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for today's Christian doctor

triple helix

NHS at 60

GMC guidance, faith and health, conscience, consultation controversies, HFE Bill, cynicism, reviews, news from abroad

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The HFE Bill

A farcical footnote in history?

Press conference outside No. 10 Downing Street

As *Triple Helix* went to press the Human Fertilisation and Embryology Bill was entering its final Parliamentary stages. We have consistently argued that the proposals for animal-human hybrids, saviour siblings and removing the need for a father for IVF children threaten individual, family and societal life more than any other legislation for decades.[1] As well as being unethical this legislation is also unnecessary, because ethical alternatives to its proposals already exist.

However, the government has been determined to get it through and so far all amendments have failed. In the Lords a powerful lobby of medical peers and institutions like the Royal Society and Medical Research Council backed it and the government whip required peers to support every aspect. In the Commons a conscience vote was allowed on the three most controversial issues (hybrids, saviours, and fathers) following protests from the Catholic Church and Catholic government MPs. Consequently, MPs debated the issues rather than consigning them to a small committee, as is usual practice.

The day before, the Prime Minister made an impassioned personal appeal in the *Observer* for allowing animal-human hybrids, saying they would lead to cures for 'millions' of people. Although lip service was given to conscience, a three line whip on attendance ensured that all amendments attempting to ban hybrids and saviour siblings were heavily defeated.

The Bill has since spent four days in 'Public Bill Committee' with discussion about 'less controversial matters' like three parent embryos; artificial gametes; repeal of the Reproductive Cloning Act (which made the practice a criminal offence); and the use of tissue from children and mentally incapacitated and dead people to make hybrids. It now proceeds to Report and Third Reading, where government MPs, some of whom oppose embryo research *per se*, will be required to vote it through. Thereafter there will be a brief return to the Lords before Royal Assent.

Previous articles in *Triple Helix*,[2,3] and extensive resources on our website,[4] have tackled the bill in more detail but what will its ultimate impact be? During discussion in the Lords the new development of 'induced pluripotent stem cells' or ips, which could well make embryonic stem cell research redundant, was being announced.[5] Even before the HFEA had granted licences for London and Newcastle bids for animal-human hybrids, the Medical Research Council was offering £600,000 in grants and calling IPs 'a major breakthrough in stem cell research'.[6] This March the US National Institute of Health counted 1,987 clinical trials using adult stem cells, 106 using cord blood stem cells and none using embryonic stem cells.[7] Adult stem cell therapies are now used in over 70 diseases; cord blood cells in over 40; whilst embryonic stem cells treat none.

The morning after the vote, *Times* science correspondent Mark Henderson, who had campaigned vigorously for 'cybrids' and ridiculed religious leaders' objections, was far more cautious: 'Admixed embryos… are not going to lead to immediate medical breakthroughs…Any insights that they might offer into diseases such as Parkinson's and Alzheimer's, too, are probably years away…' but 'they could be used to investigate how [diabetes and motor neuron disease] progress, and to develop and test new drugs'.[8]

Prior to the vote, Professor Peter Braude, who chaired the RCOG committee on cord blood,[9] said in his view there would be no need for 'saviour siblings' in a few short years because of advances with cord blood and adult stem cell technology. Scientist Stephen Minger, who had fought so hard for his licence to make 'cybrids' before the Bill was passed because the need was so urgent, informed me he hadn't yet 'got the kit' and that starting the work would be months off.

Thus far no one anywhere has produced an embryonic line from a cloned human embryo, and the much-trumpeted work by Sheng, who claimed to have produced embryonic stem cells from 'cybrids' five years ago in Shanghai,[10] has never been repeated.

So what has all the hype been about? A few scientists have become household names. A Prime Minister's reputation has had a temporary reprieve. No doubt there will be now be many attempts to produce stem cells from animal-human hybrids, whilst resources are diverted away from the more profitable areas of adult and cord blood stem cell research. But is this just Emperor's new clothes technology? My suspicion is that 'cybrids' (or 'admixed human embryos' as they are euphemistically called), like savour siblings, will in a few short years become simply a farcical footnote in the history of science and a powerful testimony to the gullibility of patients and politicians driven to grasping at straws by what the Bible calls 'the fear of death'.[11] For my own part, I am looking to ethical research for cures for degenerative disease, and beyond that to the resurrection.

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

So what has all the hype been about?

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news reviews

'Diamond geezer' or ripe for retirement?

The NHS at 60

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

Where I was in general practice, a 'diamond geezer' was a respected, mature character, perhaps somewhat of a rough diamond, but a genuine survivor. Does this describe the National Health Service at 60, or, rather, should she now be pensioned off? Former Chancellor Nigel Lawson said the NHS was 'the nearest thing the English have to a religion'.[1] Its promise of care 'from the cradle to the grave' which (centrally funded from public taxation) was also free at the point of need, offered great relief for those who could not afford to pay, and for those who cared for them.

But as Rodney and Pearl Burnham note in their comprehensive review,[2] what cost £276 million in its first year is now costing £90 billion this year, and is set to rise. At a time of growing economic constraint, it may be the UK will have to review these grand plans. Financially and managerially, there are concerns about privatisation. Ministers recently caused controversy when they announced that private firms could be drafted in to run struggling NHS hospitals and primary care trusts in England.[3]

Meanwhile, there is growing discontent among staff. On pay, members of Unison, Britain's biggest health union, voted (perhaps against expectation) to accept a three-year pay offer from the government,[4] joining the Royal College of Nursing, but while these 1.1 million employees have settled, many midwives, cleaners and porters are still up for a fight.

Junior doctors are concerned about competition for jobs that means many face unemployment. Latest figures for England indicate that 18,000 doctors applied for around 8,800 training posts, with competition ratios as high as 25 to one in some specialties.[5] In addition, there are nationwide protests by juniors and by medical students that because of reduced working hours, free accommodation is being withdrawn, amounting to a pay cut of around £5,000 per year. This threat comes on top of fears of massive debts on graduation of more than £60,000, if the government raises the £3,000 cap on tuition fees to £7,000 when it reviews the system in 2009.[6]

There are tough times ahead and tough decisions to be taken that will never please all those involved, but it seems probable that the NHS will survive. CMF members may disagree about the best policies, but in the light of that key word 'service' we will surely want to do all we can to follow Jesus who said 'I am among you as one who serves'.[7]

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Abortion upper limit

We lost the vote but won the nation

Review by **Peter Saunders**
CMF General Secretary

'Abortion fight "will go on after next election", as MPs defy public opinion to keep 24-week limit', thundered the *Daily Mail*. 'Abortion debate: MPs are out of touch', concluded the *Telegraph*. 'Widespread disappointment at vote on abortion', observed the *Times*. These front page headlines, accompanied by high resolution ultrasound images of babies in the womb gave their judgment on Parliament's rejection of amendments to the Human Fertilisation and Embryology Bill[1] aimed at lowering the upper limit for abortion from 24 weeks to 12, 16, 20 or 22 weeks.

Inside pages carried testimonies of mothers whose children were 'born before the 24-week limit…who prove the law is wrong' and called 'contemptible' the action of whips who intimidated fellow MPs and blockaded the lobbies to ensure a vote for the *status quo*.

The campaigns run by 'Alive and Kicking'[2] and 'the 20 Weeks Campaign'[3] called for a modest change and resonated with the public mood. Testimonies, ultrasound images, stories of babies born after botched abortions, European comparisons, and survival statistics from top neonatal units had won the battle in the nation's living rooms, whilst tired warnings about returning to the days of back-street abortions and denials of advances in neonatal care had failed to impress.

However, voting fell heavily along party lines. The 332 MPs opposing 20 weeks included 35 Conservative, 248 Labour, 42 Liberal Democrat and 8 others. By contrast the 190 MPs supporting 20 weeks included 120 Conservative, 43 Labour, 13 Liberal Democrat and 14 others. This reflected the huge majority of pro-choice MPs in Parliament and the lead of the Prime Minister who, opposed to reducing the present 24 week limit, ordered a three line whip to ensure that Labour MPs, who largely favour abortion, attended.

We now know where virtually every MP stands on the matter. Alive and Kicking, representing twelve organisations including CMF, has produced an on-line database of MPs' views. But it may not be needed. If the composition of the next Parliament reflects voting in recent local elections and the Crewe and Nantwich by-election, then a 20 week vote will be won comfortably next time around.[4]

As *Triple Helix* went to press a backlash was in full swing, with a group of pro-choice MPs led by Liberal Democrat Evan Harris attempting to liberalise the law through a variety of legislative, regulatory and other measures: abortion on demand up to 24 weeks; nurse-led abortions in polyclinics, cottage hospitals and GP surgeries; exclusion of pro-life doctors from counselling; and extension of the Abortion Act to Northern Ireland. By the time you read this you should know the outcome.

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A perfect storm

Micah's challenge about justice in global health

Review by **Steve Fouch**
CMF Head of Member Services

In her opening address to the World Health Assembly in May,[1] Margaret Chan warned that five converging factors were leading to 'a perfect storm' of a global health crisis: global food price inflation; environmental degradation; the potential for another influenza pandemic; the spread to developing countries of the chronic diseases of affluence; and a staggering lack of progress in improving maternal and child health.

CMF members and many other Christians are at the forefront of caring for the sick, poor and vulnerable throughout the world. In some nations Christians provide as much as 60% of health care. However, care is only one response to the problems. These global health issues are a matter of justice, and of the rich honouring their commitments to the poor. At one level we are personally responsible – our lifestyles and purchasing choices have a big impact on the poor, but it is not just about us in the West learning to live more appropriately and sustainably. As believers we should also speak prophetically to our leaders, requiring them to act justly.[2] If our lives are consistent with that prophetic voice we have even more impact.

Over the last two years many of us have engaged in lobbying government about pro-life issues,[3] but as the American preacher and activist Jim Wallis pointed out recently, care for the unborn and care for vulnerable children in the developing world are not separate issues. They are both part of a scriptural mandate for us to speak up on behalf of those who have no voice. Who will speak up if we do not?

To equip Christians to do this, 'Micah Challenge' has launched two new resources. *Impact* is an online toolkit for individuals and churches to lobby our government for change.[4] *Micah's Challenge*[5] is written by leading Christian authors including Jim Wallis, Tony Campolo, Tim Chester and René Padilla. The book explores the scriptural and practical basis for Christian engagement with global poverty, helping us to ensure we are on a good biblical foundation when we stand up.

This is a time when the Christian voice for the vulnerable and marginalised is needed more than ever. Will we speak out or remain silent?

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Advance decisions to refuse treatment

Ethical and practical concerns

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

Salford City Council has begun promoting cards announcing 'Advance Decisions to Refuse Treatment'.[1] Christened ADRTs by the media, these wallet-sized cards display a prominent cartoon bubble saying 'Stop' and carry NHS and Council logos. They are attached to an explanatory leaflet and are being promoted extensively in GP surgeries, pubs and libraries. Salford claim[2] this promotion simply reflects their statutory obligation to respond to the Mental Capacity Act, which came into force in October 2007. They have 'trained' 2,500 staff in the principle of advance refusals, and other local authorities and bodies overseas have shown interest.

Advance directives[3] are attempts to extend the decision-making capacity of autonomous patients into a period when they have lost mental capacity. They can be verbal or written, though as a safeguard against abuse, advance refusals of life-sustaining treatment must be written, signed and witnessed. Only refusals can be made; no patient can insist in advance that they receive any particular treatment.

CMF supports patient autonomy and members wish to involve their patients as much as possible in decisions about their own treatment and care. However, individual autonomy must have limits and CMF therefore has both ethical and practical concerns about ADRTs. They could be a back door into euthanasia. Historically they have been promoted by the euthanasia movement around the world, with the campaign objective of securing suicidally ideated ADs. Once patients who have refused, say, food and fluids, are seen to be suffering for long periods before they die, then it is more likely society will legalise a lethal injection earlier in that process.

Further, there are many practical concerns about application. There are often uncertainties about diagnosis and always about prognosis; the healthy do not make their choices in the same way as the sick; a North American study[4] showed that 61% of patients carrying an ADRT thought doctors should sometimes over-ride them; clinically, ADRTs may often achieve the opposite of what was intended; cards prominently saying 'Stop' might encourage negative or even nihilistic attitudes; doctors might wrongly under-treat patients to avoid prosecution; and an ADRT may make patients vulnerable to exploitation by people or institutions with a financial or emotional interest in their deaths.

ADRTs have the force of statutory law and if valid and applicable it is a criminal offence not to abide by them. However, they may force health professionals to practise with one hand tied behind their back, and appointing proxies may be safer. CMF is currently working with other groups to produce alternative ADRTs which balance preserving autonomy with safeguards.

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Rodney and **Pearl Burnham** appraise the National Health Service

The NHS at 60

Aneurin Bevan visits 'the first NHS patient'.

key points

In their 2008 Rendle Short Lecture, the authors review the origins of the NHS and identify problems almost from its beginning of finance, rationing, organisation, models of delivery, and training and staffing.

Inequalities in health are not 'the fault of the NHS' but inequities of provision may be. Rationing, competition, and other models of delivery are considered. The authors recommend 'integrated care' delivered by 'teams without walls'.

Urging CMF to have a wider ethical focus, they remind us of the challenge to Christian health professionals to show God's love in the way we deliver care in the NHS and elsewhere.

The NHS has endured buffetings but has also been a blessing to many. Nick Land is astute in considering the NHS as common grace, minimising the effects of the Fall.[1]

Paul Corrigan said that the most important word in the title was the word 'National' because the NHS should provide equivalent care wherever in the UK one lived.[2]

The word 'Health' has been criticised, as the NHS is an 'illness' service rather than one with an emphasis on prevention. However, caring for the sick was an instruction from the Great Physician, so taking resources from a service for the ill in order to use it for prevention may be short sighted, especially if we still do not do the simple things, like fortifying flour with folate that could prevent 400 cases of spina bifida each year.

The late Alan Johnson (publishing anonymously at the time) said the most important word was 'Service'.[3] His words still challenge all of us, whether we are at the beginning or end of our medical career.

The NHS in England

In 1942 Sir William Beveridge identified a national health service as one of three essential elements of a social security system.[4] Aneurin Bevan steered legislation through the House of Commons in 1946 and after a two year battle with the BMA, agreement was reached. Services were comprehensive, free at the point of need, and intended to promote good health as well as treat sickness and disease. The NHS became operational on 5 July 1948. This article will mainly deal with NHS England, where most change has occurred.

Recurring issues – 1948 to 2008

- Financing
- Provision of comprehensive service or rationed service
- Organisation
- Models of health care delivery
- Training and staffing

Looking back over the history of the NHS, one is surprised how the same issues have recurred over the past 60 years (see box above).

Finance

The original calculation of the annual cost of the NHS was £276 million; this year it is £90 billion. Enoch Powell in his detailed analysis in 1975 found it impossible to reconcile the combination of unlimited demand and limited resources provided free.[5] Sir Derek Wanless argued in 2001 that continuing to fund the health service through general taxation was the most cost effective and fairest system for the future.[6]

In 2000, the Labour Government produced a strategy[7] for reform of the NHS, coupled with investment (from £35 billion per year to £90 billion in ten years). National targets were introduced with variable success, the aim being to manage a comprehensive service more efficiently using central controls. However, even additional resources did not solve the problems and rationing in some form was required.

All supported a comprehensive service in 1948, yet Bevan said in the years that followed that expectation would always exceed capacity.[8]

A few years after it began, the NHS began to charge for some items and continues to do so.

Inequality, inequity and rationing

There are significant inequalities in health: income, unemployment, environment, education, housing, transport and life style all play important roles.[9,10] These are not the fault of the NHS.

However, inequity of provision may be. The elderly, the mentally ill and ethnic minorities do badly on such assessments.[11] Access depends on skill in managing the system, and the better educated are more likely to do this effectively. Rationing (demand management) is achieved by limiting funding and delegating decisions locally to Primary Care Trusts. The financially well off can opt out by going private or by co-payments.

The National Institute for Health Care and Clinical Excellence (NICE) provides objective, evidence-based guidelines and guidance to the NHS about medicines and technologies that should be provided, but special interest groups may try to undermine this process.

Some GPs find themselves limited by restrictions on referrals to specialists, leading to surreptitious telephone and corridor consultations to obtain expert advice. Rationing also tries to by-pass 'choice' by referrals to 'GPs with a Special Interest' or others rather than fully trained hospital specialists, which may not improve quality.

Competition

Does competition have a role to play? Some authorities believe it will not produce a perfect system, but make the system better through self-interest that benefits society.[12] Do we believe in financial incentives? What happened to Christian vocation? The Quality and Outcomes Framework targets have proved financially advantageous to GPs, increasing GP pay by £23,000 pa, but is payment for performance a desirable motivation?

A logical consequence of competition is that some hospitals may close. Manual workers are more supportive of choice than professionals who have it already, and it is believed choice is an incentive for providers to improve.[13] Thus entrepreneurial Foundation Trusts and Independent Sector Treatment Centres (ISTCs) were created to encourage choice and competition.

However, funding ISTCs in advance means that resources (including emergency services) are denied to the NHS even when it provides a good service, and ISTCs prioritise elective surgery above services for those with long-term conditions. For this to work, money has to follow the patient through 'demand side reform'. The government has tried to replicate the workings of the market by Practice Based Commissioning (PBC) and Payment by Results (PbR). PBC is not popular with GPs; PbR is payment by activity and may produce perverse incentives discouraging care outside hospital.

A better way to organise the NHS?

There is a tension between public expectation and what it is possible to achieve in a transparent and democratic way. The system cannot respond well to competing priorities. An independent NHS has been suggested.[14] A national debate on NHS values and an NHS Constitution could set clear objectives endorsed by the public. However, strategic and operational decisions within the NHS cannot be separated from their political context. An NHS constitution could either be 'motherhood and apple pie' or a restrictive legalistic document. A 'public value approach' may help to balance organisational efficiency, better outcomes, and trust and legitimacy.

What people would give up, perhaps more taxes or another service, in order to obtain another more desirable benefit, could be explored as in Canada. With more clinical and patient involvement, 'World Class Commissioning' could become a reality. Appointments to the commissioning body could follow the model for appointment of lay magistrates.

In a mandatory insurance model introduced in Holland in 2006, health insurers, who may operate for profit, are required to compete on premiums, types of health plan and service levels. The government compensates insurers for big differences in the health profile of clients.

In the USA, rising costs and the large number of the uninsured are unsustainable. The argument against competition is that the insurers do not try to improve things for patients, but try to increase income, shift costs to somewhere else in the system, and restrict services. Competition between institutions in all areas, discrete services, and local markets has been described as 'the wrong kind of competition' but competition on value (outcomes) relates to the whole cycle of health care rather than just interventions.[15]

Outcomes

Avoidance of Health Care Acquired Infections (HCAI) could be one outcome quality indicator for hospitals. The Health Care Commission found many trusts had difficulty reconciling the prevention or management of HCAIs with national targets, whether waiting-time or financial.[16] As Christian doctors, we can show our love for our fellows by being less dignified, removing our jackets, ties and wrist watches and washing our hands rather than their feet.

Workforce and Training

Over the last 60 years, there have been many attempts to improve training for NHS workers and to increase their numbers. The decisions at the turn of this century to increase the number of medical students, and later to reorganise postgraduate medical training, came together last year to produce a disastrous situation that will not be easily resolved. Even if the government accepts all the recommendations of Sir John Tooke in his report on

Photos: PA Photos

Top: The first babies born in the NHS
Above: Aneurin Bevan

As Christian doctors, we can be salt and light in the NHS

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the Modernising Medical Careers/Medical Training Application Service disaster, it may not undo the damage to morale and patient care.

The impact of the European Working Time Directive will have an effect on the provision of services in hospitals. The data show the UK has fewer doctors per head of population than other developed countries and that there is a growing number of female physicians. Part time working may increase, and thus make shifts for trained staff more likely. This in turn may further decrease continuity of care.

Increased numbers of UK graduates, the continuing presence of International Medical Graduates, and an open door for European Union graduates make future medical workforce planning difficult. A shortfall of 15,000 training places is predicted for future graduates, raising the spectre of medical unemployment. [17]

Ethical issues

CMF has been strong on some ethical issues such as euthanasia and termination of pregnancy, but less prominent in others. We would like to see a balance. For example, there is a real danger in our experience of some doctors force-feeding patients and prolonging the dying process, with consequent lack of dignity and potentially great suffering. CMF should speak out against this, as we do against euthanasia.

What about health inequalities in the UK as well as overseas, or alcohol excess, or honesty in practice and research? What about co-payments – top up of NHS care by paying extra? BUPA has suggested that GP visits could be funded by co-payments. We believe this is unethical because it encourages health inequality. What about organ donation? Have we compared presumed consent with mandated choice? We have mentioned workforce numbers, also an ethical issue. Should CMF consider a wider ethical focus than now?

Integrated care – collaboration not competition

When we completed training, there was a partnership between GP and consultant. The introduction of the internal market and the purchaser-provider split damaged this and developing the private sector has not always helped. We would like to encourage you to support the adoption of 'integrated care'.

Clinical integration can deliver prevention and care for long-term conditions, and improve efficiency. Lord Darzi's Review aims to involve local clinicians in the next stages of reform. Collaboration between generalists, specialists and other health care professionals would offer similar advantages to those provided by Kaiser Permanente in northern California. There, high levels of performance are achieved by allowing multi-specialty medical groups control over capitated budgets, to keep patients healthy and minimise future health expenditure.

Teams without Walls, [18] a document from three medical Royal Colleges, outlines and supports these ideas as a way forward. As a Christian couple we think it is appropriate for us to encourage 'team' (the old English word can mean 'family') working as we show how Jesus cared for others.

The provision of more care closer to home, in an integrated system, from specialists in harmony with generalists is possible because of a large number of new doctors to be produced in the future. By managing care outside hospital, capital costs are minimised and this will allow the employment of the doctors and health care professionals who will be available. Clinical integration may enable us to provide personal care most effectively, and in the future, consultants will deliver care rather than directing it.

To achieve this, doctors need to be engaged in the organisation and management of the service. As Christian doctors, we can be salt and light in the NHS and follow in a long line of distinguished Christian physicians and surgeons. We urge you to engage with this process.

Conclusion

At this 60th anniversary, the NHS faces significant challenges due to financial, organisational, workforce, medical and ethical factors. Although there are more buffetings ahead, we must remember that God is in charge (Acts 4:28). Christian doctors should live out the teachings of Jesus Christ in response to these challenges.

Morale has been damaged but we would like to repeat some words of Arthur Rendle Short at a Missionary Study Circle conference in 1912. [19] Speaking on Colossians 4:17, he reminded his listeners that this command – 'See to it that you complete the work you have received in the Lord' – was personal and encouraged perseverance. We should follow this advice, as we show God's love in the way we deliver care in the NHS and elsewhere.

Rodney Burnham *is a consultant physician at Queen's Hospital, Essex, and Registrar of the Royal College of Physicians, and his wife* ***Pearl*** *is a retired nurse specialist in nutrition and a magistrate*

This article has been edited by the authors from their 2008 Rendle Short Lecture *The NHS: Bevan to Brown – blessings and buffetings*

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Rachael Pickering
continues our series...

Photo: Wellcome

Let's communicate... about abortion

The last *Juniors' Forum* was all about the need to develop good general communication skills.[1] For the rest of the year though, we're going to look at common pitfalls that arise when communicating *specific* issues to colleagues and patients. This issue, we're looking at abortion...

I'm scared!

There are those in society who object to Christian doctors choosing to practise medicine in accordance with their beliefs. Whether it's offending your consultant, not getting a job,[2] or being reported to the GMC,[3] standing out as a Christian in today's NHS is getting more costly.

'What shall I do?' Alex* was well into her GP registrar year and had got into a bit of a mess:

When I started [as a registrar] I kept meaning to mention that I didn't refer for abortions. But I guess I was just scared...My trainer's the GP lead on women's health and very pro-choice. Anyway, I got lucky for a few weeks and kind of forgot about it as an issue. But then this week not one but two women booked to see me with unwanted pregnancies! They took me by surprise – I panicked, referred them both [for abortions] and now I feel terrible... (* Name changed)

Alex's reluctance to speak up is understandable. Moreover, she's not alone – more than once I've failed to act on my beliefs. When facing such situations, we would do well to reflect on the story of Esther thinking about appearing uninvited before King Xerxes.[4] This communication task was very scary. It could have cost her much more than her job as the Queen of Persia! Yet she went ahead. First though she fasted and prayed. Only then did she go in to the King, putting her job (and her very life) in God's hands.[5]

I'm not sure what the law says? And the GMC?

There is a lot of confusion amongst juniors (and quite a lot of seniors too) about what a doctor is and is *not* obliged to do when managing a woman with an unwanted pregnancy. This subject has been covered comprehensively in *Triple Helix*.[6] Have a good read – including the two excellent updates in this issue[7,8] – and get to grips with your rights to conscientiously object and discuss personal beliefs, where appropriate, with patients.

My colleagues will think I'm judging them!

This is usually an unfounded fear. I've found that it's always best to be upfront about my conscientious objection. Whenever I arrive at a new locum booking, I make a point of politely informing the senior receptionist, practice manager and GP lead for women's health about my belief. Very few of the GP partners I've locumed for have ever given me a hard time. Most are simply intrigued as to how pro-life inner city GPs handle unwanted pregnancy consultations. It also makes for a lively discussion at coffee time and can result in further coffee breaks spent discussing faith!

Of the few snide comments I have received, most have been made by colleagues who, it turns out, are actually pro-life themselves but who are acting against their consciences. Vicki recalls:

I was working at a small practice. The abortion referral rate wasn't particularly high but my conscientious objection seemed to really irritate one of the partners.

Then, quite by chance, we both ended up at a local church event. I hadn't realised that he had a [Christian] faith. Somehow, the subject of abortion came up over dinner...I found having lots of other people in on the conversation much less awkward.

A few weeks later, the receptionists told me that he [the partner] had decided to stop referring women for abortions. It turns out that he'd never been comfortable with referring but had just drifted into it because he'd been frightened of offending his patients.

I don't know how to explain to my patients!

Like every other task in clinical medicine, explaining your pro-life views to patients improves with practice. Before embarking on my GP registrar year, I talked to a Christian GP I knew and respected. She told me how she managed these consultations but encouraged me to devise my own consultation model.

Over time, I've devised a way of incorporating an explanation of my pro-life beliefs into an exploration of my patient's ideas, concerns and expectations about her pregnancy and abortion...

GP: *So, you definitely don't want this baby and you've mentioned abortion...Can I ask how you feel about abortion?*
Patient: *I don't like it doctor, but I don't believe it's killing or anything. Well, not this early on anyway. I'd never have a late abortion though.*
GP: *As we've discussed, the law does allow you to have an abortion. However, the law also gives doctors like me, who believe that every abortion involves the taking of a life, the option of not getting involved with it.*
Patient: *Oh, I think I knew that...My last doctor was Catholic – he didn't refer for abortions either...*

Why not ask a local CMF GP you respect how (s)he handles these consultations? Maybe you could try some role plays yourself. After all, practice (eventually) makes perfect!

***Rachael Pickering** is a portfolio GP in London and invites approaches from juniors interested in editing the Forum in 2009*

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Charles Foster on medicolegal aspects of new GMC guidelines

Conscience in the CONSULTATION

key points

New GMC guidance supplements *Good Medical Practice* by seeking to clarify conduct in situations where doctors may have conflicts with their beliefs.

Human rights legislation, abortion law, and the 1990 HFE Act consider conscientious objection. There are further contractual aspects for NHS GPs.

The guidance is reassuring, and should act not just as a shield, protecting conscientious objectors from trouble, but also as a sword: it should be a disciplinary offence under the guidance to fail to accord to conscientious objectors the rights recognised by the guidance.

On 17 March 2008 the General Medical Council ('GMC') published its guidance *Personal Beliefs and Medical Practice*. The guidance is long and detailed and needs to be read in full by anyone who hopes to remain on the medical register. Only an outline of a few provisions can be discussed here.

The guidance must be read in conjunction with *Good Medical Practice*,[1] on which it purports to be a commentary.[2] *Good Medical Practice* emphasises that doctors must make the care of their patients their first concern;[3] must treat their patients with respect, whatever the patients' life choices;[4] and must not discriminate unfairly against patients by allowing personal views to affect adversely either the professional relationship with them or the treatment provided or arranged.[5]

Conflicts with beliefs

It further notes that 'If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have a right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role'[6] and 'You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress'.[7]

These broad statements of principle beg a number of questions. The new guidance was drafted in an attempt to answer some of those questions. By and large it is thoughtful and helpful. Its statement of the philosophy that should govern the relationship between a doctor's personal beliefs and the doctor-patient relationship is impossible to criticise. Christian doctors will welcome the acknowledgment that 'personal beliefs and values, and cultural and religious practices are central to the lives of doctors and patients',[8] as well as the explicit recognition that doctors as well as patients have rights.[9]

While the guidance is just that, 'guidance', it is intended to be authoritative. It sternly warns that 'Serious or persistent failure to follow this guidance will put your registration at risk'.[10]

Conscientious objection: a legal overview

Article 9 of the European Convention on Human Rights (ECHR), grafted into English law by the Human Rights Act 1998, provides that 'Everyone has the right to freedom of thought, conscience and religion; this right includes…freedom...to manifest his religion or belief in worship, teaching, practice and observance'. The relevance of this Article to medical conscientious objection has not yet been definitively determined. It may well be that the future law of conscientious objection will be articulated mainly in terms of Article 9.

The law of conscientious objection to abortion has been discussed previously in *Triple Helix*.[11] The Human Fertilisation and Embryology Act 1990 also preserves an express right to refuse to participate in any treatment authorised under the Act.[12]

NHS GPs

The position of NHS GPs is important and interesting. The National Health Service (General Medical Services Contracts) Regulations 2004[13] require that GP contracts that include 'additional services' (services

that the GP is not obliged to provide) must contain particular terms. Two of those 'additional services' are contraceptive services and maternity medical services.

If contraceptive services are provided the contractor must make available 'the giving of advice about emergency contraception and where appropriate, the supplying or prescribing of emergency hormonal contraception or, where the contractor has a conscientious objection to emergency contraception, prompt referral to another provider of primary medical services who does not have such conscientious objections'.[14] The contractor must also make available 'the provision of advice and referral in cases of unplanned or unwanted pregnancy, including advice about the availability of free pregnancy testing in the practice area and, where appropriate, where the contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objections'.[15] Where practices provide maternity medical services there are provisions with similar conscientious objection clauses in relation to the referral of women 'whose pregnancy has terminated as a result of miscarriage or abortion'.[16]

It must be remembered that these are contractual obligations which are entered into by practices. It is the practice as an entity that has these obligations, rather than the individual doctors within it. The GP principals who enter into these contracts and run the practice are of course obliged to ensure that the practice abides by the terms, and failure by those principals to do so could be a disciplinary matter in which the GMC might conceivably take an interest. This would be on the basis that decent doctors do not flout their contractual obligations.

On the face of it there is nothing unreasonable about the obligations in the GP contract. No practice is forced to offer contraceptive services (for instance), but if a practice opts to, it seems fair enough to expect them at least to facilitate access to its patients of all the services under the heading of contraceptive services.

The new guidance: involvement in abortion

Paragraph 21 states that:

'Patients may ask you to perform, advise on, or refer them for a treatment or procedure which is not prohibited by law or statutory code of practice in the country where you work, but to which you have a conscientious objection. In such cases you must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. In deciding whether the patient has sufficient information, you must explore with the patient what information they might already have, or need.'

Paragraph 26 provides that:

'Where a patient who is awaiting or has undergone a termination of pregnancy needs medical care, you have no legal or ethical right to refuse to provide it on grounds of a conscientious objection to the procedure. The same principle applies to the care of patients before or following any other procedure from which you have withdrawn because of your beliefs.'

As they stand, these paragraphs raise some obvious questions. CMF wrote to the GMC asking for clarification. Here are the GMC's answers:[17]

'You ask three specific questions about whether our guidance obliges doctors to provide particular services:

1. Will doctors be obliged to sign abortion authorisation forms?
2. Will doctors be obliged to clerk patients for abortion (ie carry out pre-op examination and assessment)?
3. Will doctors be obliged to refer patients seeking abortion to other doctors who will authorise it?

The answer to all three questions is 'no' – see *Good Medical Practice* and paragraph 21. Reading paragraph 26 in the context of *Good Medical Practice* and the preceding paragraphs of the supplementary guidance (particularly paragraph 21), should ensure that readers understand our intention in the guidance. This is to distinguish between doctors refusing to participate directly in, or facilitate the execution of, procedures to which they have a conscientious objection on the one hand, and on the other, refusing to provide any other care on the grounds that the patients concerned were about to undergo, or had undergone such a procedure. It is the procedure to which the doctor objects, not the patient.'

The guidance: other areas

Doctors opposed to abortion will find these responses reassuring. But there are other types of treatment to which some will have conscientious objection. Examples include post-coital contraception and gender reassignment. Legislation does not provide specific protection for individual conscientious objectors in these areas (unlike in the cases of abortion and procedures covered by the HFE Act). Do the principles articulated by the GMC in its responses to the CMF apply where there is no statutory protection? The answer given both by common sense and by the GMC is yes.[18]

Conclusion

The GMC's guidance gives robust protection to doctors who object conscientiously to any medical or surgical treatment. Its application will need to be, and will be, watched carefully. The guidance should act not just as a shield, protecting conscientious objectors from trouble, but also as a sword: it should be a disciplinary offence under the guidance to fail to accord to conscientious objectors the rights recognised by the guidance.

If the guidance proves inadequate, either as a sword or a shield, Article 9 of the ECHR might remedy the deficiency. Article 9's main use at the moment is to ensure (a) compliance of doctors' employment contracts with the principles in the guidance and (b), a related point, to ensure that the position of conscientious objectors is protected as against people and bodies not subject to the jurisdiction of the GMC.

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Photo: Wellcome

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3. *Good Medical Practice*, Duties of a Doctor
4. *Ibid*, paragraph 7
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6. *Ibid*, paragraph 8
7. *Ibid*, paragraph 33
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9. *Ibid*, paragraph 7: '[The guidance] attempts to balance doctors' and patients' rights – including the right to freedom of thought, conscience and religion, and the entitlement to care and treatment to meet clinical needs – and advises on what to do when those rights conflict.'
10. *Ibid*, paragraph 3
11. Foster C. Conscientious objection to abortion – ethics, polemic and law. *Triple Helix*, Autumn 2005: 7
12. s. 38 provides: '(1)'No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so. (2) In any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.'
13. SI 2004/291
14. Schedule 2 paragraph 3(2)(d)
15. Schedule 2 paragraph 3(2)(e)
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17. Reproduced with the permission of the GMC. The full letter is at *admin.cmf.org.uk/pdf/ethics/2008-03-26-GMC_letter_to_PSaunders.pdf*
18. *Ibid*, paragraph 7

Kevin Vaughan considers new GMC guidelines and discussing faith

CHRIST in the CONSULTATION

Photo: Wellcome

key points

The new General Medical Council guidelines on *Personal Beliefs and Medical Practice* helpfully make it clear that 'all doctors have personal beliefs which affect their day-to-day practice'. There is no neutral default position.

We must 'treat our patients with respect whatever their life choices and beliefs', and as Christian doctors we will not want to force our views on anyone or cause distress by inappropriate or insensitive behaviour.

But by asking questions, taking a spiritual history, and raising 'faith flags', we may find doors opening so that we can legitimately talk about Christ with our patients.

In the light of March 2008's General Medical Council guidelines on *Personal Beliefs and Medical Practice*, can it be appropriate for me to talk to patients about Jesus? What are the ethical guidelines? Will I get into trouble with my employer?

These recently published guidelines are intended to provide more detailed advice on how to comply with the principles outlined in the GMC's core guidance *Good Medical Practice*, most recently updated in 2006.

'All doctors have personal beliefs'

Key extracts from the new document are:

- Personal beliefs and values, and cultural and religious practices are central to the lives of doctors and patients.
- Patients' personal beliefs may be fundamental to their sense of well-being and could help them to cope with pain or other negative aspects of illness or treatment.
- All doctors have personal beliefs which affect their day-to-day practice. [1]

These statements are helpful as they emphasise that personal beliefs are central to the thinking of all people, whether from a faith, atheist or agnostic perspective. They can be welcomed by Christians as they correct the popularly held belief that secular atheism holds a neutral default position. This means that people of all faiths or none start on an equal playing field in any debate on ethics or personal belief – whether they realise it or not, everyone has their own presuppositions.

'Treat your patients with respect'

We should give careful consideration to the following:

- You must treat your patients with respect whatever their life choices and beliefs. [2]
- Trust and good communication are essential components of the doctor-patient relationship. Patients may find it difficult to trust you and talk openly and honestly with you if they feel you are judging them on the basis of their religion, culture, values, political beliefs or other non-medical factors. For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs…However, if patients do not wish to discuss their personal beliefs with you, you must respect their wishes. [3]

As Christian doctors it is not our role to judge our patients, but rather to serve them humbly, as Christ did. [4] Paul also reminds us that in everything we do, we must do it with all our hearts because we are doing it for the Lord. [5] Being good at our clinical job is an essential part of our Christian service and witness. If our patients have trust and confidence in us, we can also take to heart Peter's injunction 'always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have. But do this with gentleness and respect.' [6]

'You must not impose...or cause distress'

Because patient vulnerability is important:

- You must not express to your patients your personal beliefs in ways that exploit their vulnerability or are likely to cause them distress.[7]
- You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them).[8]

As Christian doctors we will not want to force our views on anyone or cause distress by inappropriate or insensitive behaviour, so it is a great comfort that the Holy Spirit has gone before us in every situation. In practical terms we can leave the patient in control and look for doors that God is opening.

Asking questions

In the gospels Jesus asks questions wherever he goes and we would do well to follow his example. It is now well recognised that holistic care is part of the service that all doctors should offer and the Royal College of General Practitioners' curriculum requires 'the development of a frame of reference to understand and deal with the family, community, social and cultural dimensions in a person's attitudes, values and beliefs'.[9] By asking questions, we doctors will not be expressing our own personal beliefs, but rather exploring those of the patient. This is part of good clinical care and may on occasion also open up further conversation, when the doctor is free to share something in response to the patient's comments or questions.

Spiritual history enquiry essentially involves three areas:

- **Belief**

'Do you have a faith that helps you (in a time like this)?'
'Do you have a personal faith?'
'What is important to you?'
'Do you believe in God?'

- **Religious practice**

'How does it affect your life?'
'Have you ever prayed about your situation?'
'What principles do you live by?'

- **Faith community**

'Who gives you support?'
'Do you belong to a church/faith community?'

One doctor attended a *Saline Solution* conference organised by CMF and heard of these questions for the first time. She was keen to try them in the surgery the following week, and when she was reviewing a patient whom she had been seeing for two years, she simply slipped in the question 'Do you have a faith that helps you?' This took the patient by surprise and she initially gave a hesitant reply. The doctor wisely let the matter rest there for that day, but on subsequent visits the patient opened up greatly, there was opportunity to pray together and, encouraged gently by the doctor, she started attending a local church. What double joy! Joy for the doctor, as she discovered that God may open a door when we ask a simple question; joy for the patient, as she was able to discover Christ following a conversation with her doctor.

Faith flags

When exploring the spiritual needs of people dying of lung cancer or heart failure, Murray *et al*[10] found that, sadly, many patients expect that doctors will not be interested in spiritual issues, even though they themselves would like to talk about them. 'Many patients and carers were uneasy about turning to health and social services for spiritual support, although, if they did find professionals who were willing to discuss such needs, this was much valued.'

In order to identify ourselves as people who care about spiritual matters, it can be helpful to raise a brief *faith flag* in conversation. This should be unforced and appropriate to the moment. Even a simple comment like 'Some of my patients say prayer helps' or 'It makes a big difference to me to know that there's someone up there looking out for me' puts no pressure on patients or relatives, but gives them permission to raise spiritual concerns if they so wish.

Just before an Easter Bank Holiday I recall asking a patient what she would be doing over the weekend. She described how she would be caring for her sister who was dying of breast cancer. She then asked me what I myself would be doing, and when I mentioned that Easter was a special time for me and my family as we would be remembering how Jesus died and rose again for us, she immediately burst out 'Oh! I wish I could have a faith like that!' This opened the door for further conversation.

If our relationship with patients is built on the foundations of clinical competence, trust and good communication, the atmosphere of mutual respect will usually help the doctor to know how and when to speak sensitively and appropriately about spiritual matters. However, we will need courage and compassion for our patients, and we will need to be praying for the Holy Spirit's guidance and wisdom every day.

We will also need to be prepared to justify our actions if we face criticism from patients, relatives, colleagues, or even the GMC for what we say. May God give us all the grace and wisdom we need to be appropriate witnesses for him in our everyday life.

***Kevin Vaughan** is CMF Head of Graduate Ministries and a former GP*


Photo: Wellcome

It can be helpful to raise a brief *faith flag* in conversation

resources

The *Saline Solution* day conferences run by CMF give participants an opportunity to explore these issues practically and in greater depth, in an interactive environment. See www.cmf.org.uk/literature/content.asp?context=article&id=181

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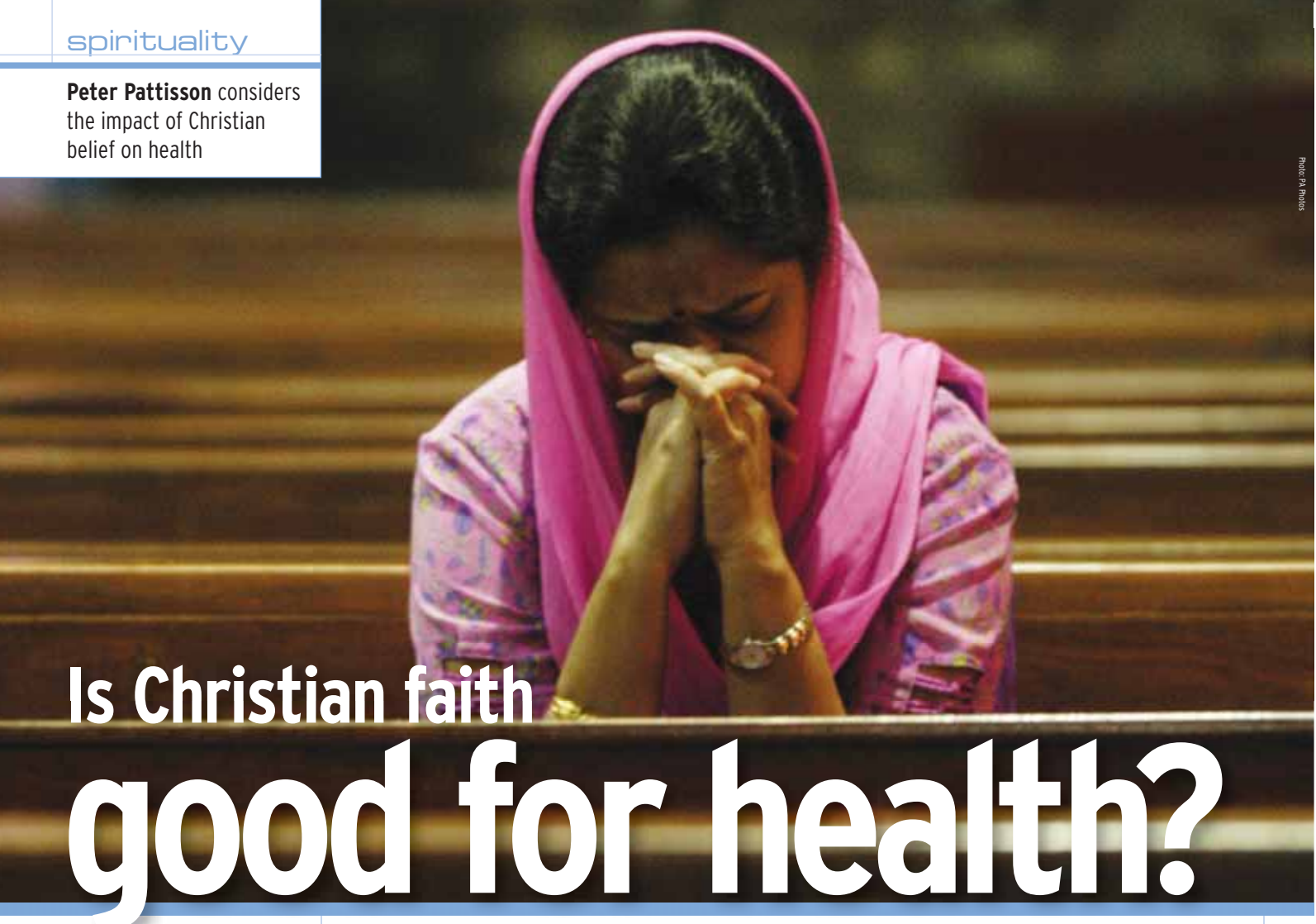
Peter Pattisson considers the impact of Christian belief on health



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Is Christian faith good for health?

key points

There is growing evidence of a positive correlation between religious belief and health parameters. These studies cover a wide range of 'spirituality' but the preponderance is for the Judeo-Christian faith.

Reviewing biblical perspectives, the author concludes that we as Christians have a powerful therapeutic armoury. But, he ponders, are we asking the right questions? For many, Christian faith can have negative health outcomes.

Nevertheless, it is worth it, as we press onwards to win the prize for which God has called us heavenwards in Christ Jesus.

What impact does spirituality have on physical and mental health? This question has been a matter of debate for as long as human beings have thought about life. Even today those from cultures steeped in pantheism or animism have no doubts as to the influence of the spiritual world on health. To practise medicine without reference to the spirit world may be regarded by them as crass ignorance and dangerous interventionism.

In the fourth century BC Hippocrates was at pains to release the practice of medicine from the shackles of magic and sorcery. He challenged the prevailing view that epilepsy was of spiritual cause describing it as no more 'sacred' than any other disease. He argued that it had 'specific characteristics and a definite cause'[1] and only those akin to the modern day witch doctors and charlatans would regard it as a primarily spiritual problem.

One thousand years before Hippocrates, Moses learnt something of the positive relationship between godliness and health when God exhorted him to listen to his voice and do what was right in his eyes. In return for this, God promised, 'I will not bring on you any of the diseases I brought on the Egyptians, for I am the God that heals you'.[2] Long before even this episode, in the Garden of Eden, Eve learned the hard lesson of the painful effects of sin.[3] All of this reminds us that the relationship between spirituality and health is not a simple one.

The scientific background

A great deal of work has been done in this field over the last ten years. Most of this lies in the arena of social science and human behaviour, and is based on observation rather than experimentation. Nevertheless, there is much cumulative evidence for a positive correlation between faith and health. One of the most comprehensive reviews is that of Professor Harold Koenig.[4] Over 1,200 studies were analysed and a 60-80% correlation between religion, spirituality and health parameters was found.

These studies cover a wide range of 'spirituality' but the preponderance is for the Judeo-Christian faith. Positive correlation is found in varied fields such as heart disease, immunological dysfunction, cancer pain and disability. One major weakness in these types of studies is the inherent difficulty in controlling for confounding characteristics, such as a healthy lifestyle, which can weaken the quality of the research.

In research specifically targeted at the Christian population, Strawbridge *et al*[5] in a report of 7,000 people over a 30 year period found that frequent church attenders had lower mortality rates. This study had the benefit of a measurable factor (frequency of church attendance) rather than the less easily defined 'Christian faith' found in many studies.

Lastly, Culliford[6] in a 2002 *BMJ* review article compared spirituality to nutrition and stated

'Inadequate nutrition is costly. If people are not fed properly, resistance weakens and wounds do not heal. Evidence is growing in volume and quality that this holds for spiritual sustenance too.' In the same article, he also quotes the World Health Organisation as saying: 'The reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process.'

Biblical perspectives

None of this should surprise us as Christians. We know already from biblical revelation that faith in God is good for you. We are told in Exodus 23 that by worship of God 'his blessing will be on your food and water'. He promises to 'take away sickness' from the Israelites if they remain faithful to him.[7] Even on the bio-mechanical model, to follow maker's instructions is the way to get the best out of any machine. Making our own instructions is destined to fail.

Interestingly, the Bible is more guarded in its statements than some modern researchers. It observes and reports correlation but less often makes direct 'cause and effect' claims. Psalm 32 describes the beneficial effects of transgressions forgiven: 'Blessed is the man whose sin the Lord does not count against him'.[8]

We are also told in Romans 5 of the justification that comes through faith, of the hope that comes eventually through suffering, and of God's love which comes into our hearts through the gift of the Holy Spirit.[9] These gifts of faith, hope and love are powerful medicines. In addition, we have the supportive value of a faith community, such as that found in Philippians 2 where its members 'welcomed' brothers in the Lord and took care of each other's needs.[10] Taking all these privileges together, we as Christians have a powerful therapeutic armoury.

Are we asking the right questions?

Historically, a portion of healthcare research (both Christian and non-Christian) has assumed that 'health' in all its parameters and long life are the ultimate goods. The Bible, especially the New Testament, would challenge this view point. We see this in Matthew 16[11] where Jesus challenges his disciples to deny themselves and take up their cross in order to follow him. 'What good will it be for a man if he gains the whole world, yet forfeits his soul?'

In many parts of the world, and throughout history, following Christ has involved some distinctly unhealthy lifestyle choices. We only have to look at the gruesome experiences of historical Christians listed in Hebrews 11[12] to gain an appreciation of the sufferings of our fellow brothers and sisters in Christ.

There are three categories of these 'negative' health outcomes of faith in God:

Following Christ may lead me into danger

Historically, faithfulness to Jesus often led to an early death. It may do the same for me or my family. The average life expectancy for European missionaries to West Africa in the mid-19th century was six months from the time of arrival. Despite this knowledge, missionaries still went to replace those who had fallen.

Following Christ will lead me into conflict

This may be within the family, amongst colleagues, or in the world at large. Conflict at the human level is generally a negative health predictor. Hidden conflict in the spiritual world can have more devastating effects, such as that seen in Job 2 where the Lord allows Satan to afflict Job with 'painful sores from the soles of his feet to the top of his head' in order to test his allegiance to God.[13]

Radical discipleship of Christ comes with its own distinct health warnings. This is seen in John 15 where Jesus warns his disciples to expect persecution, just as Christ himself was persecuted: 'If they persecuted me, they will persecute you also', and in the subsequent verse: 'They will treat you this way because of my name, for they do not know the One who sent me'.[14]

Following Christ will produce inner tensions

This may be because our expectations for 'a good life' have not been realised. It may also be related to unrealistic expectations over divine healing. Perhaps there are issues of false and unresolved guilt. We may feel the strain of commitment to work, family and church. Biblically, some of these issues are covered in the words of Psalm 73[15] where the psalmist laments 'the prosperity of the wicked' as they 'scoff, and speak with malice'. He envies their wealth, their health, and their lack of burdens as he himself struggles to keep trusting the Lord. We have all been there.

Where do we go from here?

We have seen that faith in Christ may lead to less than perfect physical health in this world. We wrestle with the joy of knowing Christ, and the conflict and tensions this produces in an imperfect and sinful universe. Surely as Christians we should see this life in the context of eternity? Not as what we are but what we shall be when we meet God face to face. We remember the rich young man in Mark 10[16] who asked Jesus, 'What must I do to inherit eternal life?' This is the question that we as Christians should be asking as, like Paul in his letter to the Philippians,[17] we press onwards to win the prize for which God has called us heavenwards in Christ Jesus.

***Peter Pattisson** is ICMDA Regional Secretary for Eurasia*

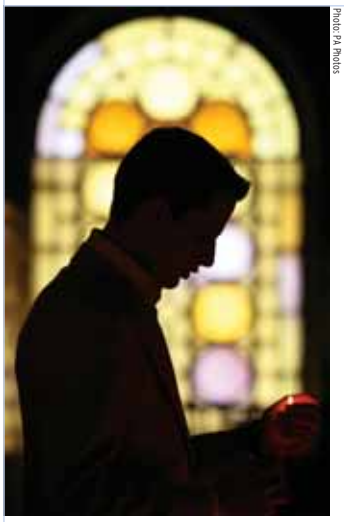

Photo: PA Photos

We as Christians have a powerful therapeutic armoury

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12. Hebrews 11:35-38
13. Job 2:7-10
14. John 15:20-21
15. Psalm 73:1-11
16. Mark 10:17
17. Philippians 3:12-14

Ex-gays?

A Longitudinal Study of Religiously Mediated Change in Sexual Orientation
Stanton Jones and Mark Yarhouse

- IVP Academic 2007
- £11.39 Pb 414pp
- ISBN 0 83082 846X

In the words of the authors, this book about the effectiveness of 'Ex-Gay' ministries 'catapults us into the eye of a storm'. On the one side, it is argued that attempts to change somebody's sexual orientation subvert three decades of progress towards 'accepting people for who they are'. Opponents of 're-orientation therapies' (and religion-based programmes offering the chance to explore change) believe these approaches re-stigmatise homosexuality, re-cast gay people as somehow sick or disordered, and risk untold psychological damage. They say that such therapies are unproven, unethical and that they should be proscribed.

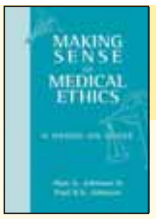
On the other side, advocates question the validity of the whole concept of sexual orientation. They point out that our categories of homo- and hetero-sexual are relatively modern inventions with poor biological validation, and they cite evidence of cross-cultural and within-individual variations in sexual desire and behaviour. They highlight anecdotal narratives from people who say they have walked the journey from gay to straight, in both secular and religious contexts. Above all, they believe that people with unwanted Same Sex Attractions (SSA) have the right to choose for themselves whether they want to explore the possibility of change.

So where does the truth lie? Mark Yarhouse and Stanton Jones, two US psychology academics, have made a significant contribution to this debate. Their book is essentially a research report from a longitudinal study of outcomes in 98 people who undertook some form of 'Ex-Gay ministry'. They find that, whilst major change happens in a relatively small proportion of subjects, more individuals can achieve substantial satisfaction in managing diminished levels of SSA, even if that means a life of celibacy. One of the most important findings was that there were few examples of psychological harm as a result of participating in the programme.

The authors recognise that, given their methodological limitations, they need to be cautious in interpreting their findings. Quite so. There are potential problems with sampling biases, reporting biases, attrition in follow-up, the handling of missing data, and debates to be had over the choice of measures. Further, whilst around 15% achieved substantial change and 23% achieved satisfaction with chastity (that is, diminished SSA but little kindling of other-sex attractions), at follow-up some 29% were still 'continuing' (with uncertain outcomes) and the remainder achieved little change. So expectations need to be modest and realistic.

Evaluating these programmes is a work in progress and it is difficult to draw hard and fast conclusions on current evidence. However, for those interested in one scholarly overview of this contentious field, this is a recommended read.

***Glynn Harrison** is a consultant psychiatrist in Bristol*



Making Sense of Medical Ethics

A Hands-on Guide
Alan G Johnson and Paul R V Johnson

- Hodder Arnold 2007
- £17.99 Pb 224pp
- ISBN 0 34092 5590

This book, written jointly by CMF's late President Alan Johnson and his son Paul, has the look and feel of a practical guide to the sometimes confusing field of medical ethics. Its simple layout, diagrams, and illustrations make complicated concepts accessible for medical students, doctors and lay people.

The authors set the scene in the first chapter and then explore the ethical theories and value systems that inform ethical principles. They discuss Beauchamp and Childress's familiar four principles in detail and untangle some of the conflicts between them, with clinical cases as examples. The chapters on ethical pathways give the reader a tool to unravel ethical dilemmas for themselves, making this book of practical use rather than just a good explanation of ethical theory.

Some issues are mentioned a little too briefly to satisfy the reader that the basic issues have been identified, and the section on aging seems to be muddled with the preceding paragraph about medical enhancement. Nonetheless, this valuable legacy from our late President would be an excellent purchase for all medical ethics teachers and interested novices.

***Emma Hayward** is a GP and ethics teacher in Leicester*

Elements of Medical Law (2nd edition)

Charles Foster

- Claerhourt Publishing 2007
- £30 Pb 175pp
- ISBN 978 1 905895 01 4

This short text provides an accessible account of a select range of complex medico-legal issues. It is a much improved second edition, revised and expanded to incorporate recent developments including the Mental Capacity Act. The first chapter examines 'legal issues before birth' and contains a useful overview of the law of genetics, fetal rights, and some of the issues arising under the HFE Act 1990 such as cloning and designer embryos. Some attention is paid to European jurisprudence, including recent case law on the protection given by the European Convention on Human Rights to the unborn child. Three chapters explore the law of consent, confidentiality and clinical negligence. Those hoping for detailed analysis may be disappointed. A number of underlying tensions, such as that reflected in the legal distinction drawn between a child's consent and refusal, are not pursued. The final chapter considers the 'law of death' and includes a discussion of murder and euthanasia, medical manslaughter, treatment withdrawal, advance directives, resource allocation, and the use and ownership of body parts. Brevity invariably limits its nature and scope, but this book is a distinctive and welcome addition to the medical law literature.

***Wendy Hiscox** is Lecturer in Medical Law at St Mary's University College*

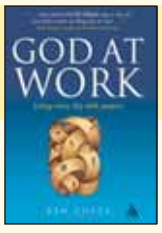
Miracle at Tenwek

Gregg Lewis

- Discovery House Publishers 2007
- $12.55 Pb 312pp
- ISBN 978 1 57293 222 7

Miracle at Tenwek chronicles the incredible life of Dr Ernie Steury, from a bashful backward farm boy to his leading and developing one of the premier mission hospitals in the world. His humility, gentleness and faithful service inspired me so much after spending a summer shadowing him as a university student that I vowed to be a missionary just like him. We served together in Kenya for eleven years and much of who I am today is a reflection of God living through Ernie's life. Ernie loved people into the kingdom, was a brilliant surgeon/diagnostician and developed a four-room clinic into a 300-bed tertiary care hospital that now trains doctors, nurses and chaplains. His passion that no patient would ever leave the hospital without hearing the gospel resulted in four or five thousand people coming to Christ each year. Ernie embodied the characteristics of the Great Physician. The local people called him 'Mosonik'. I can still hear an elder of the tribe telling me 'We Kipsigis people know that if we go to Tenwek Hospital and just touch Mosonik…we will get better!' Ernie Steury was a medical missionary giant of the 20th century. His life changed mine. His story will change yours.

***David Stevens** is CEO of CMDA in the USA*



God at work

Living every day with purpose

Ken Costa

- Continuum 2007
- £7.99 Pb 193pp
- ISBN 0 8264 9635 0

Ken Costa is a banker and chairman of Alpha International. The business world is the background for this book. His claim is that the underlying issues discussed are the same for all Christians, whatever their background. I agree. The messages are relevant for all engaged in the difficult challenge of living out their Christian faith at work, including those in medical practice. *God at work* addresses the problems that confront us all – stress, disappointment, failure and making difficult decisions. There is advice on maintaining a good work-life balance and achieving spiritual renewal. Another area Ken highlights is the concept of joy in work. I found one quote quite unforgettable: 'My work station is my worship station'. He points out that an eternal perspective on life can put the stresses and strains of a career in context. In medicine, the problems of the reconfiguration of NHS services and the MTAS fiasco are but two examples where application of this perspective would be beneficial. Christians are not taken out of the world but Jesus did pray that we may be protected from the Evil One who loves to confuse and discourage. I found this book stimulating, thought provoking and encouraging. I recommend it.

***Rodney Burnham** is a consultant gastroenterologist in Romford*

Setting Up Community Health Programmes

Ted Lankester

- Macmillan Education 2007
- £13.30 Pb 417pp
- ISBN 978 1 4050 8602 8

What is new in the third edition? First, there are nearly 100 extra pages. Also new is the large number of experts who have commented and assisted in the revision. This book is a practical manual, not a textbook. Chapters cover basic community development issues such as participatory appraisal and how to work with communities; common diseases (mostly infectious but also maternal health, nutrition, and environmental); and management of projects, people and money. The book is not comprehensive but covers 90% of the health issues in the developing world. There are no chapters on mental health issues and on health beliefs. Maybe in the fourth edition? If only I'd had a copy when I went to Uganda to run community health, and was soon asked to become the medical superintendent of a rural mission hospital, having done my GP VTS, but with no formal management training or experience. Who should buy it? Anyone interested in community health, or who wants to know more about this neglected field; those already working abroad especially; and elective students and those on short-term trips (who can leave their copy behind).

***Nick** and **Kate Wooding** worked in Africa and are planning to return*

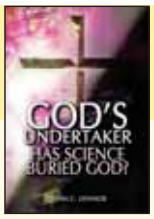
The Dawkins Delusion

Henry Callahan

- Lulu 2007
- £12.99 Pb 224pp
- ISBN 978 1 84753 095 0

This is a Christian response to Richard Dawkins' *The God Delusion*, with helpful insights which counter the Dawkins onslaught, including a short history of distinguished scientists who are also Christians, an outline of scientific method, some philosophy of science, advice on how to read the Bible properly, and quite a bit of theology. Within this he challenges many Dawkins' statements, not least: 'Who designed the designer?' There is also a chapter answering the allegation that the Bible contradicts itself. The last chapter argues that 'faith' is reasonable. There is very little science, but he does go over the Irreducible Complexity ideas of Michael Behe. Many of the things he writes need to be said loudly, and I am glad he has done so in considerable depth and with passion. There is at times a sense of personal outrage and a belittling of Dawkins, which I feel is unhelpful. There is also a lack of clear structure – the book gives the impression of being rather rushed. This is a pity because what he says is important. The title is the same as Alister McGrath's widely read book and this will cause confusion, but if you want another critique of Dawkins then I encourage you to get it.

***Anthony Latham** is a GP on the Isle of Harris, Scotland*



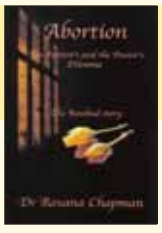
God's Undertaker

Has Science Buried God?
John Lennox

- Lion Hudson 2007
- £8.99 Pb 192 pp
- ISBN 0 74595 3034

John Lennox is an Oxford lecturer in mathematics and the philosophy of science. This slim paperback is his much awaited contribution to the science-faith debate that, for many people, has become *the* key apologetic issue of the day. Lennox provides an excellent overview and is particularly strong on the philosophical underlay, historical background, and cosmology. His text is well referenced and packed with quotations. He provides a thorough critique of Dawkins' neo-Darwinist ideas and then introduces thinking more specifically his own. He suggests that, like matter and energy, information is a fundamental component of our universe. Lennox freely admits that the second half of his book is more controversial. Yet his arguments come with hefty mathematical reasoning, making this the most persuasive presentation of Intelligent Design I have read. Moreover, he rebuts the criticism that such arguments represent an unwelcome return to 'god-of-the-gaps' thinking. Lennox's style is very concise. Many readers will like this but the complexity of his language will undoubtedly be a barrier for others. Nonetheless, this work is a must for every enquirer who remains unsatisfied by Dawkins.

***Tim Hinks** is a clinical research fellow in Southampton*



Abortion

The Patient's and the Doctor's Dilemma
Roxana Chapman

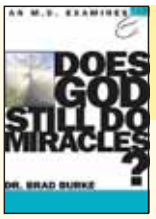
- Barham Press 2007
- £9.95 Pb 195pp
- ISBN 9780955188114

Dr Chapman has many years' experience as a gynaecologist in Russia, Australia and Britain. In this book, she uses a narrative approach to explore the issue of abortion.

A series of vignettes from Dr Chapman's practice lay out the various situations faced by some women, and also the dilemmas faced by their doctors. The different reasons for requesting abortion or for continuing a pregnancy are explored; the influence of culture, religion and social factors is also discussed. She looks at pregnancy after rape, fetal abnormality, sex selection and selective reduction for multiple IVF pregnancy. There are several stories about women suffering the sequelae of abortion, including psychological distress and infertility.

This book is rather piecemeal. The many chapters each address slightly different issues but a clear sense of direction is often lacking. A number of typographical errors also distract the reader. This is neither a handbook on unplanned pregnancy consultation nor a systematic review of abortion. It is though a vivid illustration of abortion's many facets, focusing on the personal as well as the medical. As such, it cannot fail to make an impact.

***Roxana Whelan** is a CMF Staffworker with students and a GP in Nottingham*



Does God Still Do Miracles?

An MD Examines
Brad Burke

- Kingsway Publications 2006
- £6.99 Pb 160pp
- ISBN 0 78144 2826

This excellent short book deserves to be widely read, not least by Christian doctors and church leaders. 'Health and wealth prosperity teaching' flourishes across the world. Bible teachers should understand what the Bible says about wealth, but medical people with pastoral hearts are needed in every congregation to unravel the 'mysteries' about healing. Dr Burke considers the distinctive features of Christ's miracles before comparing them to the apparent miracles of faith healers. He rightly focuses on Kathryn Kuhlman who has been so influential – Benny Hinn visits her grave to acquire 'anointing' from her bones! Her work was devastatingly exposed by Dr William Nolen who volunteered as an usher for one of her miracle services to see closely what was going on. Similarly, Burke closely observed Hinn's performances, noting that patients with visible deformities were kept away from the stage. Their findings fit closely with my own investigations of Morris Cerullo and others. Burke draws on the views of well known Christian doctors and touches briefly on Lourdes. Finally, he discusses the main Bible passages healers use to justify themselves. I have very few criticisms of this book. It is readable, comprehensive and deeply compelling.

***Peter May** was a GP in Southampton*

Future Perfect?

God, Medicine and Human Identity
Celia Deane-Drummond and Peter Manley Scott

- T&T Clark 2007
- £70.00 Hb 240pp
- ISBN 13 9780567030795

The Olympic authorities may ban Oscar Pistorius from competing because his carbon-fibre lower limbs give him enhanced power over athletes with the traditional two flesh-and-bone limbs. Is this a technical argument, or a deep philosophical and theological issue that begins with trying to establish exactly what it is to be human and then moves to look at whether adding technological fixes causes a radical change?

Future Perfect? is one of a growing list of books delving into this issue. A collection of essays, it benefits from having some chapters that are better than others. The general health warning for any reading in this area is seeing how quickly the author slips from the possible to the most unlikely. I only got to page two of the introduction before reading 'We may be entering a new phase of human evolution'. The next paragraph contained assumptions that this new era is already here! In contrast, I enjoyed Søren Holm's dissection of poorly constructed arguments. This book is not light reading. However, if you want to be challenged to think harder about what it is to be a human being, and want to see some other good thinkers struggling with the problem, then it is a good, if expensive, foil.

Pete Moore
is a scientist and author

eutychus

Doctors reject 'admixed' embryos

A bmj.com poll carried out after Parliament had voted in the HFE Bill to create so-called 'admixed' embryos for research showed an almost two thirds majority of doctors were opposed to it. 747 votes were cast and 478 (64%) were against and 269 (36%) for. Eutychus was encouraged, but the poll was only shutting the stable door after the chimera had bolted. (*BMJ* 2008; 336:1266)

Let no debt remain outstanding

The BMA predicts that massive debts on graduation of more than £60,000 will deter would-be medical students and discourage diversity within the profession. If the government raises the £3,000 cap on tuition fees to £7,000 when it reviews the system in 2009 then graduate debt could triple to £67,000 for those from London (graduates elsewhere owing about £57,000). BMA Medical Student Committee chairman Ian Noble said 'Becoming a doctor must not become the preserve of the wealthy'. Our sister organisation in the USA helps student members out with debt to free some for missionary service. Maybe that will come here? (*BMA News* 2008; 7 June: 1)

More blessed to give than to receive

Economists are reported to have been surprised by recent research showing money makes you happy – but only if you give it away. Experimental groups of students received windfalls of cash to spend either on themselves or on others, and the latter group demonstrated the truth of Paul's report in Acts 20:35 of the teaching of Jesus. (*Science* 2008; 319:1687-8)

Apocalypse now?

Eutychus cannot imagine how accurately such things can be calculated, but according to the US Census Bureau the world's 6,666,666,666th person was born on 10 May. Such apocalyptic numbers inevitably stimulated the always heated population debate, with one side lamenting that we have long ago passed our sustainability, while the Population Research Institute claimed that the number represented 'a great victory over early death won by advances in health, nutrition and longevity' and celebrated 'the birth of this milestone baby'. (Population Research Institute *Weekly Briefing* 19 May 2008)

Sex, lies and educational aspirations

On his recent visit to the USA, Pope Benedict XVI told Catholic educators 'We observe today…an aimless pursuit of novelty parading as the realisation of freedom…We witness an assumption that every experience is of equal worth…And particularly disturbing, is the reduction of the precious and delicate education in sexuality to management of 'risk', bereft of any reference to the beauty of conjugal love'. Commenting on the global significance of this address, PRI commended the Papal condemnation of what they call the current 'sexual culture of lies, misrepresentations and illusions'. (Population Research Institute *Weekly Briefing* 29 April 2008)

Betting on death

The late Professor David Short used to say that medical prognosis was a bit like weather forecasting in Britain: often right but sometimes hopelessly wrong. 58-year-old Jon Matthews from Milton Keynes seems to have agreed. He has mesothelioma and his doctor's prognosis in April 2006 was that he would be dead within nine months, so he bet £100 at William Hill's he would be alive on 1 June 2008. They gave him 50-1 odds and he collected £5,000. He will give half to the Macmillan cancer charity and spend half on himself, on 'booze and fags probably'. (*news.bbc.co.uk/1/hi/england/beds/bucks/herts/7429950.stm*)

Looking for loopholes

On the same theme of quirky behaviour by the terminally ill, Emyr Gravell introduces a reflective piece on the art of general practice with a story about the 'hard-drinking, misanthropic comedian' WC Fields. A friend called to see him when he was dying and was surprised to find him intently absorbed in the Bible. Enquiring whether he was seeing the error of his ways, Fields corrected him by explaining 'I'm just looking for the loopholes'. (*BJGP* 2008; June: 450)

Pie in the sky when you die?

Presenting research on the relationship of religion and happiness to a Royal Economic Society conference, Professor Andrew Clark of the Paris School of Economics said 'What we found was that religious people were experiencing current day rewards, rather than storing them up for the future'. Data from thousands of Europeans revealed higher levels of 'life satisfaction' in believers (both Catholic and Protestant) and that they were better able to cope with shocks such as losing a job or divorce. (*news.bbc.co.uk/1/hi/health/7302609.stm*)

More medical killing

Doctors in the Netherlands reported more cases of euthanasia and assisted suicide in 2007. The figures rose by 10% over 2006 to 2,120. Three cases were judged to have failed the legal requirements. Meanwhile, in Scotland, the number of abortions in 2007 was the highest ever at 13,703, up from 13,163 in 2006. 372 abortions were performed on girls under 16. There were 57,781 births, meaning that about one in five pregnancies in Scotland ends in abortion. (*BMJ* 2008; 336:1094 and *news.scotsman.com/abortion/Abortions-in-Scotland-soar-to.4124859.jp*)

Where there is no vision

Scripture continues to appear in the medical journals, but now in visual form too. The *BMJ* chose as its 'Picture of the Week' for 29 March a page from a calendar produced by Alma Swan to promote the open access publishing model. The page for July quotes Proverbs 29:18 in the traditional version: 'Where there is no vision the people perish', and is illustrated in what Eutychus would call an 'interesting' way. (*BMJ* 2008; 336: *This week*)

news from abroad

Responding to disasters

Once again the world has been hit by tragedies of unimaginable proportions in Burma and China, and once again there is a cry for healthcare workers to respond to the medical consequences. Perhaps we are becoming immune to the needs that scream at us from TV, newspaper and internet. Perhaps we feel there is little we can do personally or feel we are just too busy – that our commitments or employers will not let us go. Are we overwhelmed by the thought of the bureaucracy involved? Have we given up before we started, or are we simply becoming apathetic?

It is easy to reach for our chequebooks, but far more costly to get involved practically. It is perhaps questionable whether CMF, as an organisation, should be taking direct action in such circumstances. These are matters best left in the hands of agencies with the experience and international kudos to gain entry into the countries concerned.

We would however like to hear from any members who have been involved, so that we can learn from your experience and know how best to advise others in the future. We did have a specific request from a Christian agency for help in the China earthquake and two people responded to an email soliciting help, but as it turned out, foreign nationals were not allowed visas to enter the country.

Overseas vacancies

Going to our website at *www.healthserve.org/overseas_opportunites* will reveal a wide range of fascinating and challenging opportunities overseas. In recent months there have been requests for locums from members working in Uganda and Madagascar who are coming home on leave; for surgeons, paediatricians and anaesthetists on short term trips to China and Bangladesh; for longer term opportunities in Zambia, South Africa, Malawi, Rwanda, Tanzania, and Papua New Guinea where general duties doctors, eye surgeons and orthopaedic surgeons are needed.

You will find an even longer list at *www.oscar.org.uk* – a site which is well worth a visit for all the other interesting material you will find there.

We are increasingly using the emailing facility our database provides to inform selected members of such needs. I pray that such communications won't simply be binned or deleted but will provide the necessary stimulus for a positive response.

Scaling up, saving lives

This report is the work of an international task force under the auspices of the World Health Workforce Alliance which was asked by WHO to put together a plan for educating, training, and retaining health workers overseas. Lord Crisp was its co-chair. He has been involved with Sightsavers for some 20 years and, interestingly, was originally inspired to get involved in such activities by the enthusiasm of NHS staff he had met who were spending time overseas.

This is a complex issue and remains a difficult and costly one to resolve. He suggests that national governments draw up a ten year plan, focusing on a huge increase in those with basic skills at the community level. Backed by sufficient donor money such a plan could see an end to the global health worker shortage. His enthusiasm is commendable and he is encouraged by the initiatives already being undertaken by organisations such as the RCOG and LSTM&H. The full report can be found at *www.Sightsavers.org*

Courses

'Doctors Reaching School' – Do you get excited about missions? A CMF member working with YWAM says – the DRS could be for YOU! This is a new three months medical missions training course in Australia plus a three month overseas field assignment. Come and be trained in being effective and strategic in missions!

When: October 2008
Where: Perth, Australia
Prerequisite: Degree in medicine and Discipleship Training School
Info: www.ywamperth.org.au/DRS
Email: info@ywamperth.org.au

Book Review

Palliative Care Toolkit

- Improving care from the roots up in resource-limited settings
Vicky Lavy, Charlie Bond, and Ruth Wooldridge

- Help the Hospices 2008
- ISBN 978-1-871978-71-1
- Pb 96pp A4 format. CD Rom available.

Downloadable from: www.helpthehospices.org.uk and go to 'International'. For individuals based in non resource-limited settings, hard copy costs £10. Contact info@hospiceinformation.info

CMF News details the appointment of Vicky Lavy as the new Head of International Ministries. Vicky was involved in setting up a palliative care clinic for children in Malawi and in initiating a national palliative care training programme in that country. She has now co-authored this book.

It is a brilliantly practical, down-to-earth guide for healthcare workers in resource poor settings, demonstrating very clearly that palliative care isn't a matter of rocket science but that good basic palliative care can be delivered with limited resources by people without specialist training, involving the local community in the care provided. It is clearly set out and is written in understandable jargon-free English, enlivened by memorable quotes and African proverbs, with lots of bullet pointed lists and check boxes to drive home the important points.

Topics covered include team building; talking about difficult issues; controlling pain and other symptoms; and helping children – all in the context of a holistic approach that deals with the physical, psychological, social and spiritual problems that patients face. There is even a challenge and an encouragement in every chapter heading, eg: 'You can control pain and other symptoms; You can build a team; You can...; You can…'

A must buy for those working in resource poor settings.

***Peter Armon** is retiring as CMF Head of Overseas Ministries*

Paul Vincent on the consequences of cynicism

Cynicism in the surgery

'What is a cynic? A man who knows the price of everything and the value of nothing.' [1]

The following might be heard at coffee time in a staff room near you: 'Don't you just hate politicians? They don't do an honest day's work. All they do is invent ridiculous policies that make life harder for us toiling at the coalface, trying to do a good job. Meanwhile, the opposition chuck mud around hoping some of it will stick.' Alternatively, perhaps: 'Give me a cynic any time; they're the ones who know what's what!'

Now, I know you won't believe me, but I think that politicians do a difficult task to the best of their ability. They suffer from the same failings as us, and like us, they struggle on in the hope of making the world better. But I have fallen into my own trap. I have suggested you won't believe me, ascribing to you the cynical viewpoint that you doubt my sincerity.

Effects of cynicism

Some might suggest that the cynic is good for team spirit, uniting us as we lambast someone or the powers that be. However, the Bible teaches that this is not true: 'A perverse man stirs up dissension' [2] and 'Drive out the mocker, and out goes strife'. [3] Others feel the cynic knows what he is talking about, although the Bible teaches otherwise: 'The mocker seeks wisdom and finds none'. [4] Further, 'A man who lacks judgment derides his neighbour'. [5] What is the result of having a cynic on our team? We might fear being a target of our cynic's attacks. Worse, others may think that we are cynical, and that we will be cynical about them behind their backs.

The cynical clinician

The cynical team member is not as dangerous as the clinician who is cynical about a patient. This is dangerous on many fronts. First, the cynical clinician may not deal sympathetically with the patient. Secondly, his attitude might bias ours, causing us to treat the patient less well than we ought. Thirdly, we might miss the signals our colleague is sending out, and of which he may be unaware. If our colleague displays this attitude towards a patient, we should ask questions like: why did he find this patient a struggle? What difficulties might he be experiencing? Are there any learning points to be addressed? Unless we take this approach, we might miss an opportunity to support him.

How cynicism affects patients

There is a more subtle form of cynicism, and here I sometimes fail. It is the gasp I might make on seeing a certain name on my list: 'Oh no, not her again!' This should not be the voice of a representative of the Lord Jesus. [6] Patients who produce such a response are colloquially known as 'heartsinks', and may account for 11% of GP consultations. [7] To my mind, it is not the patient, but the predominantly cynical attitude of the doctor to the patient that is the problem.

This attitude results in twin risks: to one's self in making the consultation less enjoyable, contributing to personal stress or fatigue, and to the patient who is not effectively cared for. Such an attitude may be modified by seeing things from the patient's perspective. One paper states: 'general practice should reassert its acceptance of suffering, whatever its origin and presentation'. [8] This might require large leaps of imagination and empathy with some patients, but it is our challenge, particularly as we are called to be salt and light. [9]

> Its malign influence should not be underestimated

A Christian response

What should we do when we next hear the seductively acid tones of the cynic? Well to start with, we shouldn't join in: 'Do not answer a fool according to his folly, or you will be like him yourself'. [10] Further, Jesus teaches 'Do not judge, or you too will be judged'. [11] If we do speak, we should ask God to help us to be careful what we say: 'Set a guard over my mouth, O Lord; keep watch over the door of my lips'. [12] If we confront the cynic, we should remember that a mocker resents correction. [13] Better still, we shouldn't listen in the first place, if that's possible: 'A wicked man listens to evil lips'. [14] More positively, we should remain cheerful, remembering 'A cheerful heart is good medicine'. [15] If we have a team member who hasn't a good word to say about anyone, we could lead by example, praising others where appropriate.

Does this mean we should believe all we hear? Certainly not! Jesus sent out his disciples to 'be as shrewd as snakes and as innocent as doves'. [16] Paul said: 'Test everything. Hold on to the good.' [17] Although he was referring to prophecies, I think this concept can be applied here too.

Cynicism hasn't made it onto the list of the seven deadly sins described by Pope Gregory the Great. [18] But I hope I have shown that its malign influence should not be underestimated.

***Paul Vincent** is a GP in County Durham*

references

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3. Proverbs 22:10
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5. Proverbs 11:12
6. Colossians 3:17
7. *www.gp-training.net/training/ consultation/heartsin.htm*
8. Butler C, Evans M. The 'heartsink' patient revisited. *British Journal of General Practice* 1999;49(440):230-3
9. Matthew 5:13-16
10. Proverbs 26:4
11. Matthew 7:1
12. Psalm 141:3
13. Proverbs 15:12
14. Proverbs 17:4
15. Proverbs 17:22
16. Matthew 10:16
17. 1 Thessalonians 5:21
18. *www.le.ac.uk/arthistory/seedcorn/faq-sds.html*

Organ donation policy

Following the brief News Review piece (Triple Helix 2008; Easter:5), respected pro-life campaigner ***Stuart Cunliffe*** *takes issue*

Andrew Fergusson says the Christian church should support the principles of organ donation and transplantation and prominent Christian figures should become role models in encouraging organ donation. I disagree. I do not object to people donating their organs for others' use after their death, but the end does not justify the means.

Traditional criteria for certifying death were that breathing and heartbeat had irreversibly ceased. In 1976, with techniques now available to provide ongoing support for brain-damaged patients, the Conference of British Medical Royal Colleges decided that brain stem testing would establish whether or not the patient would die if support were removed.[1] In 1979, at a time of increasing demand for donor organs, the Conference decided brain stem testing would establish whether or not the patient was dead already.[2] Prognosis became diagnosis.

The Department of Health tells people organs are removed 'only when death has taken place for certain'.[3] Potential donors and next of kin are led to believe that the ventilator will be switched off and then organs excised. They are not told that ventilation will be continued until after organs are removed, and that the patient will be breathing and his or her heart beating when organs are taken. Brain stem testing does not and cannot prove lack of awareness.

In 1998 Dr Fergusson wrote 'We are in fact agreed that the current practice of removing organs such as heart, liver and pancreas from people said to be brain stem dead who are being ventilated at the moment of the removal of those organs is unethical'.[4] How he can now write about 'an altruistic free gift in a context of fully informed consent' when he knows full well the conditions in which organs are removed I fail to understand.

references

1. Conference of Medical Royal Colleges and their Faculties in the United Kingdom. Diagnosis of brain death. *BMJ* 1976; ii:1187-8
2. Conference of Medical Royal Colleges and their Faculties in the United Kingdom. Memorandum on the diagnosis of death. *BMJ* 1979; i:332
3. Leaflet *Join the NHS Organ Donor Register and give the gift of life*, undated
4. His letter to me dated November 17, 1998

***Andrew Fergusson** replies:*

First, Stuart has quoted me from a personal communication ten years ago. What he quotes remains my personal view, but in writing a *News Review* piece now, my duty is to represent the consensus view of CMF. The Medical Study Group revisited the question of organ transplantation before that *Review* was written, and the principles implicit or explicit there were based on the Study Group discussion.

Secondly, the *News Reviews* in *Triple Helix* are brief summaries of developments in the subject in question, and for fuller treatment of the issues involved, readers will have to consult the references given and read more widely, perhaps by searching at *www.cmf.org.uk*. The amplification of Stuart's particular point, which follows, can be found in this extract from a Supplementary Submission[1] made by CMF in February 2008 to the House of Lords inquiry into the European Commission Communication: Organ donation and transplantation – policy actions at EU level.

> Consent by patients and families can only be truly valid if it is fully informed

Q1. *Please would you describe any particular aspects of organ donation and transplantation which are considered ethically problematic within the context of your organisation's religious beliefs – as these are perceived: (a) within the UK; or (b) in other EU Member States?*

a. We have already expressed strong support in principle for the concept of organ donation and transplantation, as an altruistic free gift in the context of fully informed consent, and have no fundamental ethical concerns with donation *per se*.

Some members are concerned about lack of transparency in the information provided to potential donors and their families about the issue of the timing of cessation of ventilation. Organs to be retrieved are in the best condition if well perfused with well oxygenated blood, so the practice is to leave the donor on the ventilator until all the organs to be retrieved have been removed, and then turn off the ventilator. Those with concerns here have reservations about the concept of brain stem death and would argue that it is the act of removal of organs which ends the donor's life. They believe the ventilator should be turned off and removal of organs should not take place until classic criteria of death have been fulfilled – the donor stops any natural breathing and the heart stops.

Most members, fully aware of the situation about ventilation, accept the concept and criteria of brain stem death and have no such reservations. However, both sides would agree that consent by patients and families can only be truly valid if it is fully informed, and that information about this issue should be given transparently, even at the risk of lowering donation rates. The practice of organ donation must have public confidence and support.

b. We cannot speak for other EU Member states, though would expect our sister organisations in those countries to mirror the position expressed above.

reference

1. *www.cmf.org.uk/ethics/submissions/?id=50*

Bernard Palmer
on reviewing and reordering priorities

Forsaken your FIRST LOVE?

A great problem facing Christian doctors is that our responsibilities can become so important that our love for the Lord Jesus, and our desire to achieve what he wants, become of lesser importance to us. Our careers, hobbies, friends, reputations and even our families can become our first love. They can, in reality, become a god.

When God addressed the Christians at Ephesus[1] he noted they worked hard, were intolerant of immorality, were astute at recognising false teachers, and doggedly pressed on as Christians. These were all admirable. But something was wrong, and the diagnosis was very serious. They had lost their 'first love' – their devotion to Jesus. This wasn't an accident either – it was a deliberate choice. The text says 'You have forsaken your first love'. It is as if the Christians were having affairs with other gods, although of course they still claimed to be following the Christian way.

The prescribed remedy was clear: 'Remember the height from which you have fallen!' Look back to those times in the past when the Lord Jesus meant so much more to you. 'Repent and do the things you did at first.' Change direction, get your priorities right again, and begin again to do those things you used to do.

Then comes a warning: 'If you do not repent…' If you don't rethink and reorder, both you and your church will die. History confirms that when churches lose their devotion to Jesus they crumble. An emphasis on liturgy, ethics, or social matters will not save them.

How can we as doctors prevent this happening to us? Can we follow the educational vogue for appraising ourselves and being accountable, and similarly assess our own spiritual progress or regress? We could ask questions like:

- How often do I pray, and mean, 'Your kingdom come…on earth'?
- How central is the local church and its members in my life?
- How often do I study the Word of God? Daily, most days, seldom?
- How often do I talk to non-Christians about the Lord? Once a month? Less?
- Do I go out of my way to help and encourage others practically?
- What proportion of my taxed income do I give to the Lord's work?
- How much do I support overseas mission by giving, prayer and regular contact?
- How much do I fight temptations like pornography, pride, possessions?

And would the Lord agree with our answers?

***Bernard Palmer** is a surgeon living in Hertfordshire*

reference

1. Revelation 2: 1-7

uniting and equipping christian doctors

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