work with Project:London.

'I was a stranger and you invited me in; whatever you did for one of the least of these brothers of mine, you did for me.'[1] These words of Jesus Christ which closed a previous article on 'Caring for Refugees' in *Triple Helix* nearly ten years ago[2] pose an increasing challenge to us as Christians in the UK. Over the past eight years, nearly two-thirds of asylum applicants in our country have been left destitute.

Within a few months in late 2009 and early 2010, three of my patients told me that their asylum claim had been refused, they had no right to work, no money for food and in two cases had been required to leave their accommodation. A local charity had been able to give them only short-term support and they had nowhere to turn for help. I could not avoid the implications of Luke 10:33 '*But a Samaritan, as he travelled, came where the man was; and when he saw him, he took pity on him,*' and Jesus' command, '*Go and do likewise*'.

Destitution by design?

Destitution among refused asylum seekers is a direct outcome of government policy, in particular the removal in October 2002 of the category Exceptional Leave to Remain (ELR).This was previously granted for up to four years to those denied full refugee status, but for whom it was considered too dangerous to return to their country of origin. In 2002, 24% of cases were granted ELR. In spring 2003, it was replaced with Humanitarian Protection and Discretionary Leave. In each of the following six years only 1-2% of adult applicants were granted one of these two decisions. 'The Government's declared intention with the withdrawal of ELR was not only to reduce the overall number of asylum claims, well-founded as well as unfounded, but actually to reduce the proportion of successful claims. The UK's criteria for protection had narrowed, effectively barring people from protection who would previously have been granted it. All available evidence, including from the Home Office itself, indicates that these policies have not had the intended effect (of deterring asylum seekers from coming to the UK and forcing refused asylum seekers to return home).'[3]

No way back

In 2008,[4] 77% of those left destitute following the refusal of their asylum application came from ten countries, all of which have a record of violence and human rights abuses: Iraq, Iran, Zimbabwe, Eritrea, China, Sudan, Democratic Republic of Congo, Afghanistan, Somalia and Sri Lanka.

Many who have examined the asylum process in the UK have expressed grave concern about the quality of decisions.[5] Of the around two-thirds who are refused protection, a few leave voluntarily, others are forcibly removed or detained, but the majority are left destitute. They have no right to work. Support is ceased within 21 days and they must leave their accommodation. They have no recourse to public funds so cannot access statutory homeless services. They have reduced rights to healthcare.[6] Some with children, who are recognised as unable to return to their country, are given a minimal amount

of support for the children and are housed, and adults who state their willingness to return home are also given very limited temporary support.

Some of these cannot go home as their government will not allow them or they are stateless; others are too fearful for their lives. They would rather die here than be sent back to torture or death.

In 2009, the London School of Economics estimated that there were 500,000 refused asylum seekers in the UK. Research in 2008 found that one third of those who sought help had been living in destitution for more than two years.[7] They face despair. A member of the British Red Cross team in Glasgow stated 'We see very vulnerable people living homeless for months, relying on friends/volunteers who can only offer a floor or sofa for a week or two at a time. Women are particularly vulnerable to being exploited by people offering accommodation.'[8]

Vulnerability

One Congolese young woman narrowly avoided sexual assault by a stranger after she accepted a place to sleep on the floor of his flat when she had nowhere to go. She has since been staying, for over a year, with a female volunteer host and is recovering her mental health; previously she was suicidal. Two other undocumented migrant women were not so fortunate. Each of them was taken advantage of by men who offered 'support' when they and in each case their child were completely destitute. Unwanted pregnancy and termination was the result. One of my most vulnerable patients was tortured in Sri Lanka and suffers severe post-traumatic stress disorder. He is now penniless and could be made homeless at any time.

A Christian perspective

The situation of the destitute is of concern to God, who loves them, showing no favouritism but seeking justice. '*The LORD watches over the foreigner and sustains the fatherless and the widow*'.[9] '*He will respond to the prayer of the destitute; he will not despise their plea*'.[10] Jesus identifies with them and so must his people.[1] Christians and churches are recognised as taking the lead throughout the UK in responding to this need.[11] Several have believed in Christ through the love of his people. Those who are Christians have found fellowship and renewed hope. There are opportunities to accommodate and befriend, to assist in learning English, to provide food and to give emotional and spiritual support.[12]

__Becky Macfarlane__ is a GP in Glasgow in a practice with many asylum seekers. She is involved in co-ordinating the Glasgow Destitution Network
www.destitutionaction.org.uk

Project:London – Working with the destitute

It is a cold January afternoon with pavements slippery after recent snow. Once inside the basement of the church building where the clinic runs, I am grateful for the warmth of a fan heater. The first person I see has been interviewed by a support worker. I look through her records. She is 32 and from Eritrea, a failed asylum seeker, homeless and destitute. I note she does not speak English. I will need to use Language Line; never satisfactory, but there is no other option.

I greet her and invite her into the consulting room. She looks withdrawn and fearful. I confirm that she speaks Tigrinya. I phone Language Line and soon our three way conversation begins. She tells me she has headache, back and leg pain, is anxious and cannot sleep. I enquire more. Slowly her story unfolds. She belongs to the Pentecostal Church which is persecuted by the Eritrean government. The home where her church met was raided by police. She was detained for 24 hours, beaten and told to sign a paper to renounce her faith. This she did to procure her release. A warning was given that indefinite imprisonment would follow if caught again. Her husband was not released. Despite this threat, she continued to practise her faith. Next time the police came, she managed to escape. She had no option other than to flee her country. After a lengthy journey through Sudan and Europe she came to London where she claimed asylum. This was refused and an appeal dismissed. A fresh claim was made which was also turned down. All government support ceased[13] and she was told to leave her accommodation. She is surviving on food and help from homeless projects, the Eritrean Church and friends in the Eritrean community. Sometimes she has to sleep on the streets.

I examine her and note scarring on the lower back and legs. She confirms these scars are from wounds she received when beaten. I diagnose depression and post traumatic stress disorder. I refer her to a GP practice for the homeless and to the Helen Bamber Foundation for counselling and assistance in making a fresh claim for asylum. I give her a free prescription for analgesia.

All this will take time; 1 John 3:17 springs to mind: '*If anyone has material possessions and sees his brother in need but has no pity on him, how can the love of God be in him?*'

Should I offer her room in my home? But what about the other vulnerable people I am yet to see? She was forced to flee her family and country because of the faith we both share. What am I prepared to share with her? I feel challenged and disquieted but I have to move on. There are many waiting to see me.

__Gillian Webster__ is a retired GP volunteering with Project:London

__Project:London__ is a health advocacy programme that provides information, advice and practical assistance in accessing mainstream national health services for vulnerable people such as asylum seekers, refugees, economic migrants, sex workers and the homeless. For more information see www.doctorsoftheworld.org.uk

Photos: © Project:London

If anyone has material possessions and sees his brother in need but has no pity on him, how can the love of God be in him?

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Richard Brueton reflects on his journey to faith and subsequent overseas work in Malawi

FROM MUSWELL HILL TO MALAWI

key points

A Christian upbringing including education at a cathedral school led the author to question the meaning of life but the answer proved elusive. Years later through studying the Gospels and with the persistent encouragement of clergy at St James, Muswell Hill, the penny dropped.

A new desire was kindled for overseas work and, following theological training at a Bible college, an orthopaedic post was taken in Malawi which provided a variety of challenges and caused faith to grow.

When a job in Ethiopia unexpectedly fell through causing a two-month break in London to become a permanent return, God's hand was clearly seen in the remarkable provision of a teaching post at the Royal Free. Now in retirement from the NHS the author gives thanks for God's leading.

I drove northwards out of Blantyre in the bright early morning sun, passing the stream of human traffic, barefoot in the dust, flowing towards me. Sitting beside me in the front of the Land Rover, the orthopaedic clinical officer had nodded off following our early morning start to a district clinic in Dedza, Central Malawi. I reflected that two years ago, to this very day, I was sitting in a fracture clinic at St Thomas' Hospital and I could never have thought how my world would have changed.

My problem was that I had never understood what life was all about. Interested in human behaviour, I left school to begin a psychology degree but rapidly changed to medicine, in an effort to find a more scientific base from which to begin. I soon dismissed psychiatry as too vague and neurology as a therapeutic desert. Perhaps it was emerging from a car smash while a medical student, having left the M1 at speed, still alive, with just a compound fracture of the tibia and fibula, that concentrated the mind. Ten weeks in hospital certainly gave me time to think.

Eventually I decided that, if I could not fathom out the meaning of life myself, patching up other people would at least enable them to continue along life's rich pathway, giving them a chance to work it all out for themselves, where I had spectacularly failed. It was this flawed philosophy that gave me the motivation to get up in the morning for the next 25 years as an orthopaedic surgeon.

Many years later, for some reason, a crunch came and I felt the need to think again and re-assess. I had been brought up in a good Christian home and had spent many hours of utter boredom in church. I then went to a local grammar school, Bristol Cathedral School, and spent many more hours immersed in the incomprehensible, though soothing, liturgy. My overwhelming recollection of the cathedral and the liturgy was one of peace and tranquillity.

Perhaps it was this memory that led me into St James, Muswell Hill some 40 years later. I slipped in and sat anonymously at the back, or so I thought. I needed somewhere to sit and think and be alone. The only problem was that on my solitary visits, the vicar, Alex Ross, seemed to want to talk to me, though he was very discrete. I avoided him for weeks, but began to read the Gospels in my own time, with commentaries. Eventually, I relented and he lent me one book, then another that led to another.

As I was leaving the church one evening, I said to the associate vicar, Philip Sudell that I knew I was just not good enough to be a Christian. 'That is the

whole point', he said. 'None of us are and it doesn't matter.' The penny very slowly began to drop but it took a terribly long time and a lot of spadework by the vicar. For months, I used to stop off at the vicarage at 6.30am on a Tuesday morning for half an hour on the way to work, while Alex painstakingly led me through the Gospels. One day I knew that I could no longer walk away from this and took communion.

I now felt that I ought to work abroad and went to the offices of Interserve, just along the road from St Thomas'. They advised me to spend a year at a Bible college first. So I left the NHS and went to Oak Hill College in North London. It had taken me so long to become a Christian that I wanted catch up and learn as much as I could.

An opportunity then appeared to work in Malawi at a newly built orthopaedic children's hospital in Blantyre. During the previous year I had also become married, so Valerie and I packed up home in Muswell Hill and headed off for sub-Saharan Africa where we were to work for the next two and a quarter years.

The children in Malawi presented predominantly with club feet, angular limb deformities, osteomyelitis, burns contractures, untreated trauma and a variety of conditions the like of which I had not previously encountered. Many were anaemic from malnourishment and sub-clinical malaria that we treated to make them fit for surgery. I learned a variety of new skills, including patience.

We became used to the lack of infrastructure and the frequent cuts in power, water and telephone. I became used to an environment where there was a lack of accountability and responsibility; where daily living was a matter of risk reduction. I soon appreciated the two elements that we take for granted in England, but without which you will not be able to go to work. Your home must be secure, or you will not leave your family to go to the hospital, and you must have transport or you will not be able to get there. Simple but essential.

It was hard, but I knew that this was the place where we were meant to be. We stumbled but never fell. We learned to trust in God's provision and put our faith in him totally.

If the Lord delights in a man's way, he makes his steps firm; though he stumble, he will not fall, for the Lord upholds him with his hand.

Psalm 37:23

While in Malawi, we knew that a wise friend back at St James was praying for us every day. He said that we would be truly blessed when we returned and he was right. I am afraid to admit that I could never have imagined the extent of the blessing that we would receive.

Driving home to Muswell Hill from the Royal Free Hospital in North London, under a grey and overcast sky, after a busy trauma list and clinic, it was now five years since we had come back from sub-Saharan Africa. I never thought that I would be back in the NHS as an orthopaedic consultant, particularly not in the hospital where I had trained, many years ago.

So I had moved from a world with a life expectancy of 45 years back to one of fragility fractures in the elderly; from anaemic children walking on the outside of their club feet to in-toeing and worried mothers; from malunions after falls from mango trees to acute fractures in the playground. All equally deserving.

We had intended to go from Malawi to Ethiopia to a similar orthopaedic children's hospital which was to be built in Addis Ababa. We returned to London, en route from Blantyre, for a two month break at home. However, the Addis job just did not happen. Finding ourselves back in London, with a mortgage to pay, I needed a job and the Royal Free Hospital took me on. Colleagues told me that you cannot just leave one London teaching hospital job, go to Africa, come back and expect to get a job in another one, particularly at the age of 59, but my friend at St James was right.

I have just 'retired' again and have left the NHS once more. I now teach anatomy to medical students at UCL and to those preparing for the MRCS at the Royal College of Surgeons. Last summer, I spent three weeks in Kenya at the Africa Inland Church hospital in Kijabe, helping with orthopaedic trauma. A friend suggested that I should do 'Kingdom Work' in my retirement, and I am still searching for a role.

From St Thomas' to Oak Hill, to Malawi, back to the Royal Free and now teaching Anatomy at the Royal College of Surgeons. I have been on a journey the like of which I could never have imagined when I walked into St James Church one day to sit, think and be alone.

Trust in the Lord with all your heart and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight.

Proverbs 3:5

Richard Brueton *is a honorary consultant orthopaedic surgeon at the Royal Free Hospital, London*

It was hard, but I knew that this was the place where we were meant to be

Perspectives

One of the joys of my job as CMF Head of International Ministries is that I meet people who are working all over the world. It's a privilege to hear about their different challenges and learn from their different perspectives.

The tip of the iceberg

At last year's Developing Health Course I met Jachin Danielraj, an Indian doctor now based at the famous Christian Medical College in Vellore. However, she hasn't always been in this big centre. She spent 13 years in a rural mission hospital, working hard to serve the poor, but then saw a child who changed her perspective. She told me the story:

'We admitted a child with post-streptococcal glomerulonephritis – a common complication of scabies. He did very well and I discharged him after two weeks, feeling very pleased with myself. But as I chatted to his family about the village they were returning to, I heard that their son was just one of six children with the same condition. Two died soon after developing oedema. The remaining four went to the traditional healer in the village, who chanted mantras, sacrificed chickens and applied herbs – and two further children died. The remaining two went to see a quack doctor who gave IV fluids and several different drugs – and another one died. The child in front of me was the one who had survived these ordeals, and thankfully was now better. But what about the other five who I hadn't even seen?

'I realised that the patients I was seeing are just a tiny fraction of all the people needing medical help. I stopped to look up from my hectic clinical work – was this really the best way to help? My husband and I sat up late into the night, struggling with this new perspective. There are very few health workers in the rural areas, but there are many churches, and they send evangelists into the villages with the gospel. Why couldn't they take basic health care as well? It's not difficult to treat scabies – if those six children had been treated in the village, none of them need ever have got glomerulonephritis. And so it was that I moved to Vellore and started a training programme for village evangelists. We have now trained 800 – imagine how many people they can reach.'

Globally 1.3 billion people have no access to basic healthcare – that's one fifth of the world's population! In Ethiopia, 75% of the population live two days' walk from the nearest road, which may then be many miles away from a functioning healthcare facility. It's not surprising that most of these people will never see a health professional in their whole life. Working in clinics and hospitals, it's so easy to forget that we are only seeing the tip of the iceberg.

Not as simple as meets the eye

Mary Cusack and Catherine Morris are paediatricians working with vulnerable children in Orissa, one of the poorest parts of India. They told me about some of the struggles that have opened their eyes to the realities of life for these forgotten children who have no one to speak for them.

'Ramesh is a boy who presented with swollen glands in his neck. A biopsy confirmed TB lymphadenitis – both common and curable. India has a World Bank-supported nationwide TB control programme providing free treatment, but we didn't realise how difficult it might be to treat just one child in the area where we live.

Ramesh lives in a "low intensity conflict" area, where there is rebel activity. The government healthcare system barely functions, as healthcare professionals are unwilling to work there. So we ordered Ramesh's medicines from the health centre nearest to him, but it took two weeks for a government doctor to come to the clinic to approve the order. The drugs then took another couple of weeks to arrive and when they did, they were the wrong dose and out of date. So we sent them back and asked for the right ones, but then learned that there were no paediatric TB drugs to be found in our whole district or the neighbouring one. It seems that there is so little active medical care in the area that no diagnoses are made and no children have the chance to receive the therapy before it goes out of date! So we waited once again for some in-date adult drugs to arrive and spent an afternoon splitting six months' worth of different medicines into individual doses that Ramesh could take, and packaging them into little envelopes. At last he started treatment…six weeks after the diagnosis was made. What should have been a simple process was not at all simple – that's the reality of life in a place like Orissa.'

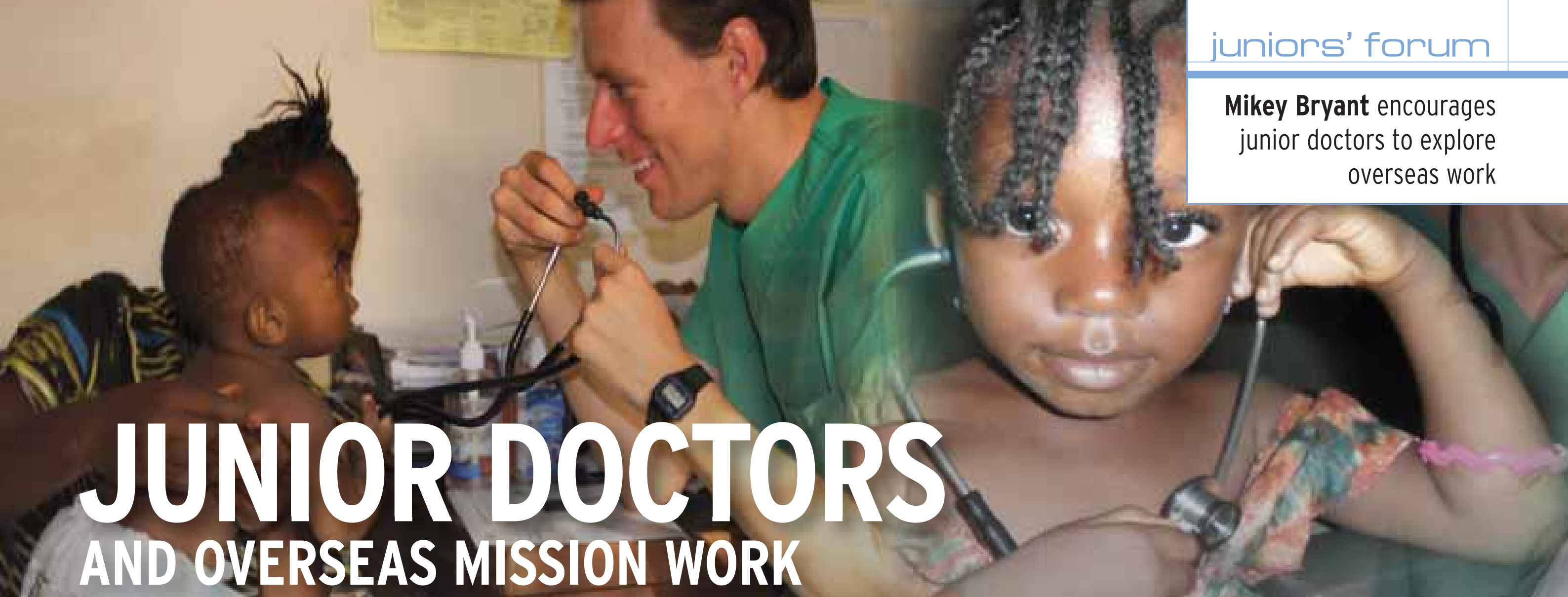
We can't do everything, but we mustn't do nothing

What are we to do in the face of such challenges? Jachin has come up with a creative way of reaching thousands of people who would never make it to a hospital. Mary and Catherine fought for Ramesh, living in a place with complex, chronic troubles. We will never solve all the problems, but these three doctors are doing all they can where they are.

'We can do no great things; only small things with great love.'
Mother Teresa

Vicky Lavy *is CMF Head of International Ministries*

Mikey Bryant encourages junior doctors to explore overseas work



JUNIOR DOCTORS
AND OVERSEAS MISSION WORK

I spent a year working in a clinic for children with Mercy Ships in Sierra Leone after completing foundation training in Wales. This article explores some of the issues facing junior doctors who want to work abroad, and shows that it is perfectly possible.

Many people worry that taking time abroad will be bad for their career in the current uncertain climate and with MMC encouraging a more rigid approach to medical careers. However, taking time out to work in the developing world is increasingly viewed in a positive light. A recent article in *Clinical Medicine*[1] highlighted the benefits brought to the NHS by junior doctors who have worked overseas, and grown in resourcefulness and clinical skill.

Time out after foundation years

There are natural breaks in the career ladder; the first is after foundation year two (FY2). A year, or even two, spent abroad will give valuable experience; three years would be the maximum. After this the skills learned in the foundation years are deemed invalid by most recruiting specialties. Taking the break while younger has advantages as there are often less contractual or family ties, but it is important for doctors at this stage to find a role consistent with their level of training and with some supervision initially. For example, an FY2 would work very well in a supervised primary care setting, but would be out of their depth running an intensive care unit single-handedly! It is important to be honest about our level of experience; if we work in the place of someone more senior, we not only risk doing harm to patients, but also deprive the organisation of the benefits of a more experienced doctor. The GMC gives clear guidance on this matter.[2]

With that caveat, there is plenty that junior doctors can contribute. A recent article in *The Lancet*[3] highlighted that only 13 countries will achieve the fourth Millennium Development Goal of reducing child mortality, and noted the most common causes of death are pneumonia and diarrhoea, easily treated by junior doctors. In Sierra Leone I saw many very sick children, which was intimidating at first, but the interventions available to us were usually very simple and effective.

Let's remember that many FY2s spend a year out in Australia or New Zealand and rarely have difficulty getting back into the system, so it is not unreasonable for FY2s to spend time working in the developing world. Christians are called to love mercy[4] and to value those who are poorest and in most need[5] so we should be looking for opportunities to use our skills to do this, as well as to train in developed-world medicine.

Time out during training

A second natural break is following core training, when the trainee will have some more experience to offer. It is not usually possible to secure a specialty training (ST) post and then defer the starting date, so you will have to step out without a job to come back to. However, it is increasingly possible to apply for jobs online and fly home for interviews if necessary. Out of programme experience (OOPE) is a great opportunity for trainees to go abroad during their ST years, with the security of a job to return to. 'Taking Time Out'[6] told the story of two doctors who had done this. The application process can be arduous but not impossible, and guidance is available in the BMA's handbook, *Broadening your horizons.*[7] Trainees are expected to have done at least a year of specialist training before doing OOPE and the maximum time granted is three years.

Junior doctors who go abroad should consider whether they have a calling to long-term overseas work following completion of specialty training. Experiences in supervised posts in the developing world are an invaluable preparation.

Church support

Being abroad is a considerable challenge and requires prayer support, so it is essential to maintain a link to a church in the UK. It took a great deal of time to find a church in Sierra Leone where I felt able to share the struggles and joys of the work in our hospital, and I found home church support was vital.

As Christians we have a responsibility to make the gospel known through our personal witness to Christ. A sensitive approach, bringing Jesus' love without coercing vulnerable people, is needed.[7] On numerous occasions, we were able to share something of God's character by simply offering to pray with patients as well as giving medicine; an approach which immediately moves the attention away from the doctor and onto Jesus as healer. Juniors going out with faith-based organisations should be as prepared to share their faith as they are to treat malaria![8]

Mikey Bryant is currently a voluntary physician with Mercy Ships in Sierra Leone and will be starting CT1 later this year

Developing Health Course, 24 June – 6 July 2012

CMF's Developing Health Course offers excellent training for time overseas. Come for a day, a week or a fortnight - see details on the website at *cmf.li/wikKjD*

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Jennifer Bute recounts her experiences as a GP with early-onset Alzheimer's

DEMENTIA
A GLORIOUS OPPORTUNITY

key points

After a brief family history, the author describes how the first symptoms of early-onset Alzheimer's went undiagnosed and instead spurred her to find coping strategies for her developing cognitive problems.

After a number of decisive events the decision was taken to retire on safety grounds and plans to work overseas in retirement also had to be abandoned. But instead of prompting resentful antipathy towards God, the illness was accepted as a God-given opportunity.

Accepting dementia as God's gift led the author to help people understand what sufferers are going through. Resources have been developed to help GPs, church workers, family members and friends learn about the condition and treat sufferers with respect.

When I was asked to write about how my dementia affected my relationship with the Lord, my first reaction was to say it was the other way round!

I had a wonderful, godly father who brought me up to question everything and think outside the box. My mother died (from a coronary) when I was four and my father did a brilliant job bringing up four girls for the next ten years, until he married again. He taught me so much by the way he dealt with life's adverse events. Often I thought his suffering was allowed for our benefit so that we could learn, from him, how to handle such trials. I learnt from a child that I could live each day in God's strength and each choice to involve God made the next choice to turn to him, easier.

I qualified from Barts in 1968 having spent four months at Nqutu (Zululand) as a student, under the amazing Anthony Barker. After house jobs in medicine, geriatrics, surgery, paediatrics and obstetrics, and with lots of practical experience, I returned to Zululand where I worked at Mseleni Mission Hospital (with Africa Evangelical Fellowship). I had told God I was not prepared to be alone in charge of a mission hospital but it is always unwise to say that kind of thing as God has a habit of making us face our 'refusals' to prove his great grace and power. I learnt so much there about the tremendous power of prayer. I came back and married Stanley whom I had met when he was head student at All Nations (my father was the Principal). We had three children and when they were all at school I entered General Practice where I worked for 25 years. My father had vascular dementia but he still knew who God was and could still pray fervently even when he no longer knew who I was.

Ways of coping

I had inherited familial hypercholesteraemia but had declined to take Simvastatin because of side effects, and I suspect the build up of cholesterol (13.6) was the cause of my transient ischaemic attack (TIA) in 2004. My GP sent me to the TIA clinic but I did not stop working (one didn't). However I noticed that I got seriously lost when visiting patients, so I bought a Satnav.

In January 2005 I had an odd experience whilst shopping suddenly being completely confused, unable to talk or pack the shopping into bags at the check-out. I was referred to a neurologist who told me, before I even sat down, that there was nothing the matter with me medically. I felt humiliated.

So I just determined to find better ways of coping. Stanley was good at practical solutions; I set up checks on my computer to ensure I was always safe and when greeted enthusiastically by people I thought I did not know, I just responded in kind.

I had a defining moment when chairing a mental health conference at work. I kept asking who everyone was, although they assured me they had known me for 20 years. I realised something really was the matter, and after collapsing on a long haul flight and needing to be met by a resuscitation team on touchdown, I reluctantly agreed to be referred to another neurologist and my cardiologist. Tests including a two-day session with the neuropsychologist who told me my intelligence enabled me to cover up and find unusual ways of solving problems. She could not say if I was, or would continue to be, safe working. I could not consider anything less than my previous high standards so I resigned, much to everyone's surprise as no one had any idea of the extent of my cover up. I was asked to continue doing appraisals although Stanley had to drive me as I could no longer find my way but could function perfectly well once there.

Definite diagnosis

It wasn't until May 2009 when the neuropsychology professor told me I needed to see Peter Garrard that I had a definite diagnosis of early-onset Alzheimer's. Stanley and I had thought of serving God together in Africa once I retired; he had been working with Tearfund's Disaster Relief Team around the world. In 2001 I returned to Mseleni after 30 years, for a sabbatical. I found it extremely difficult as I often felt out of my depth with the responsibilities and demands and had to live each day in his strength. I was the only doctor in outpatients/casualty seeing hundreds of patients every day. I was really surprised at the way God used the situation to honour him. When I received the diagnosis of Alzheimer's, we realised that neither of us could return to Africa, although I had realised for several years that I had some form of dementia. We both believed that it is not what we do for God but how we walk with him – our heart's attitude – that matters. So I said 'Well Lord here I am with Alzheimer's; I accept this unexpected gift from you. I'll see what you can do with it!'

I had learnt when Stanley was away for months at a time over the previous decade, that God's present for me was Stanley's absence (even if an unwanted present!) and from Paul's epistles that if we accepted God's gifts with both hands (ie enthusiastically) he could show his glory; he had certainly done that during those years. So it was not hard to respond positively to a more permanent 'present' of dementia. Nothing is wasted in God's economy.

Medication has made a tremendous difference to me. Most significantly it has abolished my awful olfactory hallucinations. It has enabled me to regain coherent speech, but reading is still hard. I used to speed-read and I find trying to read each word separately, which means nothing without a context, too exhausting. Each new difficulty is a challenge as I seek new coping mechanisms I have also written several leaflets for family and friends. My first was adopted by the Wessex faculty RCGP for adaption by any GP. There are so many things I know now that I wish I had known when a GP.

Church attitudes

I was amazed at my church's attitude to people with dementia, which indicated they did not understand many basic principles. I thought I could not bear to be treated like that when I became worse, so I persuaded my church to let me give a talk to the pastoral and staff team. This was so well received that I was asked to have it recorded and my son set up a website where folk could watch it and download my leaflets, which they could adapt for their own use.[1] I have been encouraged as several churches have adopted the visiting suggestions. I feel passionately that people with dementia should be as important to churches as anyone else; God sees us complete in Christ. We are all valuable members of his body. One Sunday a friend passed me a note in church (I had said to her I was unravelling and it was a challenge). She said her grandmother only unravelled things to make them more relevantly useful! This was a great encouragement to me!

We moved in April 2011 to Sandford Station, a place with on-site dementia care with brilliant staff and facilities. Stanley died quite unexpectedly four months after we arrived, just a week after my article was published in the BMJ.[2] He had always been my editor and supporter.

I have been so aware of God's hand of care and loving timing through this change. I am so glad that I live here as I am able to gain so much from talking with other people and their carers, listening to their stories, encouraging them and helping them understand some of their behaviours. I have had opportunities to do staff training locally also speaking to various groups of carers further afield at conferences on dementia. I am amazed how things have progressed as I also respond to questions and concerns through my website from folk around the world. I consider it a privilege. Each is an opportunity to share what I have learnt within the certainty of knowing God's love and acceptance as I am.

***Jennifer Bute** is a retired GP in Somerset*

God has a habit of making us face our 'refusals' to prove his great grace and power

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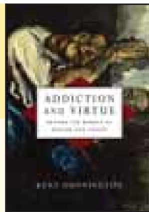


Addiction and Virtue

Beyond the models of disease and choice

Kent Dunnington

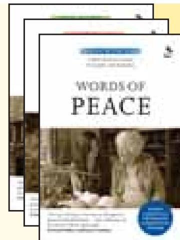
- Intervarsity Press USA, 2011
- £19.99 Pb 199pp
- ISBN 978 1 84619 186 2

This book explores varying ideas people have about addiction, seeking to advance from the false dichotomy of viewing it as either a disease or a matter of choice, using the works of Aristotle and Aquinas to see it as a 'habit', distinct from instincts and dispositions.

Addiction is considered a modern phenomenon, being adaptive in filling voids created by society moving from community-focused to self-centred. Other areas explored are addiction's relationship to sin and how it can become a counterfeit form of worship. The final chapter entitled 'Addiction and the Church - the Gospel and the hope for recovery', challenges all Christians: 'We fear that a gospel powerful enough to redeem the addict would also threaten our own lives of decent and decorous mediocrity.'

In the preface readers are rightly warned that the early chapters are the most technical, but provide the foundation for ideas subsequently developed. The book is demanding in the concentration required and also in the message it conveys, but for people with an interest in the field of addiction it is well worth the effort.

***Derrett Watts** is a consultant addiction psychiatrist at the Edward Myers Centre in Stoke-on-Trent*



Being with God:

Words of Peace; Words of Faith; Words of Hope

A Bible and prayer guide for people with dementia

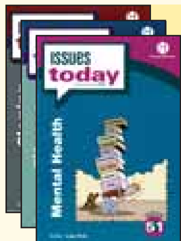
- Scripture Union Year, 2010
- £6.99 (each) Pb 48pp
- ISBNs 978 1 84427 522 9, 978 1 84427 521 2, 978 1 84427 520 5

These three books are a response by Scripture Union to the challenge of dementia and offer support to a group whose spiritual needs are often overlooked and even ignored. The approach is straightforward. Keep it short, simple, flexible and familiar, and accept the need for repetition.

Dementia is a progressive condition moving from worry about failing memory, through deepening anxiety and frustration to detachment and a 'shut in' state in which communication seems impossible. Many sufferers do retain a spiritual awareness despite severe impairment. The daily guide allows interaction appropriate to each stage of the condition. Initially the prayers, readings and 'Talk About' material may be shared. Later they may need to be 'conducted' by the carers as they learn to listen and adjust. These resources are an aid to spiritual care. They need prayerful preparation and sensitive personal understanding by the helper.

If these books and the CDs are sensitively used, both helper and 'helped' may be blessed. SU is to be congratulated on meeting a very present need.

***George Chalmers** is a retired consultant in geriatric medicine*



Issues Today

Editors: Lisa Firth and Claire Owen

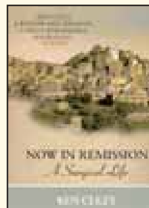
- Independence Educational Publishers
- £5.95 (each) Pb 28pp
- *www.independence.co.uk/issues-today.htm*

Issues Today is an ongoing series designed for younger secondary school children. Six of the more recent titles are *Cloning, HIV & AIDS, Fitness, Eating Disorders, Mental Health* and *Self-Harm*. Each topic is introduced with a definition. The first few chapters outline core information. Ethical dilemmas, related to the topic and how the media portrays the subject, are covered in the later chapters. Various different methods are used to engage readers – newspaper clippings, individuals' stories, pie charts, diagrams and factual information.

The vast majority of the chapters are condensed material written by third parties – one of CMF's articles appears in *Cloning*, and other chapters are edited versions of material from myriad sources ranging from broadsheets, NHS websites and some perhaps less-reliable online sources. The idea is that students learn to weigh up information that may be one-sided or biased, and learn how to come to their own conclusions. To this end, the chapters contain questions for reflection and group discussion as well as some case scenarios.

Overall, *Issues Today* is a good resource as long as it is used for what it is intended – adult-facilitated discussions with young people.

***Carmen Leung** is a fourth-year medical student at HYMS and **Rachael Pickering** is a GP in York*



Now in Remission

A Surgical Life

Ken Clezy

- Wakefield Press, 2011
- £19 Pb 288pp
- ISBN 978 1 74305 014 9

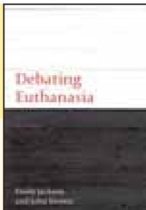
This is the autobiography of an Australian surgeon whose Christian faith pervades his writing. He shares his experience of working in places as diverse as Australia, Papua New Guinea (PNG), Tasmania and Yemen. His travels also took him to surgical meetings in many other parts of the world and famous names, including Paul Brand, are often 'dropped'.

It is a very honest book by a man who doesn't pull any punches with either medical or church hierarchies. He shares his delight in surgery, including pioneering work with ruptured spleens, third-world neurosurgery and correction of leprosy deformities. He rose to be professor of surgery in PNG, but life was not easy for him as he coped with epilepsy, depressive illness in a daughter, the rape of his wife by five rascals in PNG (there are interesting comments on Christian forgiveness) and the murder of colleagues in Yemen; he escaped by having gone late to breakfast.

If you have ever worked in a third-world country, you will definitely want to read it. So for me, having spent a month in PNG, it was fascinating.

A glossary of abbreviations would have been helpful, some chapters seem unnecessarily detailed for the general reader and some medical knowledge is essential for understanding.

***Bob Tripney** is a retired GP and hospital practitioner in cardiology*



Debating Euthanasia

Emily Jackson and John Keown

- Hart Publishing, 2012
- £15 Pb 190pp
- ISBN 978 1 84946 178 8

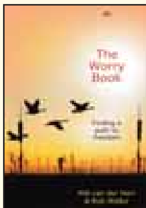
This third volume in the series *Debating Law* allows two opposing experts around 30,000 words each to make their case, 'blind' of what the other will say. The result is accessible and engaging, and is bang up to date, including global cases and references from 2011.

LSE law professor Emily Jackson writes 'in favour of the legalisation of assisted dying'. Elegantly and occasionally movingly, she makes the case as convincingly as I have ever seen it made, and for the reader unfamiliar with both sides of the argument, she is superficially seductive.

At slightly greater length, heavier in style, and more extensively referenced (169 against Jackson's 71), Professor John Keown, who has moved from Cambridge to Georgetown, argues 'against decriminalising euthanasia; for improving care'. He has done his homework. Although not seeing Jackson's contribution here, he analyses her previous publications and with the quantitative data from the Netherlands and from Oregon on his side, counters her case.

My verdict on the debate? Keown, by a knockout, though after you have read it, you may only agree he wins overwhelmingly on points. My verdict on the book? A state of the art summary of principles and practice.

***Andrew Fergusson** chairs the advisory group of the CNK*



The Worry Book

Finding a path to freedom

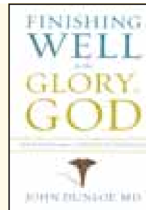
Will van der Hart and Rob Waller

- Inter-Varsity Press, 2011
- £7.99 Pb 176pp
- ISBN 978 1 84474 543 2

Dedicated to those who worry *The Worry Book* offers 'a path to freedom'. With an attractive cover and written by two directors of the popular Mind and Soul website, the book brings together the evidence-based cognitive behavioural therapy approach (CBT), Scripture and a wealth of practical hints and tips. Solutions are not just about praying harder but can incorporate proven psychotherapeutic approaches as well.

The authors are honest; Will is a worrier and Rob a perfectionist. They use lessons from their own and others' lives to inform and encourage. The tone is warm and engaging. Readers learn what worry is, how it affects them, and how to tackle it. Practical exercises and examples abound, alongside prayer and use of Scripture throughout. Christians can sometimes approach faith and life in black and white ways that worsen uncertainties and doubt. Chapters tackle this head-on and deal with issues such as how to live with uncertainly. Finally the book encourages hope and prayer as well as appropriate use of health and voluntary sector resources. This is a great book for those who worry and also for ministers, families and friends.

***Chris Williams** is Professor of Psychosocial Psychiatry at the University of Glasgow*



Finishing Well to the Glory of God

Strategies from a Christian Physician

John Dunlop

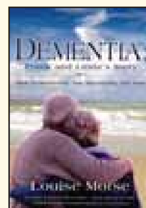
- Crossway, 2011
- £9.99 Pb 222pp
- ISBN 978 1 43351 347 3

Dr Dunlop writes from long experience as a Christian and a geriatrician. He garners from his experience stories of patients and acquaintances which illustrate strategies for preparing for and managing the end period of life, and living life as fully as possible to the glory of God. As he says, 'The greatest value we can have is that God ought to be glorified', commenting that 'dying well results from choices made throughout life'.

He writes fluently and interestingly, reminding us that for the Christian, death is an enemy and outside God's original intention for human beings. But death is also a defeated enemy as a consequence of the death of Christ. This has major implications for our choices in life.

The book has a wealth of wisdom regarding preparing for our inevitable death. It is a book for us all and will be particularly relevant to doctors, pastors, and carers who deal with life-threatening illness in themselves or others. I hope it will be widely read. Do not be put off by the occasional Americanisms – and do remember that 911 is the equivalent of our 999!

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



Dementia: Frank & Linda's Story

New understanding, new approaches, new hope

Louise Morse

- Monarch Books, 2010
- £8.99 Pb 256pp
- ISBN 978 1 85424 930 2

If dementia is a 'no go topic' for you as an individual, or a clinician (whatever your speciality), or both, then read this book! It provides the corrective re-think you need. Written by a cognitive behavioural therapist, it presents an explicitly Christian perspective structured around a married couple's 'case history'.

Clearly, practically and movingly, the day-to-day and sequential issues (and possibilities) for relationship, caregiving, communication, 'personhood', identity and support (practical, emotional, spiritual) are covered, alongside a contemporary intuitive approach (SPECAL) breaking new ground in the provision of formal and informal care (and crying out for a major research grant).

Firmly rooted in the sanctity of 'God's image', replete with practical advice and useful links, this is a resource for individual caregivers, health professionals, church families, and all thinking Christians. In chapter nine (The Care Funding Maze) I found myself challenged by the poor showing of the traditional 'medical model', the bureaucratic ineptitude of the separated 'social' one, and the clear need to re-unify the two.

If, as cited by one reviewer, 'good care is something that comes from the heart, not the system', then both need to change. Some secular progress is welcomed, but where are the Christian medics? Read it. There's a battle for Christ to be won or lost!

***Cameron Swift** is a consultant physician and professor of healthcare of the elderly*

Europe against euthanasia

The Parliamentary Assembly of the Council of Europe has adopted a non-binding resolution concerning Advanced Directives, Living Wills, Powers of Attorney and Consent to Treatment under the title: Protecting human rights and dignity by taking into account previously expressed wishes of patients. This resolution did not specifically concern euthanasia, nonetheless Article 5 states: '*Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited*.'
(*Council of Europe*, 25 January 2012, *bit.ly/zkZmSP*)

Cheap alcohol

According to a recent YouGov survey 61% of UK adults believe that excessive drinking is a problem in their neighbourhood. Three major Christian denominations have expressed concerns about the increasing availability of cheap alcohol and the effects this is having on local communities. They believe enforcing a minimum per-unit price could be part of the solution to this problem, a move that has already been taken by the Scottish Government and backed by NICE. So far, Westminster has refused to go down this route, although a growing number of local authorities are considering it.
(*The Methodist Church*, 21 December 2011, *bit.ly/wYyeZy*)

Christians are better at marriage

Latest research into the lifestyles of Christians reveals that they are happier in their marriages and better at staying married than non-Christians. They are highly likely to accept outside help and advice to keep their marriages healthy when problems arise, and make better initial preparations for marriage often through attending Church-run courses. Another highlight of the research, by the Evangelical Alliance, is the finding that cases of domestic violence in marriages between evangelical Christians is far lower than that reported by society as a whole.
(*Evangelical Alliance*, 7 February 2012, *bit.ly/zf7yuO*)

Commitment contracts for health

An article in the *BMJ* on behaviour change explores the concept of 'commitment contracts' - simple incentive schemes in which money deposited into an account can only be withdrawn if the participant is successful in keeping their commitment. Noting that such contracts already exist in the corporate world as incentives for weight-loss or conquering addition, the authors ask whether the concept could have a wider application in tackling other ill-health related behaviours. (*BMJ*, 2012;344:e522, *bit.ly/wBaHAf*)

We are not animals

The Archbishop of Canterbury has spoken out against the conclusions of the Commission on Assisted Dying warning that giving the terminally ill a 'right to die' would place patients and doctors at risk. He argued that a change in the law would create an environment in which life could be legally deemed 'not worth living' and this would lead to 'a change in the default position on the sanctity of life' which 'would be a disaster'. He summed up by saying 'A truly compassionate society will invest in high quality palliative care rather than lethal doses of poison – we are not the same as our animals.'
(*Telegraph*, 7 February 2012, *tgr.ph/ySHqld*)

British 'stiff upper lip' preventing a good death

The chairman of the National Council for Palliative Care has called for a 'change of philosophy' in the medical profession when it comes to discussions on end-of-life care. Encouraging a more open discussion of death and endorsing Anticipatory Care Plans Professor Lakhani said: 'These decisions should be made early because if you do plan early it gives you a chance to say "goodbye" and say "sorry" and say "I love you"... We are not going to be able to cure these people but actually we can help them have a good death – a happy ending.' (*Telegraph*, 3 February 2012, *tgr.ph/y19FnY*)

Abortion advertising

Commercial advertisements on TV and radio for Post Conception Advice Services (PCAS) will be allowed from 30 April. Private clinics that undertake abortions for profit will be allowed to advertise their services, whilst the new rules state that any provider that does not directly refer for termination must make this clear in the advert. It is likely, due to the high costs involved, that only the larger government-funded abortion providers like BPAS and MSI will be able to afford such advertising. Read more at *cmf.li/xaQyTy*
(*Committee of Advertising Practice*, 20 January 2012, *bit.ly/xvOGic*)

Groundless abortions

A systematic review by the Academy of Medical Royal Colleges, shows that abortion does not *improve* mental health outcomes for women with unplanned pregnancies and does not offer any real protection from mental health problems. Yet the vast majority of abortions in this country are carried out on mental health grounds amounting to 185,000 abortions in 2010 (98% of the annual total). The report shows that doctors who authorise abortions in order to protect a woman's mental health are not acting on the basis of medical evidence. Read more at *cmf.li/yP9cka* (*Academy of Medical Royal Colleges*, 16 January 2012, bit.ly/zFkzqh)

The cost of sexual freedom

The latest *Cambridge Paper* from the Jubilee Centre claims that the true cost of sexual freedom and relationship breakdown to the taxpayer and wider economy totals some £100 billion annually; about twice as much as alcohol abuse, smoking and obesity combined. This figure includes direct costs to the taxpayer, such as NHS costs for treating STIs and providing abortions for teenage pregnancies, but also indirect costs to the economy such as lost working hours following a divorce and resulting problems in mental health, educational under-achievement, worklessness and addiction.
(*Jubilee Centre*, 4 December 2011, *bit.ly/zRArj1*)

Still alive

Stephen Hawkins' 70th birthday on 8 January was a reminder of the difficulties in making prognostic forecasts for the terminally ill with months to live. Diagnosed with Motor Neurone Disease as a student in 1963 Hawkins was given a life expectancy of two to three years, and was told he would not complete his PhD, but he has gone on to live well beyond that forecast. So it is regrettable that Lord Falconer has recommended that people with 'less than twelve months to live' should qualify for assisted suicide because it is in fact impossible to have certainty on a prognosis that stretches into months.
(*CMF blog*, 9 January 2012, *cmf.li/wAxKGX* and see also *cmf.li/wTcNUh*)

Andrew Miller explores the healing of a man born blind

TREATING THE WHOLE PERSON

'They came to Bethsaida, and some people brought a blind man and begged Jesus to touch him. He took the blind man by the hand and led him outside the village. When he had spat on the man's eyes and put his hands on him, Jesus asked, "Do you see anything?" He looked up and said, "I see people; they look like trees walking around." Once more Jesus put his hands on the man's eyes. Then his eyes were opened, his sight was restored, and he saw everything clearly. Jesus sent him home, saying, "Don't go into the village."' Mark 8:22-25

The healing of a blind man at Bethsaida is the only one of Jesus' 23 recorded healing miracles in which the cure was in two stages rather than instantaneous.

In spite of numerous rationalisations, it is rare to hear a convincing explanation for this anomaly. One that fits with all the other information in this story is that Jesus knew that the man would not have been able to cope with a dramatic instantaneous result. There are several relevant clues in the account to this man's underlying personality:

1. He came to Jesus because his friends brought him. Everybody else approached Jesus directly (except those unable to do so due to paralysis). Indeed Bartimaeus, another blind man, did so in a very pushy manner, judging by the crowd's hostile reaction (see Mark 10:46-48).
2. Jesus took this man outside the village (ie away from other people) before he took any action. This too is unique in that Jesus didn't act on the spot. It is noteworthy that, although the man must have known the way, Jesus held his hand to gain his trust.
3. After the first touch, it is said that the man looked *up* rather than around.
4. Afterwards, Jesus told him to stay away from the village – even though he would have had to return eventually.
5. Afterwards he neither followed Jesus nor went around exclaiming to everybody what had happened.

All this makes sense if we see this man as someone who was so passive and had such a poor self-image (much of which may have been the result of years of helplessness, dependence upon others, inability to work, difficulties in relationships, the social stigma of being blind) that he didn't even have the motivation to seek Jesus' help and so had to be pushed by his friends towards Jesus. He needed privacy initially to be able to cope with this life-changing encounter, and privacy afterwards to allow the full magnitude of what had happened to sink in fully before going back to face his fellow-villagers. An instantaneous healing could have overwhelmed and traumatised him.

So Jesus, recognising the sort of individual that he was, gave the man the physical and emotional space to receive the full benefit in a way that he could manage. Jesus gained his trust, took time with him, touched him physically, and allowed him to see that something was really happening before he completed it, so that when the man looked up it was the first time for years that he experienced hope. Jesus found an effective way that was sensitive to the man and at a pace that he could manage, treating the whole person, not just the disability.

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