Spring 2014

for today's Christian doctor

triple helix

Caring in the light of eternity

Also: the doctor and addiction, the abortion–breast cancer link, when ideology replaces science, The Saline Process and faith-sharing, finding true significance in a culture of self esteem

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contents

When ideology drives science

In July 1949, the *New England Journal of Medicine* printed an article by Dr Leo Alexander titled 'Medical Science under Dictatorship'.[1] In it, the author explains what happens to science when it 'becomes subordinated to the guiding philosophy' of a political ideology. 'Irrespective of other ideologic trappings', he argues, the 'guiding philosophic principle of recent dictatorships' is to replace 'moral, ethical and religious values' with 'rational utility'.

Alexander eloquently demonstrates how 'medical science in Nazi Germany collaborated with this Hegelian trend' and became the source of 'propaganda' which was 'highly effective in perverting public opinion and public conscience, in a remarkably short time'.

This expressed itself in a rapid decline in standards of professional ethics and led ultimately to the German medical profession's active participation in 'the mass extermination of the chronically sick' and of 'those considered socially disturbing or racially and ideologically unwanted'.

Britain is not Nazi Germany and is a democracy rather than a dictatorship. However, all democracies are also susceptible to influence by well-organised minorities and it is very clear, in this post-Christian society, that the corridors of power are increasingly filled by those who do not subscribe to a Christian worldview and values.

In fact, many of those who occupy positions of influence in our 'mountains of culture' – universities, schools, media, judiciary, parliament institutions and entertainment industry – are actively hostile to Christianity and supportive of public policy directions consistent with a secular humanist agenda – pro-choice on abortion, supportive of 'assisted dying', embryo research and same-sex marriage.

These issues are of course highly political. But is there any evidence that the 'medical science' marshalled to support them is in any way being influenced or shaped by secular humanist ideology?

Two articles in this edition of *Triple Helix* would say 'yes'. They argue that financial or ideological vested interests can stifle the truth when medical issues become highly politicised. Both articles question the way that British Royal Colleges have handled scientific evidence in their support for a certain public policy direction.

Donna Harrison (pages 18-19), Executive Director and Director of Research and Public Policy at the American Association of Pro-life Obstetricians and Gynaecologists (AAPLOG), argues that the Royal College of Obstetricians and Gynaecologists (RCOG) has misrepresented available scientific evidence to support its view that there is no link between abortion and breast cancer.

She explains why a link between abortion and breast cancer is entirely biologically plausible and points out how oft-quoted studies which deny such a link 'often resort to errant methodology which obscures the actual scientific question they were purported to answer'. She singles out for particular criticism a frequently cited meta-analysis by Beral et al[2] on which the RCOG leans heavily in formulating its abortion guidance.[3] She then cites a 2014 meta-analysis of 36 studies by Huang et al[4] which looked specifically at the relationship between induced abortion (IA) and breast cancer. It found that IA is significantly associated with an increased risk of breast cancer among Chinese females, and that the risk of breast cancer increases as the number of IAs increases.

Peter May (pages 14-16), retired GP from Southampton, takes issue with the Royal College of Psychiatrists (RCPsych) over their opposition to 'change therapies' for unwanted same-sex attraction. He accuses the College of locking itself into a 'born gay' ideology by ignoring the evidence to the contrary. The College's argument that causation is 'biological' has led to the widespread belief that LGB people are being 'true to their nature' in homosexual behaviour. Yet twin studies do not support this view and in 2006, a major Danish study reported, 'population-based, prospective evidence that childhood family experiences are important determinants of heterosexual and homosexual marriage decisions in adulthood.'[5]

The position of the RCOG on the abortion–breast cancer link, and the RCPsych on the causation of homosexual orientation, have both been profoundly influential on public policy. In fact the latter has even helped shape policy within the Church of England.

These College positions will remain crucially influential this year, with the Department of Health about to issue guidelines on abortion and Parliament about to consider legislation seeking to ban 'change therapies'.

It is part of the role of *Triple Helix* to highlight issues like this so that our readers can participate in these debates in a fully informed way. They have profound implications, not just for public policy, but also for fully informed consent.

As Peter May concludes, 'We have a mandate to be passionate and honest about truth and to strive to teach it accurately. All truth belongs to God, and all untruths deny him. We must insist that love and truth are essential values in public discourse.'

***Peter Saunders** is CMF Chief Executive.*

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news reviews

Euthanasia

New threats on the horizon

Review by **Peter Saunders**
CMF Chief Executive

With the recent decision by the Belgian government to allow euthanasia for children, the battle against legalised medical killing in Europe has sharply intensified. We will face two new parliamentary challenges in Britain this year.

Lord Falconer plans to table his Assisted Dying Bill[1] again in June 2014.[2] The House of Lords has rejected assisted suicide on a number of occasions, notably in 2006[3] and 2009.[4] Falconer's current bill is not considered to be much different from Lord Joffe's, which was defeated 148-100 in 2006. It is based on the law currently in place in Oregon, and has been informed by his much-criticised Commission on Assisted Dying.[5] It seeks to legalise assisted suicide for mentally competent adults with less than six months to live and employs a medical licensing system similar to that of the Abortion Act 1967. Changes in the composition of Britain's upper house following the last general election in 2010 make it a serious threat.

Independent MSP Margo MacDonald launched her Assisted Suicide (Scotland) Bill[6] on 14 November 2013. It is currently being scrutinised by a parliamentary committee and will be debated in the Scottish Parliament in the autumn. It is wider in scope than Falconer's, allowing those with a 'terminal illness' or 'terminal condition' (but without specified life expectancy) to end their lives. MacDonald's last bill was defeated in Holyrood by a massive 85-16 in 2010.[7]

Doctors' groups have consistently been against legalising euthanasia on grounds that it is uncontrollable, unethical and unnecessary. Currently the British Medical Association, the Association for Palliative Medicine, the British Geriatric Society, the World Medical Association and the Royal Colleges of Physicians, General Practitioners and Surgeons of England oppose a change in the law.

In February this year the RCGP reaffirmed its opposition[8] when 77% of respondents to 'one of the most comprehensive consultations the College has ever undertaken' favoured no change in policy.[9] The voices of Christian doctors will be decisive in defeating these two dangerous pieces of legislation.

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State of the nation

The church needs to address physical health

Review by **Steve Fouch**
CMF Head of Nursing

The state of the nation's health is not good. Starting with a WHO report that predicted a global cancer epidemic,[1] we then learnt that the number of people living in the UK with type 2 diabetes has soared, so that one in 17 of us[2] are now living with the condition.

The cause is being laid at the door of two paradoxical problems of modern living. Medical advances mean we can now cure many (if not most) infectious diseases so we are no longer dying young in large numbers. Meanwhile, our technology driven, sedentary work and leisure pursuits along with the availability of cheap (but micronutrient poor) calories mean we are instead succumbing to more chronic diseases. This means that while we are adding more years to our lives, they are years that are filled with more poor health.

The knee-jerk response is to bring in something like the recent ban on smoking in cars when children are present.[3] At the same time the Government has backed away from per-unit alcohol pricing – despite the mounting evidence[4] from around the world that this might actually work in reducing problem drinking and other health problems![5]

But while some nudge policies may work in helping people not to make some harmful choices, the deeper malaise will be harder to overcome. We simply do not want to do what we need to stay healthy, as it so often involves giving up what we like (eg fatty, sugary processed foods, alcohol, tobacco) and doing what we don't like or find hard to do (exercising, limiting our calorie intake etc). This is made all the more difficult when the food, tobacco, alcohol and advertising industries are investing lots of money encouraging us to do the exact opposite! Individual human sinfulness and corporate sin and evil conspire against us. It is a public health nightmare that the apostle Paul would so readily have understood![6]

Maybe this is a challenge for the churches, which have risen to address so many of the other issues that crush human life – from HIV to care of the dying. We run food banks, we run schools, and in many parts of the world we still run hospitals. We have always had something to say about making good choices in our pastoral work and outreach. Maybe it's time for some creative thinking about lifestyle changes in diet and exercise as part of our wider pastoral ministry? But more, this is also an issue of justice and overcoming the principalities and powers – so maybe we should also be challenging the hold of commercial interests over public health? Either way, physical health should be a growing concern of the local and national church.

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Ensuring healthy lives for all

Primary healthcare is high on the post-2015 agenda

Review by **Steve Fouch**
CMF Head of Nursing

The Sustainable Development Goals Open Working Group (SDG-OWG) on Health and Population Dynamics has published its report[1] that will feed in to the Post-2105 development goal process. Its main points are that we should have an overall goal to *achieve health and wellbeing at all ages*.

The main focus is on primary healthcare that includes sexual and reproductive health, family planning, immunisations, preventative medicine, with a particular emphasis on treatment and prevention of major communicable and non-communicable diseases (NCDs).

There is a specific set of targets to reduce child and maternal mortality (to less than 20 in 1,000 live births and less than 40 in 100,000 live births respectively), and to reducing deaths caused by NCDs in those under 70 by more than 30% compared to 2015 levels. It also aims to promote healthy diets and physical activity, reduce unhealthy behaviours (excessive alcohol intake, smoking) and track social wellbeing and social capital.

This compares with the High Level Panel Report[2] on the World We Want consultation (to which CMF made a submission[3] and which was published in March 2013) which had an overall goal to *Ensure Healthy Lives*. It had specific targets similarly focused around maternal and child mortality (although had left the figures vague), increased vaccinations, increased access to sexual and reproductive health and reducing the burden of communicable, non-communicable and neglected tropical diseases. The overall thrust was towards equity of access, with 'no-one left behind'.

The emphasis on primary healthcare, lifestyle, preventative medicine and specific targets on maternal and child mortality is to be welcomed. While none of this is, in its surface language at least, at all contentious, there remains a concern that abortion and other undesirable means of birth control may be smuggled in under the family planning/sexual and reproductive health mantle.

And given the struggles the developed nations have in maintaining health services, or even extending universal access to health services to all their citizens, we cannot but be concerned that the aspiration to universal access in both reports is a pipe dream.

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Nurse-led abortion

Women no longer required to see a doctor in abortion cases

Review by **Philippa Taylor**
CMF Head of Public Policy

The Department of Health has been steadily loosening its guidelines on abortion, without announcements, public consultation or discussion in Parliament. Our suspicion is this change is part of a process culminating in a nurse-led abortion service, predominantly in private clinics, paid for by the tax-payer funded NHS.

One key change is the removal of the requirement for a pregnant woman to see two doctors.

The Abortion Act 1967 requires that a pregnancy can be terminated by a registered medical practitioner only '*…if two registered medical practitioners are of the opinion, formed in good faith…*' that it fulfills one of the specified legal grounds. The ability to form, and subsequently defend, an opinion on a woman's need for an abortion, and her health, surely requires that a doctor has at least met her beforehand?

Induced abortion is an invasive medical procedure with known contraindications and complications. Only a registered doctor will have the required training to ensure that a woman seeking an abortion is fully informed of the medical risks of the procedure, is properly cared for and that her request meets the requirements of the law. Now all this is under threat.

The previous Secretary of State for Health, Andrew Lansley, issued interim guidance for abortion clinics in summer 2012 but never published it.

However, around this time, the Department stated – for the first time – that '*there is no requirement that both doctors must see and examine the woman*'.[1] This was a significant change from guidance issued in 1999 which said that: '*…medical practitioners must give their opinions on the reasons under the Act for the termination* ***following consultation with the woman***.'[2] (emphasis mine)

When the 2012 interim guidelines were finally published on the DH website in January 2013 they said '*We consider it good practice that one of the two certifying doctors has seen the woman, though this is not a legal requirement*.'[3] By November 2013, the eventual public consultation paper included a further addition, that members of a multidisciplinary team (a nurse or other member of a team) can seek the necessary information from the woman, instead of the doctor.

Interestingly, recent polling found that most women (92%) agree that a doctor *should* always need to see the woman, in person, to approve abortions. The polling highlighted fears that women's health would be put at risk if the requirement to see a doctor is watered down.[4]

The DH will shortly release definitive new guidance for both private abortion clinics and for doctors. At that point the new interpretation of the Abortion Act – that no doctor need see a woman before authorising an abortion – could be set in stone, without Parliament ever having debated it. Such a move would fly in the face, not only of women's wishes, but of the Act itself.

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Peter Saunders relates the sequel to a horrific but iconic image

THE MIRACLE OF KIM PHUC

On 8 June 1972, a plane bombed the village of Trang Bang, near Saigon (now Ho Chi Minh City) in South Vietnam after a South Vietnamese pilot mistook civilians leaving a temple for enemy troops.

The bombs contained napalm, a highly flammable fuel, which killed and badly burned the people on the ground. The iconic image of children fleeing the scene won the Pulitzer Prize and was chosen as the World Press Photo of the Year in 1972.

The photograph communicated the horrors of the Vietnam War in a way words never could, helping to end one of the most divisive wars in American history and later becoming a symbol of the cruelty of all wars for children and civilian victims.

In the centre of the picture a nine-year-old girl runs naked down the highway after stripping off her burning clothes. Kim Phuc Phan Thi was attending a religious celebration with her family at the pagoda when the plane struck. She lost several relatives in the attack. The children running with her are her own brothers and sisters.[1]

I had the privilege of hearing Kim speak in New Zealand a few years ago and the 40th anniversary of the bombing was commemorated in 2012.[2] She said, looking back, that three miracles happened on that dreadful day.

The first was that, despite suffering extensive third degree burns to her left arm, back and side, the soles of her feet were not burnt and she could run. The second was that after she collapsed and lost consciousness the photographer, Nick Ut, took her to Barsky Hospital in Saigon. The third was that her own mother found her there later that day. Kim remained hospitalised for 14 months, and underwent 17 surgical procedures, until she recovered from the burns.

Grateful for the care she received, she later decided to study medicine but struggled to come to terms with her deep physical and psychological scars.

'My heart was exactly like a black coffee cup,' she said. 'I wished I died in that attack with my cousin. I wish I died at that time so I won't suffer like that anymore ... it was so hard for me to carry all that burden with that hatred, with that anger and bitterness.'

But as a second year medical student in Saigon, she discovered a New Testament in the university library, committed her life to following Jesus Christ, and realised that God had a plan for her life.

Kim never finished medical school, as the Communist government of Vietnam realised the 'napalm girl' had value as a propaganda symbol.

She believed no man could ever love her with her disfigurement, but later studied in Cuba where she met Bui Huy Toan, another Vietnamese student whom she married in 1992.

Kim and Toan went on their honeymoon in Moscow. During a refuelling stop in Gander, Newfoundland, they left the plane and asked for political asylum in Canada, which was granted.

In 1994, UNESCO designated her a Goodwill Ambassador for Peace. In 1997 she established the first Kim Phuc Foundation in the US, with the aim of providing medical and psychological assistance to child victims of war.[3]

Kim Phuc, now 51, lives near Toronto, Canada, with her husband and two children, Thomas and Stephen. She has dedicated her life to promoting peace and providing medical and psychological support to children who are victims of war in Uganda, East Timor, Romania, Tajikistan, Kenya, Ghana and Afghanistan.

On 30 June 2008, US National Public Radio broadcast her spoken essay, *The Long Road to Forgiveness*. In it she testifies: *'Forgiveness made me free from hatred. I still have many scars on my body and severe pain most days but my heart is cleansed. Napalm is very powerful, but faith, forgiveness and love are much more powerful. We would not have war at all if everyone could learn how to live with true love, hope, and forgiveness. If that little girl in the picture can do it, ask yourself: Can you?'*[4]

***Peter Saunders** is CMF Chief Executive.*

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Richard Scott highlights the danger of losing yourself in your work

WHOSE LIFE ARE YOU LIVING?

A weekend in a manor house in Derbyshire – the perfect setting for a reunion. Thirty years as doctors and all still in the NHS, bar one couple on their way to New Zealand. Walking and fine dining allowed us to take stock of our present situation, while slides revealing seventies haircuts and sheepish grins took us back in time. In the system, but at the bottom. Everything to play for.

Day one at medical school. The surgeon scanned our eager faces, not liking what he saw. 'Only one of you will make it.' He meant being like him, the Special One. Very deliberately, he'd introduced competition before we'd even got to know each other and the game was on. It started with avoiding the pre-clinical cull and continued into clinical as we came across patients and our new role models – the junior doctors treating them. Capable and dedicated, by necessity they were also highly competitive and we were under no illusion that their journey involving exams and scrapping in the job market would soon be ours. For every game has its rules, and to succeed is costly. How could it be otherwise?

Along with the others I started climbing, but halfway up the hill my world fell apart. Externals were partly responsible – working horribly hard, with any spare energy spent studying, ending a relationship and dealing with a housing nightmare wasn't fun. But these were details. The bigger issue was my focus. Applied to goals set by others, with a touch of hero-worship thrown in, I'd unintentionally attempted to live my seniors' lives, not my own. And God, whom I'd discovered aged 14, had been left well behind. In crisis, I re-devoted myself to Him, but still needed time away on mission to discover who I was. Returning to the NHS six years later, I was finally able to function as myself.

'For I know the plans I have for you, says the Lord'.[1] Abroad, I'd been free to do my best for patients whilst remaining true to myself. But how to make a difference back home? God stepped in. First, he moved me into general practice. Then, Alpha challenged me to tell others about my faith. My focus reset, it was clear that whatever else I provided, above all patients needed a saving knowledge of Jesus Christ. Only this confidence and clarity has allowed me to resist becoming side-tracked down time-consuming avenues at work that claim to be best for me and for patients, whilst delivering neither. Let me explain.

> If hitting numbers rather than saving souls gets us up in the morning, we're no different from efficient secular practices

Over the past 15 years as a GP-evangelist in Margate, I have been energised by talking faith with patients. Recently, I chatted with three desperate patients, one of whom took up my challenge and has begun to attend church. But there are twin dangers lurking for Christian GPs. The obvious one is the highly secular GMC, whose view of what constitutes a good doctor is betrayed by their new guidelines limiting faith discussions. More subtle, but far more pervasive and dangerous in my view is the changing nature of our work. QOF targets and prescribing meetings, to name but two, sharpen practice to an extent, but only through emphasising auditable care at the expense of non-targeted, often softer aspects of medicine, not least spiritual care. With considerable finance at stake, GPs' competitive instincts go on red alert as targets mean money. Christian GPs are not immune from such acquisitive behaviour, justifying their actions in the belief that excellent figures imply excellent doctors. With time and energy limited, our focus can become misplaced as we settle for what our bosses deem important. If hitting numbers rather than saving souls gets us up in the morning, we're no different from efficient secular practices; indeed, we're lost.

Yet, I agree – there is a conundrum. The same Paul who advised 'do not conform any longer to the pattern of this world'[2] also states that 'everyone must submit himself to the governing authorities.'[3] But I would suggest that Caesar already gets what is rightly his. The question is, does God?[4]

Whose life are you living?

***Richard Scott** is a GP in Margate.*

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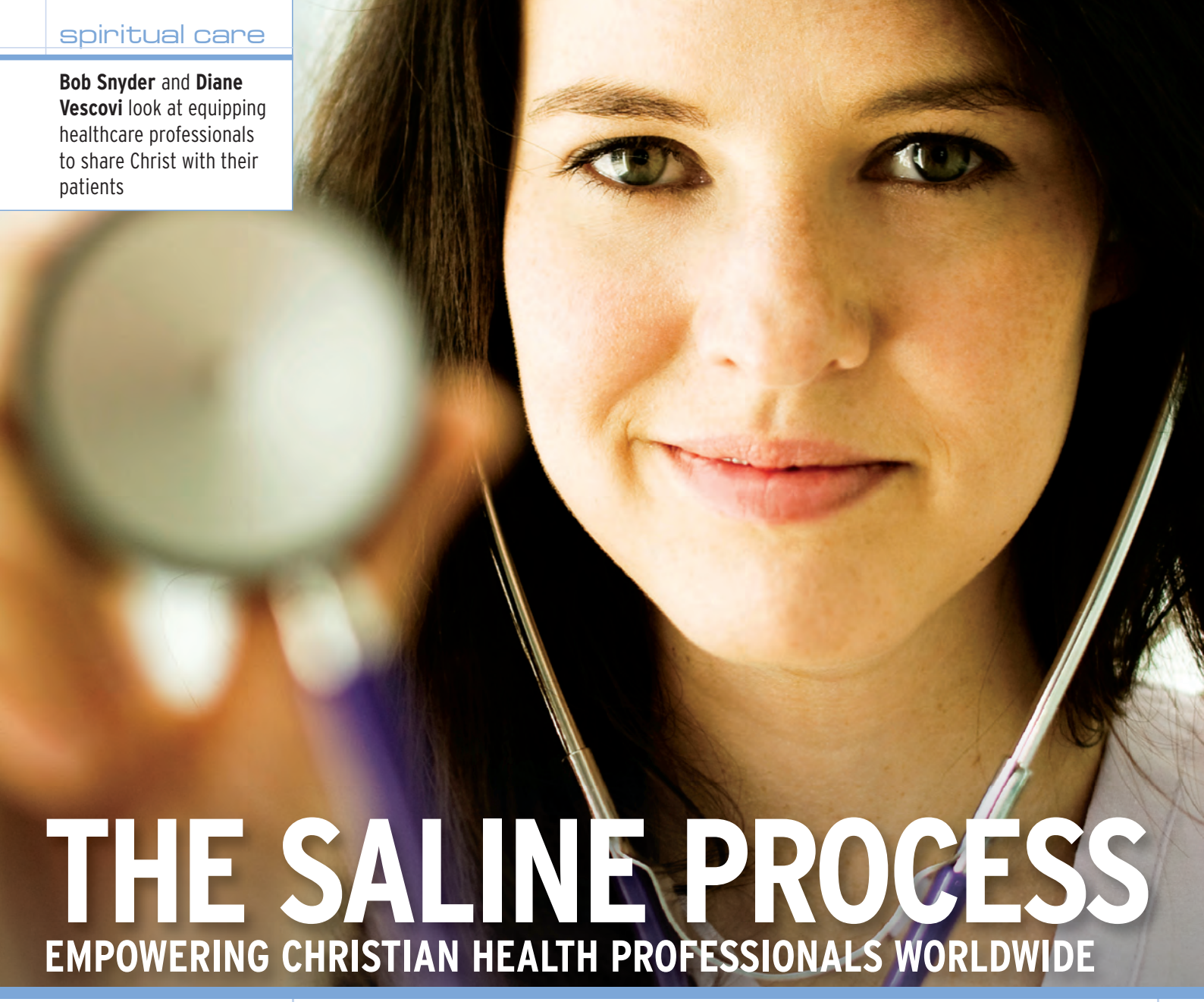
Bob Snyder and **Diane Vescovi** look at equipping healthcare professionals to share Christ with their patients



THE SALINE PROCESS

EMPOWERING CHRISTIAN HEALTH PROFESSIONALS WORLDWIDE

key points

- Christian health professionals have a unique opportunity to improve spiritual health, but often struggle to integrate faith and practice.
- With Saline, medics are equipped with vital tools that work and help people overcome barriers to being a workplace witness.
- Role-play and discussions help to work out the practicalities of sharing faith with patients.

Every Christian health professional has a unique opportunity to improve their patients' physical and spiritual health. Many, however, feel frustrated by the challenge of integrating faith and practice within time constraints and legal obligations.

Medical literature increasingly recognises the important link between spirituality and health [1] and GMC guidelines approve discussion of faith issues with patients, provided that it is done appropriately and sensitively. [2]

Many CMF members are already familiar with *Saline Solution*, a day course designed to help Christian healthcare professionals bring their faith and daily work together. It has helped growing numbers throughout the UK become more comfortable and adept at practising medicine that addresses the needs of the whole person.

But few will be aware that 'the Saline Process' is bearing fruit all over the world. Now adapted for working in any cultural context, its global influence for Christ in healthcare has been growing steadily. Training has already been conducted in 72 countries for the equipping of 11,000 workers.

Effective and evidence-based

Over the past six years, in places as diverse as Egypt and Guadeloupe, Saline has proven that being a witness in the workplace can and should be the result of *overflow* and not *overwork*. 'Being' a witness means being set free from 'doing' witnessing. Jesus said, 'You are the salt of the earth and the light of world.' He did not say 'act like salt and strive to be luminous'. He intended us to be as we are – as he is – in the world. With the training and support of Saline, medics are equipped with vital tools that work and help people overcome barriers to being a workplace witness. The process is collaborative with God's Spirit and carried out with permission, sensitivity and respect. Once trained, people often tell us they feel a burden has been lifted from their shoulders. They come away with the sense that being a witness is not a technique; it is an outgrowth of walking with the Lord, answering the call to be Christ's disciples in healthcare.

The training begins by looking at scientific research into why faith is important in healthcare. Harold Koenig, one of the foremost researchers in this field, reports that since 1997 an explosion of

literature has overwhelmingly shown the favourable outcomes of integrating faith into healthcare. Articles appear in so many journals of multiple disciplines that Koenig calls it 'a massive research literature that is scattered throughout the medical, social, and behavioural sciences'.[3]

Integrating faith and practice

Given the practical nature of being a witness, eight tools to equip witnesses are the core substance of the Saline Process:

1. **Prayer** is crucial for finding ministry opportunities in the midst of daily living.
2. **Asking Questions** is the basis for wise communication and assessing spiritual condition.
3. Taking a **Spiritual History** provides insight into a patient's spiritual journey and present needs.
4. **Faith Flags** are brief statements in the course of natural conversation that identify you as someone for whom a relationship with God, prayer, or the Bible is important.
5. **Faith Stories** explain how God, prayer or a biblical principle became relevant in your life or someone else's life, which is helpful when you sense a door opening further.
6. A **Truth Prescription** recommends something to do, to read or to watch.
7. Building a **Spiritual Referral Team** taps the resource of others of Christ's disciples who exhibit the Five Cs (see below) and are able to pick up where your involvement leaves off.
8. **Gospel Presentation** is our preparation to explain what a Christian is, and to do so accurately and concisely when the time comes.

Undergirding the eight tools are five characteristics of Christ's disciples, the 'Five Cs' of spiritual vitality that need to be present for a witness to use the tools effectively. These are Christ-like character, Competence, Compassion, wise Communication and Courage. In the context of Saline training, this means that we are first of all responding to patients' needs in ways that promote being trusted, with one listening ear toward the bedside and the other toward the Great Physician.

Monitoring a patient's responses is essential. During the training, a role-play is used to show how an encounter can go well or poorly, depending upon whether the patient's responses are heeded. This hands-on approach, and the practicality of the tools that meet patients at their point of need, have often been cited as the best feature of the training.

Since these tools are meant to be used with sensitivity, permission and respect, and given the weight of evidence from the research, we have solid ground on which to stand when facing opposition to the proclamation of faith. But of course we are not immune from attempts to quash the movement of God in healing, redeeming and restoring his image in those we meet. Courage is among the Five Cs for the reason that we need it in great amounts as Christians in healthcare, wherever in the world we work.

A global partnership

A great benefit of Saline today is that its support and promotion come through a partnership of nine healthcare organisations[4] which are united in their commitment to see every Christian healthcare worker being a skilled witness for Christ.

The International Saline Partnership, coordinated by IHS Global (previously International Health Services[5]), which developed the course, includes four organisations with international reach and five, including CMF UK, which are regionally focused. All of them have covenanted together to see their impact maximised around the world.

When it launched the Saline Process in 2007, IHS Global began immediately to employ the best methods for supporting trained workers in terms of follow-up coaching and the encouragement of a learning community connected online. In addition, the Saline Process set out to impact all healthcare professionals, reflecting the daily reality of multi-disciplinary team working.

Trained witnesses receive coaching from a multiplying trainer, who also identifies if a worker would be willing and able to pass along the learning to others. Saline trainers facilitate learning and instil confidence for gaining skills, rather than transmit knowledge. One does not need to be a gifted teacher in order to be a partner in the learning process and in cultivating faithful responsiveness to the call: 'You shall be my witnesses' (Acts 1:8).

When the partner organisation leaders and trainers came together in Budapest, Hungary for a three-day leadership summit in January 2014, they discovered how much they are motivated by God's call and how much that is an encouragement to one another! Among those present at the recent summit were sisters and brothers from countries where sharing the gospel is restricted and even forbidden.

Travelling from 20 countries that included Egypt, Spain, India, Norway, Paraguay, South Africa and the United Kingdom, the family of God gathered to celebrate their past and present impact for Christ in healthcare and planned for a future of continuing influential ministry. July 2014 presents an opportunity to experience the encouragement of the Saline Process during the ICMDA World Congress in the Netherlands when the training will be offered as a pre-conference stream.[6]

Why not take a closer look at the Saline Process? If you have been through it already and are putting into use the principles and tools, you could be equipped as a trainer. The team of trainers and coaches is growing in diverse cultural and medical environments worldwide. Most thrilling of all is the unity of God's Spirit drawing it all together in faith. So much is in place – and there is a place for you in it. Our prayer is for you to find that place.

Bob Snyder and Diane Vescovi *work for IHS Global, which coordinates the International Saline Partnership.*

Being a witness is not a technique; it is an outgrowth of walking with the Lord, answering the call to be Christ's disciples in healthcare

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Glynn Harrison examines the impact of the self-esteem movement

EGO TRIP:

HOW SELF-ESTEEM IDEOLOGY INVADED OUR LIVES AND TOOK OVER YOUR WORLD

key points

- Every day millions of people kick-start their day with self-affirming statements.
- Careful evaluations of the effectiveness of interventions to promote self-esteem have repeatedly turned up negative findings.
- The answer to putting ourselves down isn't to boost ourselves up. It is to assert who we are in Christ, and then to live imaginatively, assertively and creatively out of that reality.

'You're special!' 'I am perfect in every way'; 'I'm a loveable person'; 'I'm powerful, I'm strong'; 'Hey, to God, I'm big stuff!'

Every day millions of people kick-start their day with self-affirming statements like these. One study found that over 50% of respondents 'frequently' use them; only 3% said that they 'never' use them.[1]

50 years ago, if somebody complained about feeling down or protested that nobody liked them and that they were 'no good', a friend would offer advice along these lines:

'Don't get stuck in your own problems. Maybe you need to stop thinking about yourself so much. Instead of being a "here-I-am" person, try being a "there-you-are" person! Try to make new friends and explore some new interests. You'll never get anywhere by contemplating your own navel!'

Today the same friend would offer radically different advice:

'Hey, you need to believe in yourself more! Stop thinking so much about other people's problems. Forget about other people's expectations. Discover who you are. Be yourself. Learn to like yourself. Build up your self-esteem.'

The success of the self-esteem movement

All of this bears witness to the staggering success of the 60-year-old self-esteem movement. What started out as a simple idea loaded with good intentions – to help people crushed by criticism to stop beating themselves up in negativity – grew to become an all-purpose cure-all that now slips down as easily as a spoonful of grandma's home-made tonic.

Following its birth in the heyday of the 1960s sexual revolution, the self-esteem movement made its smartest moves when, in the 1980s, it transitioned from offering a cure to promising prevention. With pledges of extravagant benefits in drug-misuse, teenage pregnancy, social responsibility and educational outcomes, a new breed of 'therapeutic educators' made impressive in-roads into the educational establishment. As a result, competition was discouraged in our schools and learning to fail well became a forgotten art. Now, regardless of achievement or character, everybody was 'special' (not just to those who loved them) and 'all must have prizes'.

Because of the supposed fragility and vulnerability of a child's self-esteem, parents tried to inoculate their kids against it as well: 'You're incredible!'; 'Danger, Princess on Board!'; 'What have we here, a Mozart in the making or what?!' Churches are not immune from this trend either. I saw a church strapline recently that went 'you're incredible: we're here to celebrate you!' In this upside-down world of self-esteem it's not the sin of pride that we take into the confessional, but the transgression of 'not liking myself enough'.

What happened to bring this about? How did the self-esteem movement gain such a foothold in our lives?

The big fix

First, as we have seen, the self-esteem movement made bold and sweeping promises about its supposed benefits. True, making consistently negative

self-judgments about oneself is linked with a range of adversities such as poor mental health, educational underperformance, gang behaviour and teenage pregnancies. But correlation does not mean causation. And even if low self-esteem could be isolated as a robust causal factor, we can't simply conclude that 'boosting' ourselves will be the solution. If that were the case, then truly we would have stumbled across the holy grail of human happiness and wellbeing.

Second, the movement promised us *significance*. Since the beginning of time, human beings have puzzled over where we figure in the grand scheme of things and what we are 'worth'. Self-esteem ideology grips our imagination because it engages with this, the deepest and most profound problem of our lives, and tells us it can fix it. 'You're special!' 'You *just* need to believe in yourself…'

Third, with the arrival of the sexual revolution and individualism of the 1960s, the movement forged a powerful alliance with the emerging spirit of the age. The new spirit of selfism – individualism, letting it all 'hang-out', 'being yourself' – was effectively baptised with the blessing of science. Now you could have it all, and science proved it. And so, after surfing the sexual revolution of the sixties, self-esteem ideology thrived in the new humanisms of the 1970s (Tom Wolfe's 'Me Decade') and then mutated, almost effortlessly, into the materialistic orgies of the 1980s (Gordon Gecko's 'greed is good').

Eventually, the primacy of self-admiration became the default cultural mode: if we want to love one another, first we have to learn to love ourselves – right? Who could disagree with that? And, hey, didn't Jesus even say something about loving your neighbour *as yourself*? As a result, we overdosed on self-admiration and the movement reshaped secular and Christian cultures alike.

The big con?

But does it work? Careful evaluations[2] of the effectiveness of interventions to promote self-esteem have repeatedly turned up negative findings. There is little robust evidence that simplistic boosterism (as I prefer to call it) produces the benefits promised. And more worryingly, researchers have begun to uncover evidence that it may do more harm than good.

Take some research carried out at the University of Waterloo in Ontario[3] as one example. For several weeks a group of subjects were taught to repeat, and then to 'focus positively', on a range of commonly used upbeat self-statements such as 'I'm a loveable person'. A few months later, when the researchers compared the emotional responses of subjects with those in control groups, they found that participants who had low self-esteem at the start actually felt worse by the end of the study. The authors concluded that repeating positive self-statements might marginally benefit some people (those who already have good mental health), but 'backfire for the very people who need them most.' Why? Because, it's hard to believe your own propaganda.

Other researchers[4] now suggest that the pursuit of self-esteem leads to a treadmill of self-monitoring and accentuates chronic comparison-making with other people. Thus, we tend to thrive when the reviews are good but get snagged in disappointment or denial when they are bad. The result is more depression, difficulties with showing empathy to others, and erosion of confidence.

Boosterism's veneer of 'science' cannot sidestep the larger philosophical questions that stand behind it, either. The self-esteem movement spun the fantasy that questions of worth and value can somehow be uncoupled from questions of meaning and purpose. But despite the veneer of psychology, the core philosophical problem remains: how can the self be deemed 'worthy' simply because it asserts it to be so? On what basis? When you don't know what you are for, it can be hard to believe your own propaganda about what you are *worth*. And why should you?

The gospel and self-esteem

In contrast to the imperatives of boosterism, the gospel insists that we deal in reality and truth. It confronts the idolatry of self and refuses to conspire with our ego-absorption. It shows us how, when the pursuit of self-worth and self-fulfilment becomes the organising principle of mental life, we not only fall short of the glory of God, we fall short of being fully human too.

Instead, the gospel insists that before we can know what we are worth we must know what we are for and who we are. In the first chapter of John's Gospel, therefore, the God who speaks in the person of Jesus Christ also *speaks our identity to us*. No longer stranded in lonely dialogue with ourselves, abandoned to make ourselves up as best we can, the Father who spoke us into being now speaks of us, and esteems us, as his image-bearing children. And this – our identity in Christ as God's children – lays the foundations for personal growth and becomes the lynchpin of change.

Of course, the old habits of staking our identity on our achievements and on our performance die slowly and reluctantly. Many of us face a long, hard journey battling entrenched shame and self-condemnation, and a stubborn desire to prove our worth.

But as we grow in the imaginative task of inhabiting our grace-drenched 'right' (as the apostle John puts it) to become children of God, slowly, erratically, we come to know the true extent of our worth. And so the answer to putting ourselves down isn't to boost ourselves up. It is to assert who we are in Christ, and then to live imaginatively, assertively and creatively out of that reality.

And so, as self-esteem ideology slowly sinks under the weight of the evidence accumulating against it, we can have confidence that for those stuck on the lonely treadmill of self-validation, the gospel really is good news.

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The gospel... confronts the idolatry of self and refuses to conspire with our ego-absorption

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John Wyatt relates his experience of caring for a relative with dementia

CARING
IN THE LIGHT OF ETERNITY

key points

- For those with no faith, caring for people with respect seems largely an exercise in nostalgia, remembering how they were.
- Christians can care for people with dignity, respect and love because of the wonderful Christ-like person they may become in the new creation.
- In Jesus' resurrection body we catch the first glimpse of the new humanity; physical, but perfected and glorious.

To begin with, the changes were subtle. Unexplained anxiety and tearfulness, episodes of uncharacteristic blankness, irritation and anger with medics and their pointless tests. As the dementing process continued, my mother tragically changed and aged before our eyes. Her confusion increased, she was frequently distressed by terrifying visual hallucinations. Her limbs became permanently flexed and distorted. Visiting her on the acute psychogeriatric ward, I remember being overwhelmed by grief at her obvious distress and fear. I wept in the consultant's office, powerless to do anything to alleviate my mother's anguish.

Thankfully that dreadful period passed. Quetiapine had a remarkable effect in improving the psychotic symptoms, and compassionate and skilled nursing and medical care transformed my mother's condition. She became peaceful and relaxed. Although she could not communicate, she enjoyed holding hands with my father, listening to music, sometimes even singing along, especially to old hymns from her childhood in the Christian Brethren.

My father was tireless in visiting her, spending hours every day at her bedside. It was very important to him that the staff knew about her past, knew the sort of person Grace used to be. He put photographs on the wall – this is what she used to be. Grace with her children, Grace at the nursery school she pioneered, Grace laughing delightedly with a little child.

We all understood why this was so important to him. It mattered that the staff treated her with respect and dignity, because of who she really was. She was so much more than this little aged, distorted, pathetic being appeared to be.

From a secular perspective, when caring for an elderly person ravaged by disease and disability, this backward-looking perspective is the best you can get. Yes, this being in the bed seems pathetic and pitiable. But that is not the whole story. They were remarkable, once. They were strong and active, once. They used to be beautiful. For those with no faith, caring for people with respect seems largely an exercise in nostalgia.

But as our family spent time with my mother we were sometimes reminded that this was not the end of the story. As the family met at her bedside, in those occasional but special times of prayer and singing, although my mother could not speak and sometimes did not even recognise us, we knew that we shared in the Christian hope. This was not the end of the story. By God's grace we would meet again. And so we had to care for her now, not only because of who she was, but also in the light of the wonderful person she was going to be.

'And now these three remain: faith, hope and love. But the greatest of these is love.' (1 Corinthians 13:13).

In the great hymn of 1 Corinthians 13, Paul places Christian love together with faith and hope. They are three virtues which all point to the future. To use theological jargon, they are eschatological virtues; pointing towards the end times.

When we love someone who is desperately affected by disease, by a degenerative condition, by disability – the malformed baby, the person in a persistent vegetative state, the profoundly demented individual, the destitute homeless heroin addict – when we care for them with dignity, respect and love, we are saying that these are the sort of people who may, in God's grace, be transformed and enter into the new creation. We treat these individuals with respect because of the wonderful Christ-like person they may become in the future. We are saying that this is not the end of the story – there is more going on here than meets the eye. This is just the end of the beginning.

Of course we may not know whether this particular individual is dying in the Christian hope, whether they will be raised to new life or tragically to a second death. And it is not for us to decide which category this person comes into. But this does not change the way we care for them. We treat each person in the light of the new creation, in the light of what by God's grace they could become.

God's strange and wonderful creation plan was to take his amazing image and to place it in a pathetic, weak, vulnerable and fragile carbon-based life form. It was a strange and risky enterprise to make mysterious God-like beings out of the dust of the earth. And if you look at the history of mankind it seems very much like the plan has gone hopelessly wrong. There is so much evil, so much pain, so much distress, so much disease. Surely the best thing to do is to wipe the slate clean and start again? Humanity needs to be wiped out of cosmic history and there needs to be a fresh beginning.

But then Jesus, the second Adam, is born, he lives and dies and is risen from the dead. The risen Jesus is a physical, recognisable, touchable human being. His risen body isn't utterly alien and different, a completely new kind of reality. It's the same as before, but different. He is Adam all over again, but different.

The Creator God takes on a human body made, like all other bodies, from the dust of the ground. God in the form of Jesus takes up the dust he has made and incorporates it into his own body. And after death on the cross, he is raised as a physical, touchable, recognisable human being who goes out of his way to demonstrate his physical reality to his bewildered disciples.

The Gospel writers go to great lengths to emphasise the physical reality of Christ's restored body and its continuity with his old physical body. The writers are all adamant; the grave is empty. The molecules of which Christ's body were composed are no longer buried in a part of the ground in Palestine. The risen Jesus eats and drinks. He breaks bread. He talks. He is touched. He is recognised by his friends. His body even bears physical scars. There is no room to doubt the physical continuity between Jesus' original body and the resurrection body. It is the same, but different. In his resurrection body we catch the first glimpse of the new humanity, of Homo Sapiens 2.0.

As Paul writes: *'Just as we have borne the image of the earthly man, so we shall bear the likeness of the man from heaven'* (1 Corinthians 15:49). The image of God inherited from Adam will be fulfilled and transformed into a new and much more glorious image. Yes, we shall still be reflections, we shall still be images. We shall not lose our creaturely dependence. But we shall discover the true likeness that we were always intended to bear, the true identity that we were intended to indwell.

In the new heaven and the new earth there will be no sickness that needs healing, and no tears that need comforting. But there will be greeting and blessing, laughter and love, joy and peace. Our relationships with others will be healed and redeemed, there will be forgiveness and reconciliation.

And the Bible teaches us that this new age is already reaching backwards into our age. Our current age is being invaded backwards from the future. This new way of being has already started and our lives are being touched by the melody of heaven.

And even the hospital bed, the intensive care unit, the care home, the hospice, the place of disease and dementia and pain and dying, even those places can become invaded by a breath, a fragrance, a melody from the new creation, by the life-giving Spirit of Christ. That's why we are called to care for our patients in the light of the future. In fact Christian love can only be intelligible, can only make sense, in the light of the Christian hope.

'Love always protects, always trusts, always hopes, always perseveres. Love never fails…' (1 Corinthians 13:7)

From an earthly perspective it seems that, all too often, love does fail. You pour out your love, your care, your time and attention and then it's gone. It seems so often as though your love is thrown back in your face. To show persistent, sacrificial love to a disabled child, a violent disturbed adolescent, a chronic schizophrenic, may seem pointless, futile, and meaningless.

But the words of Paul remind us and rebuke us when we are despairing – '*Love never fails*'.

This hope, reflected in Paul's first letter to the Corinthians, is that though tongues will fail, prophecies will become unnecessary and partial knowledge will become complete, those hidden acts of genuine love and compassion will somehow remain. In some mysterious way they will become part of, become incorporated into the new heaven and the new earth.

By God's grace those who were round her bedside will meet my mother again. And together we will walk and laugh and sing in the new heaven and new earth. The love poured out years ago has not been lost or forgotten.

'Love never fails'.

John Wyatt *is Emeritus Professor of Neonatal Paediatrics at University College London.*

By God's grace those who were round her bedside will meet my mother again. And together we will walk and laugh and sing in the new heaven and new earth

Peter May surveys the role of ideology in the debate over homosexuality

WHEN IDEOLOGY REPLACES SCIENCE

key points

- The RCPSych appears to have locked itself into a 'born gay' ideology by ignoring the evidence to the contrary.
- A Private Members' Motion to regulate psychotherapy includes a highly illiberal clause outlawing psychotherapy for people who want help in reducing unwanted same-sex desires.
- The UK Council for Psychotherapy has been repeatedly asked to provide evidence for their claim that reparative therapy is harmful – but none has been offered.

In January 2013, a retired engineer published a remarkable paper. He examined in detail the 2007 submission by the Royal College of Psychiatrists to the Church of England's Listening Exercise on Human Sexuality and their almost identical submission to the Pilling Commission in 2012. Rarely, when doctors read medical papers do they examine all the footnotes, but Dermot O'Callaghan did.

The origins of homosexuality

He noticed that the College had made a significant alteration to their original report. The first said, 'It would appear that sexual orientation is biological in nature, determined by a complex interplay of genetic factors and the early uterine environment.' The second version however, says that it is 'determined by genetic factors *and/or* the early uterine environment'.

While the first version implied that genetic and hormonal influences work together in this, the second version logically allows that orientation could be caused entirely by genes or entirely by hormones. Conversely, it may have nothing to do with genes or nothing to do with hormones. The College thereby admits that there is no compelling evidence to say it is genetic or hormonal. Where then is the evidence that orientation is biological in nature?

Regrettably, the College ignores twin studies, a major research field for two decades. An important study published in 2000[1] showed that among male identical twins, where one was gay, there was an 89% chance that his co-twin was not. As they shared essentially identical genes and intrauterine environments, this implies the importance of later postnatal, non-biological causes, such as life events or choices, in determining sexual orientation. Certainly, genes do not dictate behaviour. Alcoholics, for instance, can resist their genetically influenced cravings. These studies also show that the common analogy with skin colour is demonstrably false.

The College claims, 'There is no substantive evidence to support the suggestion that the nature of parenting or early childhood experiences play any role in the formation of a person's fundamental heterosexual or homosexual orientation.'

Yet in 2006, a major Danish study reported, 'population-based, prospective evidence that childhood family experiences are important determinants of heterosexual and homosexual marriage decisions in adulthood.'[2] The College appears to have locked itself into a 'born gay' ideology by ignoring the evidence to the contrary. Its argument that causation is 'biological' has led to the

widespread belief that LGB people are being 'true to their nature' in homosexual behaviour.

The psychological and social wellbeing of LGB people

The College claims that 'discrimination in society... means...that some LGB people experience a greater than expected prevalence of mental health and substance misuse problems'.

It tells us that the first civil partnerships were in Denmark (1989) but doesn't mention a study carried out in that 'undiscriminating' society. Over a twelve year period, the incidence of suicide for homosexual men in civil partnerships was found to be eight times that of heterosexual men in marriages. [3]

To support its contention that increased mental illness is mainly due to discrimination and social rejection, the College cites three papers, which do not actually support that view. One stated, 'the precise causal mechanism at this point remains unknown. Therefore studies are needed...to evaluate the relative salience of social stigmatisation and lifestyle factors...'. [4]

The second paper was by Prof Michael King, [5] the lead author of the College submissions. While the College says that 'discrimination in society...means that some LGB people experience a greater than expected prevalence of mental health and substance misuse problems', his academic paper goes on to state, 'Conversely, gay men and lesbians may have lifestyles that make them vulnerable to psychological disorder.' Why does King not admit this in his submissions to the Church?

The third paper goes further: 'many people will conclude that widespread prejudice against homosexual people causes them to be unhappy or mentally ill. [This view] would be premature however and should be discouraged. In fact a number of potential interpretations need to be considered...'. [6] While none of their referenced papers actually supports the College viewpoint, this paper specifically cautions against it.

Reparative therapy

The College submission addresses the issue of reparative therapy, shortly to come before Parliament. A Private Members' Motion to regulate psychotherapy includes a highly illiberal clause outlawing psychotherapy for people who want help in reducing unwanted same-sex desires. This may be to safeguard their marriages, protect the wellbeing of their children, or because they believe that homosexual acts are wrong or such desires are socially uncomfortable. Several matters require comment.

First, there is an underlying assumption being made that a person's sexual orientation is fixed and it would be harmful to try and change it. However, there is considerable evidence that, for some, sexual orientation is fluid, and can change over the course of life, with or without therapy. This is particularly well documented among young people [7] and among women. [8,9] Furthermore, it is now recognised that more people are bisexual than homosexual, their orientation being essentially fluid. [10]

Second, evidence of harm harks back to 50 years ago, when electric shock and drug therapies were being used to 'cure' homosexual behaviour. This has nothing to do with modern psychotherapeutic methods aimed at changing or ameliorating intrusive desires. The College says one study 'showed...considerable harm', [11] but that research was retrospective, did not use any measures of harm and was unable to show a causal relationship between therapy and harm.

Third, the College, which claims to believe strongly in evidence-based treatment, ignores very good evidence of psychotherapeutic benefits. The best study available today concludes, 'the findings...appear to contradict the commonly expressed view that sexual orientation is not changeable and that the attempt to change is highly likely to result in harm.' [12]

Another study is said by the College to have claimed change 'in 13% of LGB people, most of whom could be regarded as bisexual at the outset'. In fact, that study actually claimed that *the majority of participants experienced change from predominantly or exclusively homosexual orientation*. [13] This is seriously misreported by the College.

Finally, the UK Council for Psychotherapy has been repeatedly asked to provide evidence for their claim that such treatment is harmful – but none has been offered.

Outcome

These findings were published in a booklet [14] and sent to Prof Sue Bailey, President of the Royal College of Psychiatrists on 11 April 2013, with a letter inviting the College to do one of three things: to withdraw, amend or publicly re-affirm their submission to the Church in the light of these findings. She has taken a fourth option: she has not replied!

The booklet was also sent to Sir Joseph Pilling, Chairman of the Church of England's Working Group on Human Sexuality, suggesting that he, on behalf of the Church, might engage directly with the College on these scientific matters. In his Report [15] he has commented unfavourably on the College's use of science but does not appear to have taken up any of these issues with them.

The past year has seen an international revolution in public and political thinking about homosexuality. Gay Marriage has been approved by Parliament and the Pilling Commission has reported to the Church. Yet the College has refused to address any of these fundamental issues, which undermine the advice they have given.

Now we are faced with a debate in Parliament as to whether people with unwanted same-sex desires have any right in law to seek counselling to change or ameliorate those desires. Prof Michael King has said, 'It is anachronistic even to have these debates. Society has moved on from this issue.'

But moved on from what – the science? Given its provisional nature, science itself can move on.

Christians have a mandate from Christ to love and care for all people, including those who struggle with their sexuality

The Counsellors and Psychotherapists (Regulation) Bill states: 'The code must include a prohibition on gay to straight conversion therapy' [Section 2 (3)] and 'A breach of that section of the code relating to prohibition of gay to straight therapy shall result in permanent removal from the register.' [Section 3 (2)]

Editor's note:
At the time of going to press, we understand the College is reviewing its statement on sexuality in the light of these criticisms.

But if you move on from the objectivity of science, what do you move towards? Only to a fantasy world, where all truth is subjective, malleable, prejudiced and relative. It is a world where all truths appear to be tolerated, until a bullying intolerant Bill, like the current one, comes before Parliament.

What is the science that undergirds our understanding of homosexuality? And who are its custodians? For the past 40 years, psychiatrists have not recognised homosexuality as being a mental illness, so it is no longer their business. Yet when Church and State wish to address the subject, the Royal College of Psychiatrists is the only Royal College to offer submissions – and their views are influential all over the world. Ironically, it has taken an engineer to expose fundamental flaws in the ideological 'science' they have put forward.

Christians have a mandate from Christ to love and care for all people, including those who struggle with their sexuality. Would Jesus refuse help to a man troubled by unwanted same-sex desires, which threaten his marriage and the security of his children?

We also have a mandate to be passionate and honest about truth and to strive to teach it accurately. All truth belongs to God, and all untruths deny him. We must insist that love and truth are essential values in public discourse.

Peter May *is a retired GP in Southampton.*

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Christians and same-sex attraction

This article by Peter May illustrates just some of the difficulties involved in talking about sex in the public square. Societal attitudes to sexuality have undergone significant and rapid change in recent years. Participation in public discourse has become fraught with difficulties for those of us who uphold that the right context for sex is within marriage between a man and a woman. We are likely to be perceived as lacking love and compassion.

Just because public perceptions have changed, however, it does not follow that Christians are bound to fall in with these changed attitudes. Nor is it of itself 'homophobic' – as the Church of England's 'Pilling Report' rightly insists – to hold to an historical and classic view of sex and marriage.

The Bible is very clear that all sexual relations outside marriage (a life-long exclusive monogamous heterosexual public covenant relationship) are morally wrong (Leviticus 18:6-23, 20:10-21; Romans 1:26-27; 1 Corinthians 6:9,10; Colossians 3:5; 1 Thessalonians 4:3; 1 Timothy 1:9-10; Revelation 22:15). This includes fornication, adultery, same-sex relations and all other sorts of sex imaginable, *even if you are deeply in love with the other person*.

As Christians we need to watch our language. We are witnesses to the love of Christ in our churches, neighbourhoods and in the public square. We need to address those with whom we disagree with utmost courtesy. We need to be aware that there are fellow Christians who experience same-sex attraction where inappropriate language can wound and discourage them in their discipleship.

For these reasons we warmly welcome the recent launch of the *Living Out* website,[16] containing articles, videos and personal stories to help and encourage Christians experiencing same-sex attraction. It is offered by men in pastoral ministry who admit to feelings of same-sex attraction but who also see the Bible's prohibitions on same-sex erotic relationships as non-negotiable.

The testimonies of those Christian leaders featured on the Living Out site are clear, powerful, hugely encouraging and most welcome at a time when many young evangelicals are genuinely confused about the issue.

Sean Doherty, who has experienced some degree of shift in his sexual feelings and is now married, explains how his own church experience helped him:

'Church was a place of nurture and unconditional acceptance, but at the same time the teaching was clear that I shouldn't act on those sexual desires. In an environment where young people were being encouraged to experiment, I was really grateful that I had been kept from acting on my feelings.[17]

He is reluctant to describe himself as gay and instead adopts terminology adopted by blogger Peter Ould who has a similar testimony:

'I don't speak of myself as an "ex-gay" person. I prefer the term "post-gay". You choose to move away from the label of "gay" altogether, which has come to be associated with a certain lifestyle. I've clearly experienced some change in my feelings so that I am attracted to my wife. But it's definitely not a 180-degree reorientation. All of us will continue to have desires and feelings which aren't right, until Jesus returns.' [18]

Sam Alberry and Ed Shaw share Doherty's perspective, but accept that they will remain celibate if their orientation does not change.

Last year Vaughan Roberts, a leading conservative evangelical, spoke for the first time of his own struggle with same-sex attraction in an interview with *Evangelicals Now*.[19] His testimony is clear, biblical, passionate and pastoral and well worthy of study.

The testimony of these men demonstrates the goodness of God, the wisdom of his pattern for our lives and also the fact that he grants his grace and power to enable us to live in ways which are both fulfilling and also pleasing to him.

John Martin
Peter Saunders
Editors

Liz Croton looks at the dangers of addiction for doctors

ADDICTION
AND THE CHRISTIAN DOCTOR

In 1998, a BMA Working Group report estimated that as many as 'one doctor in fifteen may be affected by drug or alcohol problems at some point in their career'.[1] The Practitioner Health Programme (PHP) was established in 2008 to provide assessment and treatment for doctors experiencing addiction and mental health problems in the London area. Over a three year period, 142 doctors with an addiction diagnosis were treated.[2] The reason for starting with statistics is to reassure you that, if you are struggling with drugs or alcohol, you are not alone.

If you were to transpose PHP's figures nationally, one wonders how many Christian doctors are afflicted. Yet the subject of addiction can be a taboo in our churches and amongst other professionals. CMF tackled the problem of drug and alcohol addiction amongst doctors back in 1997 with the publication of the booklet *Doctors, Drink and Drugs*, available on the CMF website.[3] This is a valuable resource for those wanting a biblical exposition of addiction and is essential reading in addition to this article.

This piece was written primarily to provide hope to those Christians concerned that they may have a problem with drugs and/or alcohol and to signpost the way out. You see, we may know factually that the Lord has promised never to leave us (Joshua 1:5b), but it can seem impossible to rekindle this relationship with God with this new idol (our drug of choice standing in the way). Doctors are intelligent individuals and compensate well. Addicted physicians may actually appear to function well on a superficial level until quite late into their illness, which has obvious ramifications for patient safety. There is tremendous professional pride which can impair help-seeking coupled with the denial that goes hand in hand with the addictive process. One thinks 'I can handle this', 'Just one last time', and so the excuses go on.

So how do we know if we have a problem? Narcotics Anonymous have produced a yes/no questionnaire on their website but add in the footnote, 'The actual number of yes responses wasn't as important as how we felt inside and how addiction had affected our lives.'[4] A member of Alcoholics Anonymous put it more simply, 'It's when alcohol costs you more than money.'[5] Two themes seem important here with addiction. One is a loss of control over use and the other is the repetition of the behaviour despite the negative consequences.

For a Christian, his or her relationship with God will be affected hugely. The addict can vacillate between desiring God but wanting the drugs and the booze more, and desperately hoping that God will understand. To make matters more complicated, the behaviours that go along with active addiction, the lies and the secrecy fill the sufferer with so much shame that it can seem as though God has given up on them.

The solution lies in a surrender and admission of powerlessness over alcohol and drugs. Recovery from addiction works best when it involves other recovering people who can provide accountability and support. The PHP website[6] provides a number of useful links to other local mutual support groups for addicted doctors and their families situated outside the London area. A short period of inpatient rehabilitation may be useful for some.

The 12-step groups (Alcoholics Anonymous and Narcotics Anonymous) are countrywide and easily accessible. Their 12-step programmes, originally developed from biblical principles (The Sermon on the Mount and the Book of James) provide a highly effective form of lay 'group psychotherapy'. This helps the individual to see the aspects of their personalities that made them susceptible to addiction and accept the responsibility for changing them. The groups have a spiritual dimension and members are encouraged to depend on a 'Higher Power'. Christians will have no difficulty with this and far from abandoning us, God can use these groups to restore us to relationship with him. Ultimately for Christians, the solution is utter dependence on Jesus Christ and an understanding of his grace which helps us in our weaknesses (2 Corinthians 12:9).

***Liz Croton** is a GP in Birmingham.*

useful websites

- The British Doctors and Dentists Group
  www.form2list.com/bddg/page.php?id=1
  A mutual support society for Doctors and Dentists with addiction or dependency problems
- Practitioner Health Programme
  www.php.nhs.uk
- Narcotics anonymous UK
  www.ukna.org
- Alcoholics Anonymous UK
  www.alcoholics-anonymous.org.uk

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6. *www.php.nhs.uk*

Donna Harrison examines the evidence for an abortion-breast cancer link

ABORTION & BREAST CANCER

WOMEN HAVE A RIGHT TO KNOW THE FACTS

key points

- Huge academic, political and financial pressure exists to promote elective abortion and to suppress concerns about the health of women who undergo elective abortion.
- A previous meta-analysis rejecting a link between abortion and risk of breast cancer has serious methodological errors, which undermine its conclusions.
- Evidence increasingly indicates that abortion keeps a woman's breasts in a developmental stage which increases breast susceptibility to carcinogenic changes.

To make a fully informed choice about reproductive health decisions, women need to understand the effect of reproductive factors on their risk of developing of breast cancer. Understanding basic breast physiology makes understanding the risk factors simple.

Before a first pregnancy, a woman's breast contains immature breast tissue, which is incapable of producing milk, and which is very susceptible to forming cancer. During the first 20 weeks of pregnancy, hormones from the pregnancy (oestrogen) cause the immature breast tissue to grow rapidly, giving symptoms of breast tenderness. It is not until the third trimester that this immature breast tissue begins to mature (differentiate) into breast tissue capable of lactation. And it is not until 32 weeks that the mature breast tissue predominates. Breast tissue that is capable of producing milk is resistant to forming cancer. Two simple corollaries follow:

1. The longer a woman has immature breast tissue rather than mature breast tissue, the higher her risk of cancer. This makes sense of the risk profiles for breast cancer: the low risk woman is one who avoids hormonal contraception in her teens, bears several children from her early twenties onward, breastfeeds each child for at least six months, and has few or no interruptions of a pregnancy before 32 weeks gestation. The high risk woman is one who is exposed to more than one year of hormonal contraception in her teens, is nulliparous or delays childbearing until after age 30, has pregnancy losses before 32 weeks and before a term pregnancy, has few total children and does not breastfeed.
2. Ending a pregnancy prior to 32 weeks gestation, then delaying subsequent term pregnancy arrests the breast tissue in an immature state, susceptible to subsequent mutational changes resulting in breast cancer. Studies have demonstrated that ending a pregnancy before 32 weeks, especially in a woman whose breast tissue has not been matured by completing a term pregnancy, results in an increased risk of breast cancer.[1] Thus a woman with a second trimester loss from abruption or traumatic loss from a motor vehicle accident, is at higher risk for subsequent breast cancer. And so is the woman who voluntarily interrupts her pregnancy in either first or second trimester.

But this corollary is exceedingly inconvenient. Tremendous academic, political and financial pressure exists to promote elective abortion and to suppress concerns that may arise about the health of women who undergo elective abortion. Studies designed to investigate the association between breast cancer and abortion often resort to errant methodology which obscures the actual scientific question they were purported to answer. One excellent example of errant methodology is a frequently cited meta-analysis by Beral et al (2004)[2] on which the RCOG leans heavily in formulating its abortion guidance.[3] The authors report no association between abortion and breast cancer. But how did they arrive at that conclusion?

The Beral study incorporated a number of

different methodological errors, three of which are briefly discussed here:

1. **Biased data selection**: The studies reviewed were divided into two types: retrospective and prospective. Analysis of the 39 retrospective studies demonstrated an increased risk of breast cancer with induced abortion. Analysis of the 13 prospective studies showed a decreased risk of breast cancer with induced abortion. The authors handled this conflict by discarding the retrospective studies on the unsubstantiated grounds that the 39 studies all had 'recall bias' and were thus unreliable. Interestingly the authors also admitted that it was possible that recall bias also could have taken place in the prospective studies, but did not reject the prospective studies. The authors offer no substantiation for discarding 39 studies in favor of a sub-analysis of 13 studies. Further, they excluded 13 peer-reviewed studies and failed to note the existence of at least five additional datasets.[4]
2. **Unsuitable comparison group**: The authors compared the breast cancer risk of women who aborted with the risk of women 'never having had that pregnancy'. If by this obscure wording, the authors meant women who have never been pregnant, then both sets of women are at increased risk of breast cancer. The appropriate comparison should have been between women who completed their pregnancy to term and women who elected to abort.
3. **No stratification for the gestational age of the abortion**: The expected effect of an elective abortion on breast cancer risk depends upon stimulation of the immature breast tissue by pregnancy hormones. Thus one would expect a much greater effect from second vs first trimester terminations of pregnancy. Without this subgroup analysis, the authors cannot correctly conclude that induced abortion has no effect on the risk of breast cancer.

These types of methodological errors are not confined to the Beral study. A recently released paper[5] reviews published research to date, and includes a discussion of twelve common methodological errors found in papers on breast cancer and abortion including the following :

1. Incomplete questionnaires, low user response and unsuitable circumstances for data collection.
2. Incorrect time frames for obtaining data (It takes 8-10 years after an abortion for a breast cancer initiated by the abortion to reach clinically detectable 1cm size)
3. Unsuitable comparison groups
4. Combining data from induced and spontaneous abortions
5. Publication bias (excluding data without scientific grounds for exclusion)
6. Insufficient sample populations
7. No distinction between first and second trimester abortions

One may also find that the data published give information not mentioned in the author's conclusions. Dolle[6] and researchers from the National Cancer Institute in the US published a study in 2009 which included a table of the relative risk of triple negative breast cancer in relation to reproductive factors. Table 1 in their study reveals a relative risk of 1.4 (ie 40% increased risk) for women who reported any induced abortion compared to women who reported no induced abortion.

A new 2014 meta-analysis of 36 studies by Huang et al looked specifically at the relationship between induced abortion (IA) and breast cancer. It found that IA is significantly associated with an increased risk of breast cancer among Chinese females, and that the risk of breast cancer increases as the number of IAs increases. Women who had had at least one IA had a relative risk of 1.44 (ie. 44% increased risk). For those who had had at least two or at least three IAs the figures were 1.76 and 1.89 respectively.[7]

Lecarpentier, using a database from the French National BRCA cohort, confirmed the association between terminations of pregnancies before the first term pregnancy and breast cancer in women who have genetic susceptibility to breast cancer (BRCA mutations). They found that in women who carry the breast cancer gene, full term pregnancies lower the risk of breast cancer. But, when women who carry the breast cancer gene end their pregnancy before having a full term pregnancy, then these women are at much higher risk of breast cancer. For women who had terminated three pregnancies before a term pregnancy, their risk increased 239% [HR 2.39 95% CI 1.28-4.45].[8]

This is critically important information that women who have a BRCA gene mutation have a right to be made aware of when considering terminating their pregnancies.

As research on the association between breast cancer and a woman's reproductive history continues, it is becoming increasingly evident that elective abortion not only robs a woman of the protection of a full term pregnancy, but also arrests her breasts in a developmental stage which increases breast susceptibility to carcinogenic changes. In a society that values informed consent, it is essential that women be made aware of this increased risk prior to obtaining an induced abortion, and that the risk be appropriately stratified by the gestational age of the fetus at the time of abortion. In order for women to control their reproductive capabilities, they must be informed of the implications that their reproductive choices may have on their future health.

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Studies examining the association between breast cancer and abortion often resort to errant methodology which obscures the scientific question they were purported to answer

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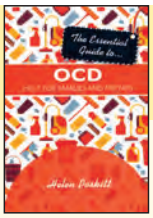
reviews



The Essential Guide to OCD:

Help for Families and Friends
Helen Poskitt

- Lion Books, 2013, £8.99 Pb 176pp, ISBN 9780745955803
- Reviewed by **Chris Williams**, Professor of Psychosocial Psychiatry, University of Glasgow

The author has gone to a lot of effort letting the sufferer – and their families and friends – be listened to. The book is structured around extensive quotes from OCD sufferers so that all the main presentations of OCD – rumina-tions, checking, cleaning etc are well-covered. This approach works well so the reader gets a very full understanding of what life with OCD is like.

The same approach is attempted with practitioners, but less successfully as few responded to the author's request for interview. The result is that some content does not always reflect current treatment guidelines.

Whilst the book is strong on understanding OCD, it falls short on describing interventions in a way that could enable change. It is not a self-help book and aims to inform rather than help the reader change or self-manage their symptoms. Likewise, inter-ventions are described but not prioritised – so similar levels of information are provided for some non-evidence based treat-ments and rarely used approaches (eg psychosurgery) perhaps leading to confusion in readers' minds.

In summary – this book will help readers understand OCD, but is weaker in helping explain what can be done to help.

Thank You with a smile:

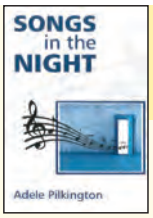
A personal battle with mouth cancer
Christine Dunningham

- Trafford Publishing, 2008, £7.99 Pb 104 pp, ISBN 9781425170806
- Reviewed by **Andrew Brown**, retired Maxillofacial/Head & Neck Surgeon

Mouth cancer is an under-recognised form of malig-nancy by many doctors. Patients, when given the diagnosis, may even express surprise that it exists. However, there is evidence that it is on the increase in the UK and this personal memoir confirms that it is not confined to the traditional heavy smoker and heavy drinker.

This short account of combined complex surgery and radiotherapy is essentially an expanded personal diary. Key reminders it contains for profes-sionals are the importance of a strong support network in coping with devastating illness, the role of 'lesser' members of the multi-disciplinary team in coming alongside at critical moments, the frightening environment of the intensive care unit if communication is difficult, the near bereavement experience of losing taken for granted normal oral function, and the deleterious long term effects of radiotherapy on the oral cavity.

Unfortunately the personal recounting of the day to day medical events, plus the naming of many friends and family members, may make this book of limited value to general readers. However, the author's positive approach, undergirded by her personal faith in Christ, shines through; as do the caring support of her husband and the prayerful encouragement of her church fellowship. Other patients are much less fortunate in this regard.



Songs in the night

Adele Pilkington

- Onwards and Upwards, 2013, £9.99 Pb 84pp, ISBN 9781907509711
- Reviewed by **John Caroe**, retired General Practitioner

This is a collection of 60 short poems covering a range of everyday spiritual ideas and situations. These poems have evidently been written by Adele Pilkington as a personal expression of her wonder, gratitude and love for her Lord. It takes great courage to share such things.

Poetry springs from the heart, and seeks to speak to the hearts of others. It does not generally pretend to arise primarily from intellectual understanding, yet in communicating its message it may submit to the cerebral disci-pline of rhyme, meter and language to different degrees. Readers will vary in their particular taste for the range of styles thus available to a writer.

Those who are setting out on their exploration of poetry and the faith may well respond to Adele's clear adherence to the basic tenets of poetry that we all learn. Those who seek to fly higher in the Spirit into the wonders of the spiritual realm with Jesus may find here that the worldly rulebook detracts attention from the journey into those mysteries.

Well done to Adele (and to CMF) for the courage to explore this vital mode of communication and communion that when anointed can speak deeper than many an essay in prose.

Primary Healthcare in East Africa

For how long shall countries run after diseases?
Nick Wooding, Teddy Nagaddya & Florence Nakaggwa

- Fountain Publishers Kampala, 2012, £10.00 Pb 322pp, ISBN 9789970251483 (To purchase email *nickwooding@doctors.net.uk*)
- Reviewed by **Emma Pedlar**, medical student in Manchester

The 1978 Alma Ata Declaration saw primary healthcare (PHC) as the key to solving the world's healthcare problems. CMF member Nick Wooding and African colleagues ask, 'In the intervening 30 years has health for all been achieved?'

Their focus is largely on Uganda with examples from other East African countries, referring to the Millennium Development Goals as a platform for evaluation.

The authors include a detailed overview of the fundamental principles of PHC in Uganda and other East African countries. Selective and comprehensive PHC are compared, and case studies demonstrate effective strategies. The book emphasises community participation, with examples of successful partnership and problem solving. It provides methods of healthcare system evaluation which can be used in other contexts.

This is an excellent reference source for anyone interested in PHC in East Africa, whether academically or practically. I found it particularly useful in studying for a Masters in Public Health even though my country of interest is Malawi. There are many useful principles which are transferable.

It is particularly helpful to have a resource which is supportive of the role of faith-based organisa-tions in providing for people's needs. It concludes that although providing Uganda with access to basic PHC is a challenge, it is worth it, so to keep pushing on!

My Right Hand in the Father's:
Knowing God's comfort and strength through breast cancer
Helen E Jones

- Verite CM Ltd, 2012, £7.99 Pb 160pp, ISBN 9781907636530
- Review by **Helen Sweetland**, Consultant Breast Surgeon in Cardiff

This is Helen's personal story of her diagnosis and treatment for breast cancer, including surgery and chemotherapy. It is an honest reflection of how she and her family (including two young sons), dealt with that journey.

The account of the physical and emotional effects of treatment is permeated by her testimony of how her Christian faith was challenged by events yet grew stronger as the months progressed. She was supported by Christian friends and relatives, who are the focus of many of the situations described, and there are many humorous anecdotes.

Each chapter is short but with plenty of food for thought. Alongside the facts there are inspiring Bible verses, hymns, poems and prayers that have helped Helen through this challenging time. Each chapter could be used as a focus for personal meditation on God's love and care.

This book would be helpful to someone dealing with breast cancer treatment and friends or relatives, as it provides useful insights into how patients, carers and friends can react to each other during treatment. It gives guidance on simple practical ways of providing care and support for someone in that situation. A helpful chapter on life after treatment provides useful tips on how to deal with life physically and spiritually.

So many Everests:
From Cerebral Palsy to Casualty Consultant
Diana and Victoria Webster

- Lion Books, 2012, £8.05 240pp Pb ISBN 9780745955957
- Reviewed by **Jean Maxwell**, retired consultant in Palliative Medicine

This is the story of Spratty, real name Victoria, who was born in 1965 with cerebral palsy and a generous helping of determination. The book is set mostly in Finland and told first by her mother Diana, and then by Victoria herself.

Although eager to keep reading, I felt confused by a health system that I could not identify with, and frustrated for the family by the obstacles they faced. The unexpected death of her father, the problems at school, her struggles to improve a speech impairment and the prejudice she faced by others painted a picture I hope would not be seen today – but maybe it would, and maybe that is the reason to read this book.

As I read the determined accounts of being accepted for medical training, I remained confused that her suitability then continued to be questioned. I found the decision making through her training a little tedious, but felt endless admiration for her achievements, and particularly how she introduces herself to patients. 'Hello, I'm Victoria Webster. I'm your doctor. I have a speech handicap, but I hope it doesn't bother you'. And it didn't seem to, which is as it should be. She finally reached the top of the mountain – and is the first Casualty Consultant in Scandinavia.

Soul Pain: *Priests reflect on personal experiences of serious and terminal illness*
Jennifer Tann (ed)

- Canterbury Press, 2013, £16.99 Pb 244pp, ISBN 9781848252776
- Reviewed by **Claire Stark Toller**, Locum Consultant in Palliative Medicine

This collection of essays is written by Anglican ministers who have experienced serious or terminal illness. The opening chapter explores the meaning of 'healing' and 'wholeness', examining biblical accounts of healing and Jesus' experience in the Garden of Gethsemane, and reviewing these concepts in ancient and current Christian writings.

Topics covered include living with stroke, experiencing multiple miscarriages and living with leukaemia. One recounts a recovery from acute heart failure described by his cardiologists as a miracle. The final chapter encourages the sufferer to lament, and offer this as worship to God.

Many of these reflections could be shared by any Christian but several contributors highlight the impact it has had on their ministry. One reflects on the suffering minister as an 'icon of Christ' revealing the sufferings of Jesus. Others struggle to know how to manifest their suffering when some parishioners expect them to bear their illness with unswerving courage. One notes how his experiences help him empathise with sick parishioners.

This book would be helpful to anyone, and to Christian ministers in particular, wishing to explore suffering in the life of the Christian. It could also provide insights for doctors facing their own illness and considering its impact on their therapeutic relationship with patients.

Serving without sinking:
How to serve Christ and keep your joy
John Hindley

- Good Book Company, 2013, £6.79 128pp, ISBN 9781908762351
- Reviewed by **Emma Pedlar**, medical student in Manchester

Have you ever thought 'well now I can tick that bit of service off the list'? Or felt overwhelmed by all the commitments you've signed up to? If like me the answer is yes, then here is a book is for you!

Serving without sinking begins by examining our attitudes towards serving, and shows how we can get our perspective all wrong. Hindley then realigns our thinking: the Bible says Jesus came to serve us. By Jesus' death we are given a new identity; we are friends, children and his bride. We don't grumble about helping our friends; a child should delight in pleasing her parents; we love to make our loved ones happy.

We should think the same way about serving God. Serving is a privilege, and our righteous acts make up the wedding dress of the bride. Hindley concludes by noting that we are spoken of as God's servants, but this must be seen in light of the other aspects of our identity in Christ. When we recognise that God is good, loving and gracious, and that Jesus sustains us by his Spirit, prays for us and is with us as we serve, then we can delight in having such a master. Serving is Jesus' gift to us, and this short, readable book shows us how joyful it can be.

eutychus

Anger: bad for health

'In your anger do not sin: do not let the sun go down while you are still angry,' warns Ephesians 4:26. The Bible is replete with warnings not to indulge anger. Now, new research cited by the British Heart Foundation reinforces age-old biblical wisdom about the need to find ways to avoid anger. The dangers to health are clear. BHF says in the two hours after feeling angry, the risk of a heart attack increases nearly five-fold and the risk of stroke more than three-fold. (*BHF website*, 5 February 2014 *bit.ly/1kAmqnD*)

'Cut down on sugar' says WHO

Activists supporting William Wilberforce boycotted sugar, because of its links to the North Atlantic slave trade. Now the WHO wants people to halve sugar intake because of its link to obesity and tooth decay. New WHO draft guidelines propose sugars should be less than 10% of total daily energy intake and say an even more drastic reduction to below 5% (six teaspoons) would be beneficial. Many are unaware of 'hidden' sugar in processed foods: ketchup (one tablespoon contains around one teaspoon), a can of sugar-sweetened soda (ten teaspoons). (*WHO,* 5 March 2014 *bit.ly/1hMsoy5*)

Smoking still a global issue

Smoking has become less popular in some countries but overall numbers of smokers continues to rise. In 2012, 967 million people smoked every day compared with 721 million in 1980 according to data from 187 countries. Patterns are changing. Countries such as Canada, Iceland, Norway and Mexico have mounted successful campaigns to persuade citizens to quit. People most likely to take up smoking live in resource-poor countries. Top of the league is East Timor with 61% of its population smoking every day. Next in line are Indonesia, Kiribati, Armenia and Papua New Guinea. (*JAMA*, 8 January 2014 *bit.ly/1q5AOFl*)

Three-parent children

Another flawed consultation process. The Department of Health has published draft regulations to implement mitochondrial donation to prevent the transmission of serious mitochondrial disease from mother to child. Deadline for responses is 21 May. The process flagrantly sweeps aside ethical considerations, side-stepping whether this is desirable, focusing merely on how it should be implemented. *CMF File* 51 (2013) anticipated this issue and concluded: '...it would seem wiser, given the scientific uncertainty, ethical problems and availability of alternative approaches, if we did not take a further step down that road.' (*BBC Health*, 27 February 2014 *bbc.in/1kJF3Wh*)

Male suicide higher than female

Males: the stronger sex? Not according to 2012 suicide statistics released in February (Office of National Statistics). Male suicide deaths were 4,590 compared to 1,391 female, a ratio of more than 3 to 1. Suicides among males aged 45-59 are 40% higher than a decade ago. Stalling careers is a commonly cited cause. The Samaritans claim men from the most socially deprived areas are ten times more likely to commit suicide than those from most affluent areas. Decline of traditionally male industries is cited as another key factor. (*Mail Online*, 19 February 2014 *dailym.ai/1cR7qK9*)

Blaming LCP is 'like blaming the Highway Code'

Debate about the Liverpool Care Pathway continues despite recommendations that it is no longer used. There are worries among health professionals about creating an alternative system likely to meet the same fate in a few years. Dr Claud Regnard, a consultant in palliative medicine in Newcastle-upon-Tyne, suggests the media, government and the Neuberger panel were wrong to finger the LCP. Human error was the core problem: issues about communication, training and decision-making. Blaming the LCP was like 'blaming the Highway Code because of a few bad drivers'. (*BBC Health*, 14 January 2014 *bbc.in/1nFJeRG*)

After antibiotics, what?

In May the World Health Assembly is set to discuss a scenario where antibiotics no longer work. Professor Jeremy Farrar, the new head of Wellcome, the medical research charity, said in his first media interview in the job that the growing threat of antibiotic resistant organisms is set to become a 'truly global issue'. He said the golden age of antibiotics could soon come to an end unless action is taken. He echoed the views of England's Chief Medical Officer Dame Sally Davies who said last year that growing resistance to antibiotics is a 'ticking time bomb', presenting a threat to the nation that should rank alongside terrorism. (*BBC Health*, 8 January 2014 *bbc.in/19dOrwU*)

Teenagers reject booze

We tend to think of binge drinking as a teenage vice. In reality, however, the number of young people in the UK consuming alcohol has declined sharply. It's middle aged people who are more likely to drink too much. NHS statistics gathered in 2011 show just 12% of 11 to 15-year olds said they had drunk alcohol in the previous week, that's down from 26% a decade earlier. The proportion who said they had ever drunk alcohol fell from 61% to 45% over the same period. (Health and Social Care Information Centre, 2012 *bit.ly/1onvVUm*)

Quality of care threatened

Cutting senior nursing posts is causing a 'dangerous drain of experience and skills' in the NHS, the Royal College of Nursing claims in the new report. It says nearly 4,000 senior nursing posts have been cut since the Coalition came to power. Matrons, ward sisters and clinical nurse specialist posts are most affected. Official statistics reveal there are now 4,500 more nurses on wards than in May 2010, but this masks an 'under-the-radar haemorrhaging' of senior staff. RCN states that matrons and ward sisters are 'a vital part' of patient care. (RCN, *Frontline First*, 11 February 2014 *bit.ly/1cuk6Mb*)

Gruesome...

How else can we describe the reality behind revelations that the thousands of bodies of aborted and miscarried babies have been routinely incinerated, even used in 'waste to energy' plants to generate heating for hospitals? Ten NHS trusts admitted the practice in a Channel 4 *Dispatches* programme, aired on 24 March. At least 15,500 foetal remains were incinerated by 27 NHS trusts in the last 24 months. Parents who lose children in early pregnancy are often treated without compassion and not consulted about what they wanted to happen to the remains. (Report, *Telegraph,* 24 March 2014 *bit.ly/1dhsSxq*)

Samir Dawlatly offers an imaginative remake

A CORINTHIAN FRAGMENT

If I speak in the language of physicians or of surgeons, but do not have compassion, I am only a resounding gong or a clanging cymbal. If I have the ability to diagnose and can fathom all symptoms and all pathology and if I have a knowledge of evidence-based medicine that can answer almost any clinical dilemma, but do not have compassion, I am nothing. If I work for a pittance and give all my time to my patients, that I may boast to others of my selflessness, but do not have compassion, I gain nothing.

Compassion is patient, compassion is kind. It does not envy the ability of colleagues, it does not boast of correct diagnoses, it is not proud. It does not belittle patients, it is not self-seeking nor does it just tick boxes, it is not easily angered by lateness, it keeps no record of multiple DNAs. Compassion does not delight in the correct diagnosis but rejoices with the doctor-patient relationship. It always protects the patients' interests, always trusts in the humanity of interaction, always hopes for the best, often expecting the worse, always perseveres beyond the ten minute appointment.

Compassion should never fail. But where there are primary prevention medicines, they will one day cease; where there are explanations, they will be unnecessary; where there is evidence-based medicine, it will be superseded. For we know in part and we hope we are aware of what is unknown; but once the syringe driver is set up, the importance of our knowledge shrivels away.

When I was a student, I consulted like a student, I thought like a student, I reasoned like a student. When I became a doctor, I put the ways of childish student life behind me. For now we mostly diagnose illness based on what we can measure; in the future we should aim to view our patients as whole people. What can be measured is only part; I should aim to know them fully, even as I know myself.

And now these three remain: knowledge, consultation skills and compassion. But the greatest of these is compassion.

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