Summer 2010

for today's Christian doctor

# triple helix

# models of medicine

social networking, teaching medicine Christianly, losing an infant, supporting medical students, coping with interruptions, wider horizon, dating, reviews

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# contents



# Elections, Christians and the Gospel

## *Out into the open as never before*

The 2010 general election, with its television debates and hung Parliament leading to a Lib-Con coalition engaged a public, normally bored with politics, like no other in living memory.

Perhaps predictably, the economy and immigration were the issues that most captivated media attention. Several weeks of preparing the public have now culminated in the 22 June 'tough but fair' budget with its cocktail of spending cuts and tax increases, and we will wait to see in coming months if the plan results in the deficit reduction and 'enterprise-led recovery' promised or founders on the rocks of union unrest, stalled growth and increased unemployment.

The effects on the health service of the expected spending cuts and restructuring are yet to be seen and it may take much longer before they materialise.

What has been particularly striking about this election, however, has been the level of involvement of Christians and Christian groups. British Christians wanting to vote in an informed way have never been better resourced to do so. The election brought Christians out into the open as never before.

Faithworks [1] issued a declaration calling on candidates to 'recognise the important contribution that local churches and Christian charities have made historically in providing services within local communities, acknowledge the indispensible role that faith in Christ plays in the motivation and effectiveness of Christian welfare programs and encourage and promote further initiatives and deeper partnership underpinned by legislation'.

Christians and Candidates, [2] sponsored by CCFON and fronted by former Bishop Michael Nazir-Ali, ran a roadshow and published MPs' past voting records on key ethical issues.

A massive online database of MPs' votes produced by the Christian Institute, [3] the result of over ten years' detailed analysis, was supplemented by a 50-page resource on each political party's stance on a whole host of issues from embryo research to reform of the House of Lords.

CARE's campaign 'Make the Cross Count' [4] featured policy papers, hustings events and 'My manifesto', outlining the dreams of Christian leaders about policies they would like to see enacted. On a similar theme 'Election Crossroads' [5] published a questionnaire voters could use as a basis for quizzing their local candidates at surgeries or hustings meetings.

The Evangelical Alliance launched its 'top ten reasons for Christians to vote' [6] along with regular news updates, resources on the major parties' positions on key policies, and electoral maps. [7] Christians in Politics [8] encouraged Christians to longer term involvement in the three main parties.

CMF played a key role in launching the Westminster 2010 Declaration of Christian Conscience, [9] styled on the US Manhattan Declaration. [10] This was eventually signed by over 66,000 UK Christians calling on candidates to pledge 'to uphold the right of Christians to hold and express Christian beliefs and to act according to Christian conscience'. It began with the affirmation 'We believe that protecting human life, protecting marriage, and protecting freedom of conscience are foundational for creating and maintaining strong families, caring communities and a just society' and focused specifically on areas where Christians have recently faced discrimination. Over 1,000 candidates were assessed on the basis of public statements, answers to written correspondence and past voting records.

As I write this US professor of theology Wayne Grudem is embarking on a UK tour under the title 'Public Hope: Politics and the Great Commission', which looks at 'how civil freedoms thrive in the slipstream of the spreading gospel, how good works (including in public life) flow from grace-saved sinners, and the limitations of government'.

In my last *Triple Helix* editorial [11] I raised ten issues, apart from health, education, crime and the economy, which will concern Christian doctors (euthanasia, abortion, embryo-destructive research, sexual health, poverty and health, freedom of worship, marriage and family, addiction, obesity and inactivity, marginalised groups). How will we fare with these during the next Parliament and how can we help shape our society's response?

Jesus' 'Nazareth call' to preaching, healing, deliverance and justice remains. [12] Regardless of what challenges we face and what opposition we encounter, he still calls us to 'seek the peace and prosperity of the city to which he has carried [us] into exile' and has plans to give us 'hope and a future' [13] as we seek to walk in his footsteps in gospel witness and in living out the practical love of Christ to our generation.

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


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# news reviews

## The End of Life Assistance (Scotland) Bill

*Implications for physicians*

Review by **Calum MacKellar**
Director of Research, Scottish Council on Human Bioethics [1]

12 May 2010 saw the close of the Scottish parliament's public consultation on the End of Life Assistance (Scotland) Bill, expected to be voted upon at the end of the year. This Bill was put forward by Margo MacDonald – Scotland's only independent MSP – who suffers from Parkinson's disease.

The overall aim, supposedly to legalise both euthanasia and assisted suicide, is based on a very strong understanding of autonomy. As Ms MacDonald herself acknowledges: 'The Bill and its motivation rests on respect for the ability of those with a progressive, irreversible condition and/or terminal illness to decide whether or not their lives have become intolerable and whether or not they would prefer to seek assistance to end their own lives'.[2]

It is clear the Bill is about (1) choosing whether or not to end one's life; (2) choosing when and where to do this; (3) choosing who should assist; and (4) choosing how to end one's life. Should this Bill eventually become law, however, worrying expectations arise for healthcare professionals. For example, they would have to:

- Make judgments about the intolerability of someone else's life
- Agree with the person on the actual method of termination (the Bill assumes that doctors actually have the required expertise)
- Agree with them on who should actually conduct the life-terminating procedure (it does not necessarily have to be the doctor) and where this will happen
- Provide or administer appropriate means for the life to be terminated
- Be present at the actual life-terminating procedure, even if not conducting it
- Be obliged either to provide for assisted dying, or to refer the person to another doctor prepared to do it – there is no conscience clause permitting opt out

If euthanasia and assisted suicide become law, moreover, a numbing affect on both physicians and society regarding the inviolability of human life would take place.

The sanctity of life, historically a foundation stone for society in general and for medical practice in particular, would be compromised. A grave insult to Christian values could become unimportant and commonplace. The legislation would fundamentally change the role of the physician, change the doctor-patient relationship, and change the role of medicine in society.

The Committee released on 18 June a preliminary analysis of the consultation responses. Of 610 submissions, 521 were opposed, 39 supportive of the Bill or at least the principle behind it, and 41 had no position.[3]

To object, support Care Not Killing;[4] Scots can contact their MSP; GPs in Scotland can sign the letter of opposition.[5]

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## Common Call to world mission

*Incisive but lacks recognition of medicine, health and healing*

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

In June 2010, mission leaders, theologians and church leaders from Protestant, Pentecostal, Catholic and Orthodox traditions met in Edinburgh at the Centenary of the historic 1910 Edinburgh Missions Conference.

They worked to forge new alliances and new vision for mission in the 21st century, to open up a new conversation between the mission movements of the North and the South and East, and to celebrate the last hundred years of global mission.

The 'Common Call'[1] which resulted is a nine point joint statement, affirming the Gospel, the call of the church to be engaged in worldwide evangelism, a commitment to social justice and care for creation.

The statement is clear and incisive, although it may be lacking in a sense of urgency (there is only a brief reference to eschatology and finishing the Great Commission before the Lord's return).

However, from a Christian medical perspective there was almost nothing on the call to healing and caring for health which is part of the mission of God's people.

There is an affirmation in point 3 of the Common Call that 'we are called to become communities of compassion and healing'. However, this is couched in the language of social justice and reconciliation, and seems not to recognise the historic and current role of God's people in bringing physical, as well as spiritual and social health and wellbeing, as we share the Good News of Jesus.

Such declarations have a place, and can act as benchmarks to evaluate how we are engaging in the Great Commission,[2] but in October this year 4,000 evangelical leaders meet in Cape Town for Lausanne III,[3] following on from the 1974 and 1989 meetings on world evangelisation in Lausanne and Manila which produced the Lausanne Covenant and the Manila Manifesto respectively.

We trust this Third Lausanne Congress on World Evangelisation will produce a more explicitly evangelical re-statement of current global mission priorities.

At that conference, we further hope that the health and healing ministries of God's people are not so neglected.

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# Abortion update

*Numbers down but troubling trends*

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

On 24 May Marie Stopes International (MSI) broadcast for the first time on British TV an advertisement for its abortion services. However 'sensitive' *Are you late?* may or may not have been, British women surely are sufficiently aware of how to access abortion services. Television is a powerful medium for influencing decisions and its use was unnecessary, the advert seeking to normalise abortion as a part of life.

The Broadcast Committee of Advertising Practice (BCAP) has reviewed its 2009 public consultation on abortion ads (to which CMF contributed [1]) and on 1 March revealed the draft code, enforced from September: 'Advertisements for commercial post-conception advice services offering individual advice on personal problems are not acceptable'. [2] However, BCAP says 'commercial' does not include not-for-profit organisations. While Marie Stopes is a charity, it has an income of some £100m pa, much from contracting with the NHS for abortions. MSI may have followed the letter of the law but certainly not the spirit.

MSI has courted further controversy by using UK taxpayers' money to fund the opening of abortion clinics in China, money left over from NHS abortions being used internationally. Five clinics have been opened in Jiangsu and there are plans to open three more. [3]

2009 statistics just published [4] show the total number of abortions in England and Wales fell slightly on 2008's, to 189,100. This is down 3.2% on the 195,296 recorded in 2008. Of these, 63,390 of the woman had previously ended a pregnancy, compared with 51,987 a decade ago – a rise of 22%. Some 18,000 abortions were carried out on girls under 18, including more than 1,000 on girls aged 14 or under, and around half of all teenage pregnancies now end in abortion. Peter Saunders commented 'Abortion is simply being used as a form of contraception by a growing percentage of girls and women, and tired policies of values-free sex education, condoms and morning-after pills are not working'. [5]

Further concerns arise after figures published by the Human Fertilisation and Embryology Authority (HFEA) show that about 80 abortions are performed in England and Wales each year on women pregnant after IVF treatment, some of it funded by the NHS. [6] Although an HFEA spokesman commented 'I had no idea there were so many post-IVF abortions and each one is a tragedy', Infertility Network UK explained 'There may be serious problems with the child, or someone's individual circumstances may have changed so profoundly that they no longer feel it is right to have that baby'.

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# The Resistance Campaign

*A new direction in the assisted dying debate*

Review by **Peter Saunders**
CMF Chief Executive

Disabled people's leaders launched a new campaign in Westminster on 3 June calling for better support and opposing any change in the law to allow 'assisted dying'. Not Dead Yet UK's [1] 'Resistance' campaign [2] has been prompted by fears that calls to legalise assisted suicide and euthanasia are likely to intensify. These fears have grown with current economic difficulties and calls from politicians from all parties for cuts in public services.

The campaign is backed by three of the UK's largest disabled people's organisations (Radar, UKDPC and NCIL). It calls on the country's 650 MPs to sign a seven point charter recognising that disabled and terminally ill people should have the same legal protection as everyone else, and committing themselves to supporting access to health and social services and to opposing attempts to legalise assisted suicide.

Campaigners argue that high profile cases of disabled people who want the law changed to make assisted suicide easier are the exception rather than the rule. They are particularly concerned about recent attempts to change the law. These include Lord Falconer's amendment to the Coroners and Justice Bill, which was aimed at decriminalising taking 'loved ones' abroad for assisted suicide; and Margo MacDonald MSP's End of Life Assistance (Scotland) Bill, [3] presently before the Scottish Parliament, which includes in its catchment people who are 'permanently physically incapacitated to such an extent as not to be able to live independently and find life intolerable'.

The Falconer amendment was defeated in July 2009, at least in part because of a passionate speech by Not Dead Yet's convenor, disabled peer Baroness Jane Campbell of Surbiton. This was accompanied by a letter from over 30 disabled people's leaders from both sides of the Atlantic, urging Britain's upper House to reject the amendment. [4]

Director of Public Prosecutions Keir Starmer removed from his definitive guidance this February a clause making disability a mitigating factor for assisted suicide prosecutions after an outcry from disabled people claiming that the measure was profoundly discriminatory.

The launch of the 'Resistance' campaign has been supported by the Care Not Killing Alliance, [5] who at the same time have launched a new DVD featuring disabled people arguing for the right to life. Members of the new coalition government may be reluctant to sign a charter committing themselves to maintain spending at a time of national financial belt-tightening but, if nothing else, the Resistance Campaign has created a fascinating new division in the debate. One cannot now easily be both pro-disabled people and pro-euthanasia.

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**David Misselbrook**
on consulting with QOF

# What is the right MODEL of medicine?

Photo: PA

## key points

The Quality and Outcomes Framework (QOF) was introduced into UK primary care in 2003 and measures around 100 clinical and various non-clinical parameters believed to represent good quality in general practice. Typically, around 20% of a GP partner's pay is linked to attaining QOF points.

The author considers the benefits of QOF, the arguments against, and QOF's omissions. How far does QOF relate to the goals of medicine? And for Christians, what are these?

He concludes that QOF may push us further towards a biomedical model to the exclusion of a broader and more humane model of medicine.

Medicine is not a pure science like physics, rather an applied one like rocket engineering. It uses science to pursue goals. This is beautifully expressed in the motto of the Royal College of General Practitioners, my own: 'Cum Scientia Caritas' – 'with science I care'.

A central innovation of the 2003 'New Contract' for GPs was the Quality and Outcomes Framework (QOF). This was a mutually negotiated response to perceived quality problems in general practice and is a framework that measures around 100 clinical parameters and various non-clinical ones that are believed to represent good quality. Each is weighted to yield a number of possible points, with approximately 1,000 points attainable in total. About two thirds of QOF points relate to biomedical markers, eg the proportion of diabetics whose HbA1c is below 7.5%. These markers cover the main chronic disease areas that account for most preventable illness in the UK. About one third relate to administrative outcomes, including the result of patient satisfaction questionnaires.

QOF points are derived remotely from data entered in standardised ways in patients' electronic notes. Standardised data entry is therefore essential in many or most GP consultations. Typically, around 20% of a GP partner's pay is linked to attaining these points.

## The benefits of QOF

Specific claims have been made in support:

- QOF finally addresses the quality 'tail' in GP
- QOF increases the implementation of evidence based medicine (EBM) in chronic disease management, and therefore should lead to increases in appropriate prescribing, improvement in health markers, and improved outcomes
- It is hoped QOF will reduce health inequalities

There is growing evidence to support these claims:

- Ashworth *et al* reported in 2008 that '…blood pressure monitoring and control have improved substantially. Improvements in achievement have been accompanied by the near disappearance of the achievement gap between least and most deprived areas'.[1]
- Prescribing in chronic disease has increased dramatically. Oliver reported that 'primary care prescribing in over 65s has increased 50% over the past three years'.[2]
- Lester states that 'the greatest contribution that [QOF] has made to practice will therefore be the largely unintended consequence of generating more equitable healthcare'.[3]
- In a *BMJ* letter responding to criticisms of QOF Roscoe commented '…what I am doing for my patients is improving their health so I will continue to do it…'[4]

Surely then QOF must represent a win-win situation? GPs are happy that hard work is rewarded. The DOH is happy that perverse disincentives are reduced, and the 'tail' of poor quality general practice has finally been addressed. And patients should be happy they can be confident of receiving the best quality of care.

But might there be unintended consequences? If so, do they matter? Overall, does QOF improve care?

## The case against QOF

There are a number of arguments against:

- QOF represents 'one size fits all' medicine – what about patients' own priorities?
- Might QOF mean more computers but less communication?
- *Is* it good EBM?
- What about opportunity costs?
- Are there really fewer inequalities – could there be a potential for more?
- Might QOF deprofessionalise medicine?
- What about the conflict between individual patient care and public health?

Again there is evidence to support these charges:

- Heath *et al* argue that 'measurable differences do not necessarily translate into meaningful differences in patients' lives', and that 'clinical care

needs to be tailored to individual patients rather than using a mechanistic approach'.[5]

- Rouf found that '…exam room computers decreased the amount of interpersonal contact'.[6]
- Increased prescribing is a two edged sword – Oliver comments that 'Iatrogenic illness relating to polypharmacy accounts for many admissions of older people to hospital…'[7]
- Curtiss argues that managed care leads to greater medicalisation: '…preventing specific diseases and chasing pre-disease markers are not the same as promoting health'.[8]
- Starfield points out that '…fewer than a fifth of trials use health outcomes as criteria of benefit'.[9]
- Heath reminds us that 'Most randomised trials systematically exclude patients' symptoms, functional status, comorbidity, severity of illness, ideas, and preferences.Yet these are the factors which should fundamentally affect decisions about appropriate treatment.'[10] She further criticises the unthinking reliance on intermediate outcome measures, commenting 'none of the framework measures clinically important outcomes'.

A major source of discontent however is what QOF leaves out. Mangin comments: 'QOF will never deliver on the elements that patients value so much: the giving of hope…trust, reassurance, faith, the complexity of general practice…greater status is given to what is coded than to what is spoken between doctor and patient'.[11]

It seems unlikely QOF will greatly reduce health inequalities. Crawley comments that 'The quality of chronic disease management in England was broadly equitable between socioeconomic groups before this major pay for performance programme and remained so after its introduction'.[12] Ashworth echoes this view.[13]

## The 'target culture'

And what of the effect of the 'target culture' of which QOF might be seen as the paradigm case in the NHS? Davies states that 'excessive supervision and micro-management will destroy the motivation of many professionals, and so ultimately reduce the quality of service'.[14] This is echoed by Mangin: 'The progressive loss of independence to external influence is central to the deprofessionalisation inherent in the QOF. The medical profession is already trying to disentangle itself from the influence of the pharmaceutical industry, and now faces an increasing, unwanted and often unrecognised influence from the state. Both threaten its independence'.[15]

Jeffries views QOF as a Trojan Horse, creating an ever increasing target workload. He states 'As each target is attained so it is removed from the equation and a new one introduced…now that NICE is getting in on the act, financial considerations will loom ever larger, and decisions about QOF will be made with less and less reference to working GPs.'[16] Abholz points to the inherent conflict between individual patient care and public health. He asks 'will QOF push us away from individual patient care, further towards public health?'[17]

## The goals of medicine

Christians believe that men and women are special because we are made in God's image – we are not just clever apes.[18] If this is true then each person is of immense significance and worth. As doctors we are fortunate to be able to reflect God's own care for each, but we must remember we are part of the creation; let us not confuse ourselves with the creator! Doctors are not always strong on humility – we should be.

So what sort of medicine should Christians be standing up for? Or, what are the goals of medicine? Aristotle stated that 'the end of the medical art is health'.[19] However this leaves us with a small problem – although we are prepared to spend dizzying sums on healthcare no-one seems quite sure what health is. Of course the World Health Organisation made a bold offer. Their definition of health is 'not merely the absence of disease or infirmity but a state of complete physical, mental and social wellbeing'. But this utopian vision is an unattainable ideal, bearing no relation to the struggles of real people in an imperfect world.

The WHO definition however represents the logical aim of the biomedical model. If we are closed knowable systems then imperfections should be fixed. As none of us is in this complete state of wellbeing, we are all in need of medical intervention to correct 'abnormalities' that obstruct our path to perfection. But should we view any deviation whatever from perfection as pathology needing treatment? Is the biomedical model *sufficient* as a target for medicine?

A biomedical model fails to capture critically different meanings of *ill-health*:

- **Disease** is defined by pathology, and is traditionally capable of being established as objective fact. However, this simple definition has recently become extended by 'surveillance medicine'.[20]
- **Illness** is the patient's ill-health experience, and has a large individual subjective element greatly influenced by psychological and social factors. It is experienced within a life narrative, not as a scientific construct. Its relationship to disease is extremely variable.
- **Disability** is impairment of function. It has a large subjective element, and is partially socially determined.

Health as the attainment of biomedical norms is becoming by default our dominant definition. It is the only definition that makes sense within a biomedical model. But a norm-referenced definition of health ignores the difference between disease and illness.

The WHO definition should also alert us to another paradox. It seems dated. Its faith in an attainable Nirvana is touching, but not credible. It is a flagrantly modernistic statement, and, like a statue of Lenin, appears now as the ironic icon of a bygone age. Perhaps our definition of health will be linked to the thinking of our time, and will have a sell-by date.

## Medicine needs values

Medicine needs values, but values cannot be derived from facts. Much of the current confusion surrounding medical goals is because we have become scared of

Photo: PA

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Photo: PA

We should practise medicine in a way that responds first to the patients' agenda.

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being clear about our values and have sought to retreat into facts. QOF makes the implicit assumption that it in some way represents our goals in practising medicine, but is this true? Is health just the absence of disease, or is it a more positive concept? Can we go beyond normative facts and admit values into our concept of health? Can we go beyond a disease model and encompass the patients' experiences of illness and disability also?

In the mid 20th century Maslow developed within the psychology literature a model of human flourishing. He proposed that humans have a *hierarchy* of needs[21] and described five levels, aiming for a mature human autonomy:

**Level 1:** Physical survival needs, eg air, water, food, sleep, warmth, basic health, exercise, sex

**Level 2:** Safety and security needs, eg physical safety, economic security, freedom from threats, comfort, peace

**Level 3:** Social needs, eg belonging, acceptance, group or team membership, love and affection

**Level 4:** Need for self-esteem, eg important projects, recognition, intelligence, prestige and status

**Level 5:** need for self-actualisation, eg opportunity for innovation and creativity, autonomy, self-awareness

We need to link a positive concept of health with a renewed concept of human flourishing. We can immediately see that healthcare is relevant to level 1 survival needs. But perhaps we underestimate the effects both illness and healthcare may have on a person's overall wellbeing at Maslow's other levels. Serious illness may threaten ability to flourish at any of these. Unfortunately healthcare interventions themselves may impair flourishing, for example by reducing a person's sense of autonomy or self-esteem.

## Swimming against the stream

If we truly believe in a multidimensional model of health, which includes the biomedical, social, psychological, anthropological and spiritual dimensions, then we are swimming against the stream. The current NHS reforms are staunchly biomedical and managerial in their gaze. Evidence based medicine is predominantly biomedical. We are in a culture that pays lip service to the needs of the patient, but ignores any attempt to catalogue or understand those needs. Patients' needs are multidimensional. Can our gaze rise to the challenge to see them?[22]

Dietrich Bonhoeffer defined health as 'the strength to be',[23] saying that health is the ability to pursue our life story without insurmountable obstruction from illness. Thus health can be seen as the ability to flourish without being unduly impeded by illness or disability or, if necessary, by overcoming them.

So might this give us a clue as to what healthcare is *for*? However advanced our treatment of disease may be, we can never banish illness. At the very least medicine must recognise and deal with both disease and illness, and the disability that may stem from either. Healthcare exists for the benefit of the patient. Healthcare must therefore include both processes and outcomes that are valid primarily in the world of the patient, not primarily in the world of the doctor.

I would offer this goal: Healthcare should aim for the state of least possible illness or disability, or of maximal functional adaptation to illness or disability. We need such a definition unless we wish to see the whole population deemed unhealthy as defined by a utopian biomedical gaze, and thus in need of medical intervention. This definition does not decry the role of biomedicine, but rather redirects our attention as to its purpose and proper function.

If anything stands in the way of me fulfilling my life goals that biomedicine can fix, then this model tells me to fix it. But in reality there is so much sickness we cannot fix, and this model gives me a more dynamic and a more patient oriented way to seek ways round, or ways of coping with, the unavoidable.

We know that the ability to increase control of one's world improves health.[24] But the more we control, the less the patient controls. Medicalisation damages their ability to continue to control themselves, which is morally undesirable, and may actually damage their health. QOF must now be added to the list of drivers for medicalisation.

It amazes me that, faced with a call from help from an obviously blind man, Jesus asked 'What do you want me to do for you?'[25] He did not assume he knew the man's needs better than the man himself. Indeed Jesus' whole ministry is very focused on the needs that people express, not on 'one size fits all' solutions.

## My verdict

My verdict on QOF would be that it may well offer some advance in the quality of some intermediate outcomes in healthcare, and this is likely to benefit some patients. But QOF also has three grave failings:

- QOF falls for the 'empiricist fallacy', ie the wrong belief that quantitative methods must always be better in human affairs
- QOF hijacks the patient's agenda and substitutes the doctors' and the politicians' biomedical one
- QOF risks deprofessionalising GPs. According to Dunstan we are society's 'accredited moral agents'.[26] We should not limit our vision to being merely biomedical technicians

QOF is a huge uncontrolled experiment whose outcome is too early to determine. While QOF has certain modest benefits to patients, it may not overall be in patients' long term best interests. QOF is probably best seen as a move within the politically driven control of the medical profession.

We should be encouraging a societal debate about the proper limits to medicine's domain. We should not pursue the problematisation of normality that is currently extending medicine's control over the healthy. We should practise medicine in a way that responds first to the patients' agenda.


The family shortly before Eva's death

**Peter and Catriona Waitt** review an instructive personal experience

# Is any one of you in trouble? HE SHOULD PRAY[1]

In February 2009, national attention was drawn to the case of Caroline Petrie, a community nurse suspended after offering to pray for a patient.[2] She was subsequently offered her job back on the proviso she asked patients about their spiritual needs first before offering to pray for them. Her employers stated she had 'failed to demonstrate a professional commitment to equality and diversity by offering her prayers'.

The General Medical Council states that doctors 'must not discriminate against patients by allowing their personal beliefs to adversely affect their professional relationships'.[3] The following case study illustrates powerfully how the free discussion of spiritual matters coupled with excellent clinical treatment leads to the provision of truly patient- and family-centred holistic care.

## Case study

A previously healthy nine-week-old female infant suffered a cardiac arrest while being carried by her mother in the market. A cardiac output was obtained following two cycles of CPR. Initial investigations revealed no cause for the event and despite normalisation of her cardiorespiratory parameters, weaning from the ventilator was not possible due to the development of seizures.

After 36 hours, the baby was transferred to the nearest paediatric intensive care unit. Three days after the original event, she developed cerebral oedema causing significant neurological deterioration. Following extubation, she was found to have spastic quadriplegia, cortical blindness, a bulbar palsy and intractable seizures. Tragically, she died from pneumonia six weeks later.

## The parents' perspective

Twelve hours after we had set off to the market with Eva Grace, our daughter, we sat in the intensive care unit helplessly watching the monitors. The resident doctor stayed with us throughout the night. She explained that medically everything was being done appropriately, but that as a clinician she could only treat with medicine; it was God alone who could bring healing. She spoke of her own faith and we prayed together. This brought tremendous comfort and perspective to the situation: 'All the days ordained for me were written in your book before one of them came to be'.[4]

Initially it seemed that Eva would have some degree of cerebral palsy, but catastrophic neurological degeneration changed the picture radically. We struggled to understand why, following a seemingly successful resuscitation, our daughter should be so disabled.

Whilst trusting that God had a 'perfect plan for her life',[5] we struggled with our broken dreams. The uncertainty was most difficult to deal with.

Following an apparent stabilisation, Eva would then suffer status epilepticus or a chest infection. It was subsequently decided that further intensive care admission was not going to be appropriate. On several occasions, members of the nursing staff comforted us with Bible passages and personal examples of God's faithfulness.

As the weeks passed, a neurological consultation was arranged at the nearest teaching hospital. When we saw the professor, he reminded us to see our daughter as God created her to be. He explained that we consist of body, soul and spirit and although Eva's body was badly broken, she was still the same child God had made her to be. This helped immensely as we prepared to return home for what we accepted would be a limited time. Sadly however, our plans did not come to pass as Eva developed pneumonia complicated by septic shock, and died in our arms.

## Faith in practice

These events took place in Malawi and subsequently, following transfer, in Johannesburg. In such cultures, discussions about spirituality and God are often parts of daily life. Had we been in the UK, it is unlikely that the medical and nursing staff would have felt able to share their faith with us. Medically, the situation was entirely futile and if there had been any possible intervention, at any cost, we would have wished to pursue it. If our only source of hope or faith had been in modern medicine, we would have been utterly disillusioned!

Instead, we were given the support we needed to accept her illness as terminal, to continue to see her as a gift from God[6] and to observe the many ways in which God was honoured through her life.

We chose the name 'Eva' which means 'giver of life'[7] because we prayed that through her life, many would come to see true spiritual life. Her second name 'Grace' was a reminder of God's undeserved favour to all of us. We believe that throughout her life and especially during her illness, many people came to hear about the goodness of God.

Since 1948, the World Health Organisation has defined health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[8] This definition is oft quoted but do the implications truly underpin medical practice? We thank God that, in our experience, the clinicians were truly able to offer us holistic care.

***Peter and Catriona Waitt*** *are physicians working in Malawi*

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**Richard Vincent**
summarises his 2010
Rendle Short Lecture

# FOUNDATIONS FOR PRACTICE
## – How should Christians teach medicine?

### key points

The 2010 Rendle Short Lecture reviewed the move from authoritarian and belittling teaching to an emphasis on students' needs for support and encouragement to acquire the knowledge, skills and professionalism relevant to their future practice.

Making patients the central concern of our clinical practice and placing students at the centre of our medical teaching represents substantial progress from the early days of stridently doctor-centred professionalism.

But placing Jesus at the centre of our thinking honours him most and inspires our own best contribution to patients, colleagues and students alike.

The days of Sir Lancelot Spratt are long past. Sixty years ago Richard Gordon's preposterous surgeon in *Doctor in the House* dealt with *cases* rather than *people* and taught medicine by aphorisms and bullying.[1] Physical mechanisms of ill health and its cure were central to clinical practice. Students were expected to soak up facts for later regurgitation, while understanding was optional and questioning discouraged. Teachers were objects of reverence and fear.

Since then, medical science has expanded dramatically, spawning numerous developments in diagnosis and treatment; but the focus of our evidence-based practice has remained biophysical. Against this has arisen a welcome and growing literature promoting a broader appreciation of the causes of illness and the needs of people in *disease* that includes psychological, social, and spiritual as well as physical dimensions.[2,3,4]

In the same period, medical education in many countries, though by no means all, has witnessed the gradual demise of authoritarian and belittling teaching in favour of an emphasis on students' needs for support and encouragement to acquire the knowledge, skills and professionalism relevant to their future practice. *Patient-centred care*[5] and *student-centred learning*[6] are concepts of the moment whose practical implementation is wholly endorsed by the GMC[7,8] and many others. But is there a place for a specifically Christian approach in medical teaching, both valid in principle and possible in day-to-day practice?

## A different worldview

Christian teachers bring to their work a worldview that is substantially different from that of the prevailing culture.[9] Increasingly, our society is permeated by a God-free, naturalistic philosophy, self-contained and allowing no explanation other than the material. It influences our country's ethical judgments, financial priorities and social structure. It underpins a growing public antagonism to the Christian faith and its proponents. Under a veneer of material advance and alleged (though clearly unreal) equality, it starves its population of any basis for meaning, purpose, value or hope. And naturalism, commandeering science for its justification but extending its tentacles into other disciplines, fills our halls of learning. In this setting we have reason to engage our students in a discussion about worldviews that recapture the spiritual as well as the material – including a Christian apologetic relevant to medicine and couched in compassionate terms. But how?

Christian teachers may already have areas of an established curriculum, or could set out to find them, in which at least a general discussion of worldviews and their implications could be introduced or expanded. Possible examples would be in medical or research ethics, end-of-life care, public health, communication skills and history-taking, international health, the doctor-patient relationship, the consultation, and epidemiology. The WHO statement of the need for a holistic approach[10] and the GMC's requirement that medical graduates 'will respect patients' right to hold religious or other beliefs, and to take these into account when relevant to treatment options'[8] would support sensitive and informed discussions in several of these areas.

Short periods of elective study taken by students at various points in their course ('Special Study Modules' or similar) provide opportunities to focus on an eclectic range of optional topics across both science and the humanities. Modules in which a small student group is led, for example, through studies on whole person care, the historical foundations of western medicine, medical anthropology, everyday ethics in medical practice (not necessarily just the 'big' issues), trans-cultural medicine, the

philosophy of medical research, or professionalism, would allow a fascinating exploration of worldviews and values in a broad medical arena.

Outside the formal medical curriculum, Christian doctors have both the privilege and responsibility of encouraging younger colleagues in their faith. One-to-one discussion, the facilitation of student-led meetings, supporting educational events, invitations to a meal, and sponsorship for students' attendance at key conferences provide useful opportunities to develop the thinking and professional lifestyle of Christian practitioners. The aim is that in both mind and heart their faith becomes closely interwoven with their growing medical understanding and practice in environments that are fiercely challenging in many different respects.

It is also worth underlining that wherever our teaching and discussion with students takes place, our most powerful influence on learning is our demeanour and conduct; and there's no such thing as being 'off duty'. Christian-based, whole person medicine, to be properly understood and developed in practice, needs to be observed and appreciated in action. Modelling a robust consistency between its rhetoric and actual clinical care will have high impact and make the clearest sense to our students and colleagues of a whole-person approach.

## A Jesus-centred view

Making patients the central concern of our clinical practice and placing students at the centre of our medical teaching represents substantial progress from the early days of stridently doctor-centred professionalism. But as in all other human relationships and transactions, placing *Jesus* at the centre of our thinking honours him most and inspires our own best contribution to patients, colleagues and students alike. Here, for reflection, are several aspects of our Saviour bearing directly on our practice of medicine and medical teaching:

## Jesus' love

Jesus' love was expressed in his understanding, compassion ('suffering with'), and costly self-giving.[11] How far does this translate into the medicine we practice and teach in these days of targets, service efficiency, and competitive materialism? Love casts out fear,[12] is forgiving and merciful; is humble and abundantly generous.[13] It promotes peace and healing;[14] and, if we allow it, will re-shape our outlook, goals and objectives. Christ's love fully lived out in the clinical or teaching arena cannot help but be noticeable to our patients, our colleagues and our students.

## Jesus' mind

Our faith does not require us to abandon our minds, but rather to set them by a heavenly compass.[15] To move from the foolishness of an unspiritual mind to the freedom and truth of the mind of Christ is our ongoing work, yet access to his wisdom (the 'wisdom from above') is our constant privilege.[16] The outlook of the Christian mind will differ starkly from the surrounding culture, but is intended fully to engage with the scientific, ethical and human dimensions of our work in medicine and teaching; there is no place for a divide between the 'spiritual' and the 'secular'. Medical students and young doctors are likely to need help in developing a faith fully integrated with their professional lives; acknowledging the single reality of the somatic, psychological, social and spiritual.

## Jesus' teaching

In first century Palestine Jesus was recognised as a remarkable teacher.[17] With no compromise to his humility Jesus taught with authority and clarity. He spoke the truth. His teaching on many occasions was case-based and related immediately to real life. He knew the value of stories and pictures that connected with this audience.[18] He was clearly aware of his students' current understanding and underlying thinking. He knew his seekers' real goal as he answered their questions; but he would also address their underlying needs – often the more important.[19] Where a questioner was truly motivated to learn (rather than disguise an invective with a plausible enquiry) he gave answers that were compassionate, applicable and where necessary, plainly directive.[20] He gave feedback and promoted reflection and application of what he taught.[21] His discussion was intended to move people forward not to diminish them. Could we find a better example of teaching?

## Jesus' lifestyle

Jesus' words were clearly effective but the most powerful proclamation of the truths he came to teach was by his life of service on earth. *No-one* could find a mismatch between his words and actions.[22] We surely need his help to travel a similar path.

## Jesus' shepherding

Jesus knows well our personal needs for strength, encouragement, wisdom, forgiveness and love as we seek to follow him. His generous promise individually to be our shepherd is practical and ongoing, allowing us to be energised and inspired as doctors and teachers.[23] No other resources, personal, intellectual or organisational can match his gift.

## In conclusion

- Christianity in the UK is increasingly rejected, yet a great spiritual hunger remains
- Even secular research points to the value of a spiritual dimension in patients' care
- We urgently need further to equip our Christian students and young doctors to understand and implement a Christian worldview in medicine
- A heart and mind truly centred on Jesus will promote the best patient care and student learning
- Jesus himself is our strength, our hope, and our life

***Richard Vincent** is Emeritus Professor of Cardiology and formerly Associate Dean of the Brighton and Sussex Medical School*

Photos: J. Arthur Rank Organisation

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**Giles Cattermole** on encouraging students

# SUPPORTING medical students

## key points

The first CMF General Secretary, Douglas Johnson, used to say that 'if we look after the students and publications, everything else will look after itself'. His words remain true. The challenge is: are we looking after this generation of students?

Describing present structures and the hope that for each medical school there would be a 'Medical School Team' of local CMF doctors willing to support students, the author makes some specific suggestions.

These are illustrated in the active ministries of three very different Medical School Secretaries.

Medical school is a critical time for students. Many will be away from home for the first time, exposed to new ideas, lifestyles and temptations. Most will make life-changing choices of career; some will make eternal-life-changing decisions of faith. They are ready to learn and discover deeper truths for themselves, and yet often find it difficult to integrate into churches because of their short time periods at university: long holidays when preclinical; placements when clinical.

Christian students will be the next generation of Christian doctors, often with huge influence in their churches and society. Evangelism and discipleship are crucial, and are becoming more difficult in our increasingly hedonistic and materialistic culture that is becoming more overtly hostile to Christianity.

The first CMF General Secretary, Douglas Johnson, is often quoted as saying that 'if we look after the students and publications, everything else will look after itself'.[1] His words are as true now as they were then. The challenge for us as older members of CMF is this: are we looking after this generation of students?

### Medical School Secretaries and Teams

At the moment, each medical school has a 'Medical School Secretary' (MSS), a local doctor able to support the local student CMF group. Their roles differ according to their situations (see boxes). Student groups across the UK and Ireland also differ in what they do, often depending on the role of the local Christian Union (CU) on their campus. But wherever they are and whatever they do, it's crucial that we support them, and especially the student reps as they lead their groups. Over the coming years, we hope that for each medical school there'll be a team of local CMF doctors willing to support our students, the 'Medical School Team'.

I took over as the Durham MSS in 2006. I establish regular contacts by email and telephone with the students at all stages in their training. I encourage them to attend our local Teesside CMF meetings where there is opportunity to meet other Christian students and doctors (GPs, consultants).

I also encourage them to attend various CMF events such as the National Student Conference, regional conferences, and others such as *Confident Christianity.* I meet with the local CMF student representatives to pray with them and help them to plan their local CMF/CU meetings within the campus, and also provide them with details of speakers for meetings.

I feel the most important aspect of this role is having a burden for the students; encouraging, mentoring and praying with them so that they will continue to have Jesus in the centre of all they do as they progress through their career.

***Vijay Kunadian*** *is a specialist registrar in cardiology who is Medical School Secretary, Durham*

### No-one should do everything; everyone could do something

CMF members could contribute to student ministry in lots of ways. No individual should have to do everything – in fact, no individual will be gifted to do everything.[2] Instead, each will be able to contribute something as part of a team. A more senior doctor could speak on behalf of the student group as their patron in the university; some people will be able to offer their homes as a meeting place; some will be able to provide meals; some could co-ordinate the team

As MSS for the Hull end of Hull York Medical School since end 2006, I've been blessed so far in having a well organised and enthusiastic student CMF committee who arrange many of their own meetings. They also organise social events and, combined with the University CU, some evangelistic events. The current cohort of year 3, 4 & 5 students have been great encouragers of their fellow medical students.

My main input has been hosting the monthly 'CMF Open House' meetings which are in fact student meetings with occasional junior or senior doctors, and very occasionally AHPs or nurses. We cook for them (pasta or risotto then ice cream), then there is a talk or interactive discussion on various topics. We have covered self esteem, forgiving fallibility (how to cope when you make a mistake), student electives, being a Christian doctor rather than a doctor who is a Christian, abortion issues/post abortion counselling, and enticers for *Confident Christianity* and *Saline Solution*.

***Dave Crick** is a GP and Medical School Secretary, Hull*

members and contact lists; some could lead the team as MSS, working closely with the CMF regional secretaries; some could lead Bible studies or speak at CMF meetings; some could give apologetic or evangelistic talks in medical schools; many could meet up with individual students to pray and read the Bible together. All of us could be role models of Christians living and speaking for Jesus as doctors.

## One-to-one

Meeting with a student once a fortnight or so, to study the Bible together and pray, is a huge privilege. Helping someone grow in their walk with Christ helps one's own growth too. This is biblical, pastoral discipleship; investing time building each other up in God's Word, as Paul mentored Timothy. I am enormously grateful for those men who met with me when I was a student – they taught me so much, and encouraged me immensely. The idea of meeting 1-1 can seem daunting because we're not sure how to do it. There are some great resources to help,[3,4] but at the end of the day, it's simply two Christians reading God's Word and praying together. It's something you learn by doing! It can also seem daunting because we're so busy – but we can probably make room for a coffee or lunch, for half an hour to an hour. It can seem daunting – but the investment is of eternal worth!

## Through church, through CMF

Many of our students, and especially leaders, will be discipled 1-1 in their local churches, but some won't be. We hope therefore that doctors would be active in seeking out medical students in their own churches to disciple and mentor; it's only doctors who'll be able to set that example to medical students of godly living *as a doctor*. We hope that students would feel able to ask doctors to mentor them – and that if there aren't any doctors in their own churches, that through CMF other Christian doctors would be able to support them.

'It is not good for man to be alone.' God's desire that his people should live in supportive and nurturing relationships, while clearly applying to marriage, also has a much broader application. The intended relationships between Christians, as described in the 'one another' phrases in the New Testament, illustrate this. The rabbinic discipleship model which Jesus adopted and the mentoring relationship between Paul and Timothy are other examples.

A modern medical career makes it all too easy for individual Christian doctors to 'be alone'. Part of my MSS role has been to challenge this 'go it alone Christianity'. Mentoring is a useful term which is used widely in contemporary culture. To me it means walking alongside another person with the intention of sharing the life of Jesus. We have offered mentoring relationships to students involved in CMF leadership, and held a CMF conference on 'Creating a Mentoring Culture'.[5] Being a mentor to individual students and junior doctors or, with my wife, to two medical students as they approached and began married life, has been a huge privilege.

As Christians, we all have in 'earthen vessels' the amazing treasure of the life of God. Finding ways to share his life with others so they can grow closer to him personally and professionally is an opportunity we all have, and in so doing, we can for a season, be a 'suitable helper' to another Christian medic.

***Ross Bryson** is a GP and Medical School Secretary, Birmingham*

## Final thoughts

By God's grace, I hope we see the growth of local teams of doctors pooling their gifts to serve students. Actually of course, much of what I've said applies to juniors…and even seniors. We could all benefit from being discipled by a godly, older and wiser Christian! Retired members could disciple seniors, who could disciple juniors…there is a role for all of us. It's likely that older doctors will be more established in and supported by their local churches. So as we begin this work, let's remember Douglas Johnson's wisdom, and start with our students and juniors: they're at a turning point, and they need someone to read them the map.

Please consider how you could play a part. Contact your local MSS (through the CMF website). Ask your pastor for advice about 1-1 discipling (read Sophie de Witt's or Christine Dillon's books). Most of all, pray God will give you opportunities and time, and help you develop your gifts for the service of his people.

***Giles Cattermole** is CMF Head of Student Ministries*

'...if we look after the students and publications, everything else will look after itself'.


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# Working from home - across the world

You don't have to live overseas to be involved in international work. Our survey is finding that hundreds of CMF members are contributing in a whole host of ways: short term trips for teaching and supporting, mentoring those abroad or preparing to go, praying, giving, partnering with CMFs abroad or hospitals overseas, sitting on boards and committees (somebody has to!), befriending international students and in many other ways being a part of what the medical arm of the body of Christ is doing throughout the world.

## Mark Lee: supporting medical students in Armenia

*Mark is a palliative care consultant in Newcastle (drmarklee@hotmail.com).*

'It all started at an ICMDA conference in 2001, when some medical students asked my prayer partner Chris Richards to run a summer camp in Armenia and he asked me to help. I didn't even know where Armenia was but agreed and have been going every year since. We run a six day camp each summer which mixes Bible teaching, clinical cases and ethical discussions. The students love the interactive sessions – so different from the didactic teaching they get.

Although Armenia is a Christian country, it's all about tradition and religion rather than personal faith. We place great importance on doctors supporting students, and are trying to replicate that with the Armenian Christian Medical Association. I was so encouraged to meet at a conference a doctor who had been a student on one of our camps years before. Over the years you plant seeds and often don't see fruit, but here was a young man, standing for Christ in the medical profession.

CMF in Newcastle has supported the camps with regular prayer meetings and giving. Different members have gone to lead – usually four or five. For a couple of years we also ran a camp in Georgia where they are desperate for support. One student said to me 'I have prayed for this for two years. I can't believe you've come!' But there aren't enough of us to run camps in both countries. We have so many resources – I'd love to see others taking up this opportunity to encourage our brothers and sisters in countries where they have so little support.'

## David Curnock: hospital link

*David is a paediatrician, now retired from the NHS but busy in Ethiopia and Tanzania.*

Hospital links are a wonderful way of contributing. I have been involved with a partnership between the university hospitals of Nottingham and Jimma, Ethiopia, going for 17 years. It was set up through the Tropical Health Education Trust (THET - *www.thet.org*), which develops and supports hospital links to improve health services in developing countries. The link involves short visits in both directions. Our trips follow requests made by our Ethiopian colleagues for teaching on a particular topic or help in a particular area. My role has been teaching neonatal care and resuscitation, but the link involves the whole hospital so all sorts have been out – radiographers, physios, librarians, laundry managers, human resources and medical records staff. Our Chief Executive went and returned enthusiastic to develop the link, not just for altruistic reasons but because he saw how much it contributes to personal and professional development in Nottingham. Lasting friendships are formed even though the visits are short – the link is a long term relationship.

The Department for International Development has recently created a new £5 million Health Systems Partnership Fund to give grants to support links. So now is a good time to get involved! Find out from THET about your nearest link, or explore with colleagues setting up a link through THET for your own hospital.

## Stephen Miller: mentoring pioneers in palliative care

*Stephen is a GP with a special interest in palliative care.*

I had always wanted to work in the developing world – I looked at possibilities many years ago but it didn't fit with family commitments, so I put the idea on the back burner and plunged into general practice. Twenty-five years later, with children grown up, the opportunity arose through a church link with a mission hospital in Muheza, Tanzania. My wife and I visited and found they were developing a palliative care programme and needed mentors – here was an opportunity for me.

I spent three months working with local health professionals and volunteers, teaching palliative care in the classroom and at the bedside. Together we saw patients in clinics, on wards, and in the community, discussing cases and working out how best to provide holistic palliative care. This was a steep learning curve, as medicine in Africa is very different from medicine in the urban Midlands! Local clinicians will continue the work, and I will keep in touch by email and text. I hope to visit again in the future – possibly longer term.

It was a fantastic experience – a privilege to be part of a local team and a challenge to rely on my clinical skills. Resources were very few but nonetheless we could make a real difference. I remember seeing a four year old girl in severe pain from a neuroblastoma, whose parents wanted her home to die. Teaching her family how to use morphine transformed the whole situation, and the skills the team are learning will do the same for many more.

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

The new editors join **Andrew Flatt** on believers and the bleep

# INTERRUPTIONS – how should we respond?

It is a typical busy hospital day on call and the bleep is going off incessantly. Urgent reviews, angry or upset relatives, drug chart changes, abnormal blood results or cultures – the list of jobs to juggle on top of our normal day to day activities can seem endless. It is no different for GPs:

Late morning came a call to do a home visit on a lady with a PR bleed, and as I was preparing to go, I was phoned from the treatment room to come and see a patient with an odd-looking ECG. In between, the district nurses were knocking on the door conveying their concerns about various patients they'd seen that morning. And this was while I was trying to continue a morning surgery.

Trying to find the house on the visit (no house number, just a house name) provided frustration, as did the difficulty accessing the key code (not in the patient's notes), let alone waiting for the lady to finish using the toilet before she shuffled back with her Zimmer frame to the bedroom in order for me to examine her. One was thinking 'that was ten minutes wasted that I could've been using to get caught up with triage calls'.

## The burden of the bleep

For eager medical students an exciting novelty, the bleep is now so often a burden. It can make us feel frustrated, tired and annoyed, and this can negatively affect our interactions with our colleagues and patients. Encountering repeated interruptions, with limited physical and mental resources, how may we act?

I think the story of the Good Samaritan[1] can help us here. Despite potential danger, social division, and cost to himself, he spontaneously gave the resources he had, to him who was suffering and in need. The spontaneity of love for all those we see and speak to, and the courage to fulfil it, must grow in us. When facing a summons for help out of the blue, we must overcome the strain of our own desire for rest, in addition to any bias against the one asking.

How can we ourselves overcome these obstacles and love as we should? We cannot. God's love, realised in Christ and given in the Spirit, is our needed resource for the joy, peace and wisdom to tackle all that is thrown at us. As St Paul exhorted, we need to be 'gentle, kind, humble, meek and patient'.[2] We should pray for these things and be confident that God will supply all our needs with the wonderful blessings from Christ Jesus.

Spontaneity of love is one thing, but these virtues should also be the bedrock of managing our daily job lists. On his way to Jairus' dying daughter, Christ was interrupted by a woman in search of a cure for chronic bleeding.[3] Both were healed. Likewise we must achieve both spontaneous and planned work for the glory of God.

The antidote to frustration and annoyance is genuine love, for each patient, nurse, allied professional and colleague. Again, in prayer we find refuge, as praying for each one will help us remember their needs and how we can address them. It will help us not to be proud. In the parable of the sheep and the goats,[4] both groups seemed not to recognise Christ in the vulnerable and needy. Surely the test of any individual, group or nation is how they treat the most vulnerable; the poorest, least ranked, and least able to speak out. How do we fare?

## Practical tips

So are there any practical suggestions that could help us cope with the bleep and its demands in a loving, servant hearted way?

- Learn from God's word – asking him for help, strength and wisdom. This must be a priority though it is easy for this to be squeezed out of an already busy day
- Pray – even a very short prayer before answering each bleep can help focus us, especially if we are struggling
- Prioritise and delegate, in loving gentle ways
- Try to foresee any potential problems
- Work as a team, and be able humbly to ask for help if needed
- Rest – there is another we are called to love, another for whom God died and loves eternally, and that is us ourselves. We must treat ourselves to good times of regeneration, to rest in mind, body and spirit
- Take breaks, however short, and keep well fuelled
- Find forgiveness and forgive yourself. We must confess our own shortcomings to God and 'turn all our anxieties over to him'[5]

At the end we must regard each person (including ourselves) as too loved by God for us to give any less than our all, and in our mind's ear hear each bleep and summons as the voice of Christ saying this child has need of you; go to them in my name.

***Katherine Brown**, FY1 in the North West, and **Anne Hounsell**, CT2 in East Anglia, are the new Series Editors of Juniors' Forum. **Andrew Flatt** is an ST2 in Microbiology, University College Hospital, London*

references

1. Luke 10:25-37
2. Colossians 3:12
3. Luke 8:40-56
4. Matthew 25:31-46
5. 1 Peter 5:7

**Giles Cattermole** has launched the official CMF 'Facebook fanpage'

# Social networking

## Definitions

**Web 2.0** - Sites that let users contribute interactively to the website's content, in contrast to sites which provide information that can't be changed by the user

**Blogs** - 'Web logs' are sites with regularly updated commentary or news, which function like an online diary. They usually allow readers to add their own comments

**Twitter** - A micro-blog, allowing only 140 characters of text with each post, or 'tweet'. It can be thought of as a sort of SMS text, visible to the whole world. Twitter is often linked to blogs or websites to give rapid updates or alert readers of those other sites to any changes, or direct them to other websites

**Facebook** - A social networking site, whose users link to one another as 'friends'. It is a means of networking, picture or video sharing, and game playing. Common interest 'groups' and 'fanpages' allow discussion forums, advertising of events, and communication to large numbers of people. Facebook pages can also 'import' posts from blogs and Twitter, as well as linking 'out' to other websites

***You used to moderate the CMF Forum on the big doctors-only website, doctors.net.uk, so presumably you've been a fan of electronic communication for a while?***

**GC:** Yes – it's rapid, cheap and reaches many people at once. That of course has its dangers: hastily written emails, replied 'to all' are often a source of regret! Relationships should be between people, not pixels. But handled wisely, electronic communication serves as a tool to connect people and disseminate ideas far more effectively than previously.

***What do you think of the current CMF website,* www.cmf.org.uk*?***

**GC:** It's pretty good as a library of information and resources: we've got access to *Nucleus*, *Triple Helix* and *CMF Files*, which is great when looking for articles on specific topics. It's useful for getting information about CMF, but there's only limited interactivity: we can send emails through the website, update our member information, book for conferences, or order books. But we can't collaborate or network – both of which could be better served by Facebook.

***We understand all these new media integrate easily? Is that the most important thing about them?***

**GC:** It's certainly very helpful. Because they all integrate so easily, the same information can be sent very efficiently: eg, by posting a quick 'tweet', both a blog and a Facebook page can be updated simultaneously. Each of them can direct users to the others; Twitter can alert users to a new audio download available on the website; Facebook can link users to the Doctors.net.uk forum to discuss topical issues.

***So why have you been so keen for CMF to have Facebook, etc?***

**GC:** Few people use all these media; most use some of them. If we want to reach as many members as possible, we need to realise that some prefer post, some email, but that increasingly people look to Twitter, blogs or Facebook. And not just for communication, but collaboration: these allow members to contribute their own ideas and engage with each other. Facebook also gives CMF a 'presence' in another public arena, letting the world see the role we play.

***But aren't all these sorts of things just fads that come and go? Hasn't a big social networking site just gone bust?***

**GC:** That's true, but it's no reason not to grasp the opportunities while they're there. When Paul went to Athens, he went to the Areopagus, the place of public discourse. We should be where people are; today that includes Facebook, tomorrow something different. We need to use the means of communication God's provided.

***Can you just sum up the advantages of these sites?***

**GC:** Beyond what the CMF website 'library' can offer, these social media provide rapid, mass communication; a means of networking and discussion for members; and a presence in the public arena.

***Be honest. What practical problems are there?***

**GC:** We need to be careful we don't compromise ourselves. Remember that Facebook is public – privacy and confidentiality need to be respected. It'd need to be moderated for inappropriate postings, and it might take time to administer.

***Elsewhere you have said 'time wasting triviality and retarded relationships'. Surely Christian organisations shouldn't encourage students to spend hours electronic navel-gazing? Wouldn't the same time be better spent on a proper Quiet Time, with Bible study and prayer and reflection? Can't we be virtuous and not virtual?***

**GC:** That people read unhelpful novels is no reason not to provide good Christian literature. People do misuse the internet, both in the time they waste and the content they view. But that's no reason not to provide a helpful and constructive resource to benefit people. Would they be better served in time spent with other Christians, deepening personal relationships and studying the Bible and praying? Of course. But that applies to reading Christian books too. The resources we provide, whether in books, journals or websites, should all direct people to know and love God and his people more. I hope our 'social media' will establish relationships online that are then realised in person, and will direct people to resources that through God's Word, deepen their relationship with God. Soli Deo Gloria!

***Giles Cattermole** is CMF Head of Student Ministries*

# eutychus

## 'Could kindness heal the NHS?'

This moving *Personal View* by portfolio GP Angela Jones is about lack of caring in the NHS: 'I regularly treat acutely unwell elderly patients in need of hospitalisation who beg me not to send them in. I know sensible people who have given up going to their general practice, disillusioned by doctors who seem to be more interested in their computer than in them.' She contrasts evidenced and anecdotal experience with the values espoused in the NHS Constitution, and recommends 'abstaining from unkindness'. (*BMJ* 2010;340:c3166)

## Sick and (not) tired

A Royal College of Physicians study has found a link between introducing rotas compliant with a 48-hour week and rising rates of sick leave among junior doctors. In the year before implementation of the EWTD more than one in three took sick leave; in the year after, nearly three in four took time off. Although causation cannot be proved, the College comments that changes resulting from EWTD implementation may have led to a breakdown of the traditional medical team which offered much support to trainees. (*BMJ Careers* 10 April 2010; GP112)

## Dying for a child?

The world's oldest mother is dying, in India, just 18 months after giving birth at the age of 70, too weak to recover from complications after her IVF pregnancy. Rajo Devi Lohan gave birth in November 2008 but is now confined to bed and so frail she cannot lift her little girl. 'I dreamed about having a child all my life. It does not matter to me that I am ill, because at least I lived long enough to become a mother.' (*Daily Mail* online 15 June 2010 *tinyurl.com/3yymmjw*)

## Belgian nurses killing patients without consent

Belgium's law on euthanasia allows only physicians to perform the act. An investigation of nurses' involvement in the decision-making and the preparation and administration of life-ending drugs showed that nurses illegally administered lethal drugs, often without an explicit request from the patient. The authors somewhat euphemistically conclude: '...the nurses in our study operated beyond the legal margins of their profession'. (*Canadian Medical Association Journal*, 15 June 2010 *www.cmaj.ca/cgi/content/abstract/182/9/905*)

## Investing in saving life

CMF member Will Sellar had an interesting comparison published about the 2009 abortion statistics: 'There were 189,100 terminations of pregnancy in 2009... In the same period there were around 3,000 road deaths. The government spends about £36m per annum on road safety education and a further £135m on road safety schemes – around £1m per 20 deaths. I wonder how much is spent by government to reduce the annual abortion carnage in this country that is more than 63 times greater than that from road deaths?' (*BMA News* 19 June 2010: 8)

## Days numbered for homoeopathy?

Before the General Election, the outgoing House of Commons Science and Technology Committee urged in a report that the NHS should cease funding homoeopathy and that the Medicines and Healthcare products Regulatory Agency (MHRA) should not allow homoeopathic product labels to make claims without evidence of efficacy. They further concluded that, not being medicines, homoeopathic products should no longer be licensed by the MHRA. (Science and Technology Committee Report 22 February 2010)

## Educators cautioned re homosexuality

The American College of Pediatricians (a Christian group) has cautioned US educators about managing students experiencing same sex attraction or showing symptoms of gender confusion: 'it is not uncommon for adolescents to experience transient confusion about their sexual orientation...most students will ultimately adopt a heterosexual orientation if not otherwise encouraged'. They warn against affirming 'non-heterosexual attractions among students who may merely be experimenting or experiencing temporary sexual confusion'. (*www.americancollegeofpediatricians.org*)

## Inspired by an elective

Bristol student Tom Fox spent his medical elective in Papua New Guinea. 'My supervisor was Sister Joseph, a Catholic nun from Manchester who trained as a vascular surgeon in London...Sister Joseph was an inspiration, and no surgery appeared to be too challenging for her. In theatre she kept us entertained with her tales of practising medicine while wearing a habit...The scale of the health problems in the country is huge, although Sister Joseph shows that one person certainly can make a difference.' (*BMA News* 19 June 2010: 6-7)

## 'Near death' experiences – $CO_2$ the cause?

It is thought up to a quarter of cardiac arrest patients have experienced sensations such as seeing a tunnel or bright light, a mystical entity, or looking down from the ceiling in an 'out of body' experience. Others describe a simple but overwhelming feeling of peace and tranquillity. Eutychus has heard these presented as evidence for eternal life, but in a study of 52 cardiac arrest patients 11 who had such experiences were found to have significantly higher blood $CO_2$ levels. Previous research has shown that inhaling $CO_2$ can induce hallucinatory experiences. Historic and personal evidence for the resurrection of Jesus Christ is a much better basis for belief. (*http://news.bbc.co.uk/1/hi/health/8607660.stm*)

## What do you call a Scouser who...

is overweight? Liverpool City Council is formally considering banning use of the word 'obesity' from its health campaigns because of concerns it might offend the overweight. Apparently the 'Liverpool Schools Parliament' thought the word 'obesity' had negative connotations. (Christian Research *Quadrant*, 2010; May:2)


## The new atheism

*10 arguments that don't hold water*
*Michael Poole*

Lion Hudson 2009
£3.99 Pb 96pp ISBN 978 0 74595 393 9

This excellent little book tackles ten assertions made by Richard Dawkins, Christopher Hitchens and others in recent polemics against God. Each chapter considers a different topic, convincingly demonstrating the limitations of atheist arguments about faith, memes, evidence, types of explanations and the nature of science.

Sometimes, the illustrating stories are not so relevant or useful. The first chapter seems addressed to a 'Straw Man' as Dawkins and others argue that religion is evil because it is the *cause* of evil actions by believers, not simply because believers *do* evil things. More frustratingly, arguments are examined too briefly. In a book this length, it's perhaps to be expected. But sometimes unwarranted assumptions are made of the reader's knowledge of the concepts involved, especially concerning the anthropic principle and infinite regress. One is often left itching for more explanation to flesh out important ideas raised so tantalisingly. This would be good if it pushed us to read further, but although the book is thoroughly referenced, there is no recommended 'next level' reading list. Overall, though, I strongly recommend this as introduction or quick revision. It's reliable, easy to read and understand - great value.

***Giles Cattermole** is CMF Head of Student Ministries*


## A Different Dream for My Child

*Meditations for parents of critically or chronically ill children*
*Jolene Philo*

Discovery House USA 2009
£10.99 Pb 267pp ISBN 978 1 57293 307 1

This book was written from the author's experience of having a critically ill newborn and the years of isolation, hospital admissions and operations that followed. The spiritual wilderness and lack of spiritual support Philo experienced spurred her to write these simple meditations on caring for a critically or chronically ill child. It is frank, humorous at times, and does not avoid tough issues like preparing for and dealing with the death of a child.

Each meditation is preceded by a verse of scripture, and ends with a brief prayer and reflection. Meditations are grouped thematically around headings like 'Hospital Life' and 'Juggling Two Worlds', so are ideal for readers to dip into at different times. There is also a companion website with further resources and from which the book can be ordered (*www.differentdream.com*).

Philo does not focus on her story alone but relates the stories of other parents with seriously ill children, of relatives, and of the nurses and doctors who cared for her child. This gives a rich range of perspectives and insights and can enable both families and health professionals better to understand the spiritual needs and questions raised by these circumstances.

***Steve Fouch** is CMF Head of Allied Professions Ministries*

## Working from a place of rest

*Jesus and the key to sustaining ministry*
*Tony Horsfall*

BRF 2010
£6.99 Pb 135pp ISBN 978 1 84101 544 6

The paradox in the title draws the reader into this book. Horsfall draws on his extensive experience of training to provide guidance for sustainable Christian life. He uses the example of Jesus' meeting with the Samaritan woman at the well in John 4 as Jesus 'working from a place of rest'. Here we find the Lord at rest, refreshing his bodily needs. His journey had been long but even as he rested, he found the energy to share something of his Lordship with a sinful woman.

Horsfall likens life to a journey and recognises that in the task of Christian ministry, we can operate on human effort rather than allowing ourselves sustenance through the Spirit. To avoid exhaustion, we must learn to rest in Jesus and prayerfully depend on him. As we receive his Spirit, our rest becomes the launch pad for a life of active service in his name. The wisdom in this book is invaluable for anybody involved in Christian ministry; it should be read in its entirety again and again to remind us of the tremendous partnership we have with Christ Jesus.

***Elizabeth Croton** is a GP `in Birmingham*


## Grasping Heaven

*A Young Doctor's Journey to China and Beyond*
*Annelies & Einar Wilder-Smith*

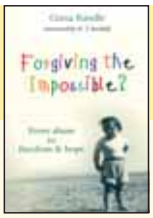
Armour Publishing 2010
£8.33 Pb 320pp ISBN 978 9 81427 019 9

*Grasping Heaven* recounts two great adventures in the life of Tami Fisk, a brilliant young Christian doctor from the USA. Despite her gifts for medical research, Tami chose to serve and love the marginalised poor in a mountainous area of southwest China where both medical facilities and living conditions were basic.

The other adventure was not her choice. Back in the USA doing a medical fellowship, she discovered a melanoma behind her ear. While she had successfully battled to adapt to the customs and lifestyles of the Chinese and her international colleagues, battling against cancer was far harder. The story shows that whatever life brought, Tami had a special shield in her faith in God. Whether from her Bible or received in her prayer times, she knew how to draw from a very deep spiritual well. Such was her example, that when both adventures came to an end, those around her were richer for having known her.

The authors were two medical colleagues with whom Tami worked, lived, and grew in faith. This story will inform and probably amuse those working in a cross-cultural context, and medics will be interested in her fascinating medical career. Above all, Tami's story will warm and challenge all readers.

***Joy Lankester** is a careers consultant working with universities in the south east*




## Forgiving the Impossible?

*From abuse to freedom and hope*
*Greta Randle*


- IVP 2010
- £7.99 Pb 144pp
- ISBN 978 1 84474 433 6


This is a sobering story for those who think that sexual abuse of children takes place only outside the church, or mainly in one sector of the church, if the church is involved at all. It happens in evangelical churches too.

It's a courageous book on many levels. The author writes under her real name and for her to tell her life story in this kind of detail makes her very vulnerable. She also heads a national Christian counselling organisation. This book is moreover a tribute to her family, friends and church members, many of whom would have had to agree for this tale to be told with such openness.

Most of all, the book is a tribute to the redeeming love of God for whom no pit of darkness is too deep that he cannot rescue us from it. This is a book to bring hope to adults abused as children, and their families. CMF members who have been abused themselves, as well as those who are GPs or psychiatrists, will find it of particular value.

***Trevor Stammers** is the Programme Director in Medical Ethics, St Mary's University College, London*


## Sexual Issues

*Understanding and advising in a Christian context*
*Joanne Marie Greer and Brendan Geary (Eds)*


- Kevin Mayhew Ltd 2010
- £34.99 Pb 464pp


This is an engagingly written, substantial book from 13 international specialists. Its strapline should attract Christian health professionals and pastoral ministers, but will it meet their expectations?

Certainly, it addresses contemporary issues only, and references recent quality research. The discussion of sexual development and practice is largely in the context of the deChristianised moral climate of westernised countries, current ecumenical church postures, and the impact of the internet. Key issues including gender identity, sexual preferences, abuse and perversions are given detailed and compassionate treatment. The implications of cohabitation are explored sympathetically, as are the many intrusions that threaten to destabilise marriage.

So, the book provides a good basis for understanding how people might see their sexual issues and the so-called 'enlightened' sexual agendas of our society. However, those who believe the Bible is God's Word will be disappointed that the theological reflections view Scripture through the lens of experience, rather than applying Scripture to our confused sexual *mores*. Surprisingly, the authors have limited themselves to Jesus' response in the Gospels and they conclude that Jesus had nothing directly to say. The rest of the Bible is excluded. Thus, this book may help understanding but its advice lacks biblical clarity.

***Paul Adams** is a pharmaceutical physician and pastor in Surrey*


## Why Us?

*How Science Rediscovered the Mystery of Life - and Ourselves*
*James Le Fanu*


- Harper Press 2009
- £18.99 Hb 303pp
- ISBN 978 0 00712 027 7


We have a problem. Look at most scientific papers. While the paper starts with a question and proposes an answer, it ends by recommending further work. Although it has increased our bounty of known knowns, it also identifies some new known unknowns, and gives us a sense of other unknown unknowns out there. As Karl Popper pointed out, knowledge is finite, ignorance infinite.

Does this matter? Le Fanu believes so. For him, the problem is that all these unknowns reduce the value of the knowns. For example, we know a huge amount about the human genome, but the pace of transferring this into useful 'things' is slow, because we are increasingly aware of how much we don't understand. Take the brain as another example. We can examine, dissect, scan, and record its electrical activity. But ask about consciousness, happiness, or our appreciation of love, and we have little genuine revelation.

Le Fanu does a great job of showing how our thirst for knowledge has led to remarkable discoveries, but concludes the most fundamental discovery of all is that we are extraordinarily mysterious beings in a vast and mysterious universe. Science has revealed mystery. I doubt anyone would agree with all his claims, but well worth a read.

***Pete Moore** is a science communicator based in Bristol*

## Growing up ... growing wise

*Lovewise 2009*


- £20 Resource pack (available from the Lovewise office)
- info@lovewise.org.uk 0191 281 3636 www.lovewise.org.uk
- ISBN - N/A


Many parents are uncomfortable with relationships teaching delivered from an overtly secular standpoint that promotes a strongly liberal morality.

This is a four-part interactive lesson resource for school years 5 and 6. Focusing on a couple who are engaging and relaxed as they discuss their marriage in a positive but realistic manner, it covers friendship, puberty, love, marriage and the facts of life from a Christian perspective. Though some teachers might be wary of references to God, these are not heavy because the resource is aimed at state schools. Developed by an experienced team, it contains everything needed for a lesson, including PowerPoint slides, video clips, lesson plans and worksheets. The video clips begin by exploring children's aspirations for adult relationships and are an excellent resource you might use outside school. While many children don't come from a stable home, there is no implied criticism of other backgrounds.

Clearly placing sex within the context of a positive view of marriage, this resource is high quality and of great value. We'll definitely be recommending it to our children's school!

***Tim and Naomi Hinks** have four children and work in respiratory medicine and general practice in Southampton*



# Climate change - debate hots up

CMF File 41 *on 'Climate change' triggered opposing responses. London SpR in Public Health* ***Helen Barratt****:*

Thank you for the excellent *CMF File*. Climate change has been described as 'the most important public health challenge of the 21st Century'.[1] As readers will be aware, the NHS and the wider medical establishment (including many of the Royal Colleges) are increasingly turning their focus towards efforts to mitigate the effects of climate change, many of which also yield health benefits in their own right. Consequently, a significant part of my work in public health currently focuses on climate change.

The NHS aims to become 'the leading public sector organisation in promoting sustainable development and mitigating climate change'[2] so the issue is likely to increase in prominence for doctors in the UK. Jason and Rachel Roach provide us with a succinct summary of the problem, as well as a robust Christian response. The *File* has really helped to crystallise my thinking around this issue, and I will certainly be passing it on to friends and colleagues.

## references


1. The Faculty of Public Health. *Sustaining a Healthy Future: Taking Action on Climate Change*. London: Faculty of Public Health, 2009
2. *www.sdu.nhs.uk/page.php?area_id=1* Accessed 26 May 2010


*Consultant anaesthetist* ***Chris Hanning*** *took a contrary view and the following is abstracted from correspondence with the authors:*

I look to the *CMF Files* as authoritative statements of Christian belief on ethical and medical topics and they do not usually disappoint. However, the paper by Jason and Rachel Roach falls far short of the usual standard and seems to be more a statement of their faith in Anthropogenic Global Warming (AGW) than a balanced review of the science.

I do not dispute the Christian duty to make careful use of the resources God has given us in this planet on which we live, nor our duty to act justly and care for the poor. Such is clear from Scripture alone and does not need the dubious 'science' of AGW to support it. The evidence for AGW, which has now morphosed into 'climate change', is not irrefutable nor is it 90% certain. A large number of reputable scientists cast doubt on the degree and rate of temperature change, the relationship of any temperature change to atmospheric $CO_2$, the consequences of any change, and the appropriate response even if our worst fears are realised. Those who take this stance are varyingly labelled 'sceptics' or 'deniers' and routinely denigrated. It is reminiscent of the Church's persecution of those who denied the earth was flat and was the centre of the Universe.

The claims for unprecedented temperature rise are false. It was clearly much warmer during the Medieval Warm Period, when $CO_2$ levels were lower. The earth's temperature varies with a periodicity of about 30-40 years as well as with longer cycles. In the 1970s it was relatively cold and the then current scare was for a new Ice Age. The planet then warmed until about 2000 but there has been no significant warming since.

Most of the changes predicted by AGW proponents simply are not happening. The sea levels are not rising, Arctic ice is almost back to recent average while Antarctic ice is growing. Overall global sea ice is steady and the polar bears are doing nicely. Several studies have shown that, even if the IPCC's worst predictions are fulfilled, it is cheaper to mitigate adverse changes when and if they occur rather than to ruin our economy now on the 'precautionary principle'.

There is no evidence that 'extreme' weather events are becoming more common other than by better reporting. The attribution of increasing disease to AGW rather than local factors is also unproven and real studies rather than computer models and apocalyptic predictions have not shown any correlation.

Much of what Roach and Roach advocate for action has my full support, both by helping the poor and by using the resources God has given us responsibly. Scripture commands us so to do and we should not need the overstated and erroneous claims of AGW to do our Christian duty.

***Jason Roach*** *responds briefly:*

Feedback is always welcome! We were encouraged that you agreed with the substantive application of the article, namely that we have a responsibility to care for the environment. I make three responses.

We entirely agree that the debate has become highly politicised. As we have recently argued, 'climate change' has undoubtedly become the 'gospel' of our age. It claims that our chief problem is neglect of the earth, and that salvation for us and the planet hinges on our repentance. For climate change to be used as a political tool and imbibed as a false gospel in this way is a terrible travesty.

Secondly, we agree it is difficult to predict with certainty the precise rise in temperature and the precise scale of the effects in such a multifactorial process. We also suggested that it is too early to show any change in disease patterns as a result of changes in heat distribution.

Thirdly, we note your criticism of the IPCC's language of '90% certain' and 'irrefutable' evidence for anthropogenic global warming. We agree scientific consensus can be proved wrong; just because the claims are based on broad scientific consensus does not necessarily mean that they are correct. Nevertheless, as we highlighted, we believe we must act on the basis of the information available at a particular time, aware that scientific conclusions are always subject to change in the light of new data.

# Abortion referrals

*The article summarising four GP members' approaches to abortion 'referrals' (Easter 2010:14-15) stimulated two new contributions and a second bite at the cherry.* ***Philip Davies****, an STI training in general practice in Birmingham:*

I often look to other Christians both as role models and to seek advice from them. I believe it makes it easier for a Christian GP to make a stand on an ethical issue if many other Christians are taking the same stand. I understand that Christians will disagree on some issues, but abortion should not be one of them. We can make a difference by seeking to love the unborn child.

I was recently shocked to hear that Christian GPs refer patients to abortion clinics to undergo a termination of pregnancy (in medical terminology) or killing of the unborn child (if we want to name sin for what it is). I have always held that abortion is wrong, but have recently come to the decision, after discussion with an older, wiser GP, that it is my duty as a future GP to ensure that I don't make it any easier for a baby to have his or her life ended. This may mean telling a patient that in her case, an abortion is not justified legally, morally or medically. This may mean not telling a patient which colleagues do and do not refer for TOPs (at the same time honouring the GMC's guidance regarding doctor's personal beliefs on the 'right to see another doctor').

I also thought it was wrong ever to write a referral letter to an abortion provider. However, reading your article has changed my mind. The idea of 'referring' to an abortion provider stating that there are no grounds in law for a TOP in this instance is a bold and challenging way of handling a request – this would enable a GP to keep a clear conscience and also challenge the abortion provider's own conscience.

We should be seeking to keep our consciences clear before God, seeking to refuse to participate in evil (eg 1 Thessalonians 5:22) and remembering that we are all personally accountable for our actions. As a junior doctor, I urge more of my seniors to take a stand on this issue.

*Salaried GP* ***Jim Newmark****, whose initial enquiry stimulated* Triple Helix *to canvass the views of other GPs, persisted with his supplementary question:*

Thanks for allowing me my say. My other point is a plea to Christian colleagues to clarify what the *theological* (as opposed to *practical*) difference is between a 'referral' to a colleague and a 'referral' to the hospital? In all the correspondence and discussions I have had the response has always been evasive. And to persist makes the other person characteristically irritable, which is perhaps revealing in itself! This point is alluded to, but not clarified, by Greg Gardner in his statement 'it depends on what your view is of complicity'. Precisely.

I am more than impressed with Mark Houghton's response. A 'referral' letter which effectively states that in his view 'if the abortion is to go ahead it would be illegal' is brave...and startling. I would be fascinated to know what the response has been. This seems to be a completely new take on the subject and deserves much wider publicity in Christian circles. It does the Terms of Service job of putting the woman 'into the process' but also firmly nails the 'referring' doctor's colours to the mast. In addition, by not evoking the wretched conscience clause, it involves no other colleague with all the complications that involves. By doing this Mark is far less complicit (whatever that really means) in the process than anybody who evokes the conscience clause to refer to a colleague and then disappears from sight in a puff of righteous froth.

***Hilary Cooling*** *works in sexual health in Bristol and argues that we need more data:*

As a statement of scientific fact, Mark Houghton's '...abortion is more dangerous than a delivery' is highly contentious, and deserves a robust reference. He provides only his own submission to the Science and Technology Committee of the House of Commons. This submission itself provides references, but is nowhere near a systematic review. Perhaps he could propose just such a systematic review to the *BMJ* or another well recognised medical journal?

The subject could be 'How does morbidity (physical and psychological/psychiatric) after induced abortion compare with that which follows term pregnancy or spontaneous miscarriage?' It is a subject where the conclusions that people draw continue to be so dependent on their prior position on abortion (pro-choice, pro-life) as to make clarity difficult to achieve. The intellectual integrity of health professionals from any position in the abortion debate deserves to be valued. And this is no more than women affected by abortion deserve, to support respect for their autonomy and wellbeing. Let's all aim for increased intellectual honesty.

**Andrew Fergusson** continues the Christian dating agency discussion

# MEETING DR RIGHT PART 2

In 2006 *Triple Helix* asked whether single Christian doctors should embrace twenty first century dating techniques.[1] Stephanie[2] is a consultant physician in her forties who read the article and subsequently registered with a couple of the introduction agencies featured. Through one she met James[2], an engineer a few years older, and within seven months they married. This update is based with permission on their story on the *Friends First* website[3] and on a recent interview.

## Stephanie's story

I had made a Christian commitment at the age of 13, so always limited my sights to Christian men. There were just two in our medical school intake of 60. I had a crush on one of them, was abruptly let down, and retired wounded. Later, climbing the hospital ladder, there were no suitable men, let alone Christian ones.

Church did nothing for singles, and after a very few, short-lived romances I began to have serious doubts I would ever marry. It became a painful longing which would not go away. I wrestled with God in prayer, demanding he tell me if his plan for me was for lifelong singleness. I felt I could live with that certainty better than with doubt. God spoke to me through verses in the Bible, but in 1991 I was reflecting on a brief yet very heart-warming relationship when he spoke to me directly: 'He's Ishmael, there'll be an Isaac'. The words resonated with our church's teaching – Ishmael was the son of the flesh, born of man's will and desire, but Isaac was the son of the promise, born of God's provision when hope had ceased.[4]

In the mid-1990s I joined three or four Christian 'introduction agencies' and met men socially, over a drink or for a meal after work. It kept me circulating socially and boosted my confidence, but I felt I needed a break so stopped for a few years. Then I read the *Triple Helix* article. I thought it was interesting, well written, thoughtful, realistic, and I liked the way it targeted doctors. I looked up all the websites mentioned and particularly *Friends First* which was featured. I registered with them because I liked their concept of relationships, and their realism about success rates, particularly for women. I joined at the top rate and received men's profiles every month. I responded in writing to all of them, and in the first year met up with three men. In the second year I met two – and one was James.

It was the letter paper that did it! His photograph was unflattering and I wondered what I had let myself in for. We met for coffee in a country hotel and the rest, as they say, is history. Texting has transformed romance – without texting we couldn't have done it so easily. Within eight weeks we were seriously discussing our long-term future and seven months later we were married. God graciously confirmed to me that James was the long-expected 'Isaac'.

## James' story

I grew up as one of five and for a long time while my contemporaries were all getting married and having children it wasn't high on my list of priorities. I had plenty of social relationships so my need for friendship was satisfied, but around the age of 50 I thought I should be more active in seeking somebody out. There really ought to be something in churches for singles, but there isn't so I joined one or two organisations. There was nobody I really hit it off with and I was looking for a more stable long-term relationship, so when somebody pointed out *Friends First* I joined.

I joined at the cheapest level and a great wodge of profiles arrived. I wrote to three or four, but was particularly attracted to the photo of Stephanie and we agreed to meet up. I wasn't put off by her being a doctor because I come from a medical family, and the rest you know.

I would recommend this option. There is nothing wrong with taking the initiative and I liked the approach of the agency. Some people might regard it as rather sad, almost a cattle market, and it was sometimes difficult looking at all those pages, but the church just doesn't do anything about it…

## It's a happy ending – but is it 'Christian'?

Spending several hours with them convinced me theirs was a marriage made in heaven, but I asked whether they were both completely comfortable biblically and theologically? They had no concerns at all:

'It's not taking God out of the equation. If you're intending to buy a house, or move to work, you don't just pray about it and wait for years to see if anything happens, you go and make it happen…'

They reminded me that our romantic Western stereotypes of falling in love with someone we meet incidentally are relatively recent cultural phenomena, and pointed to the biblical account of Abraham using an agent, his servant, to find a wife for his son Isaac.[5]

Stephanie's final advice to single Christians who want marriage is:

- Pray – tell God your longings, your dreams and your pain
- Persevere – don't give up
- Prepare for the unexpected – God may have a different plan from yours

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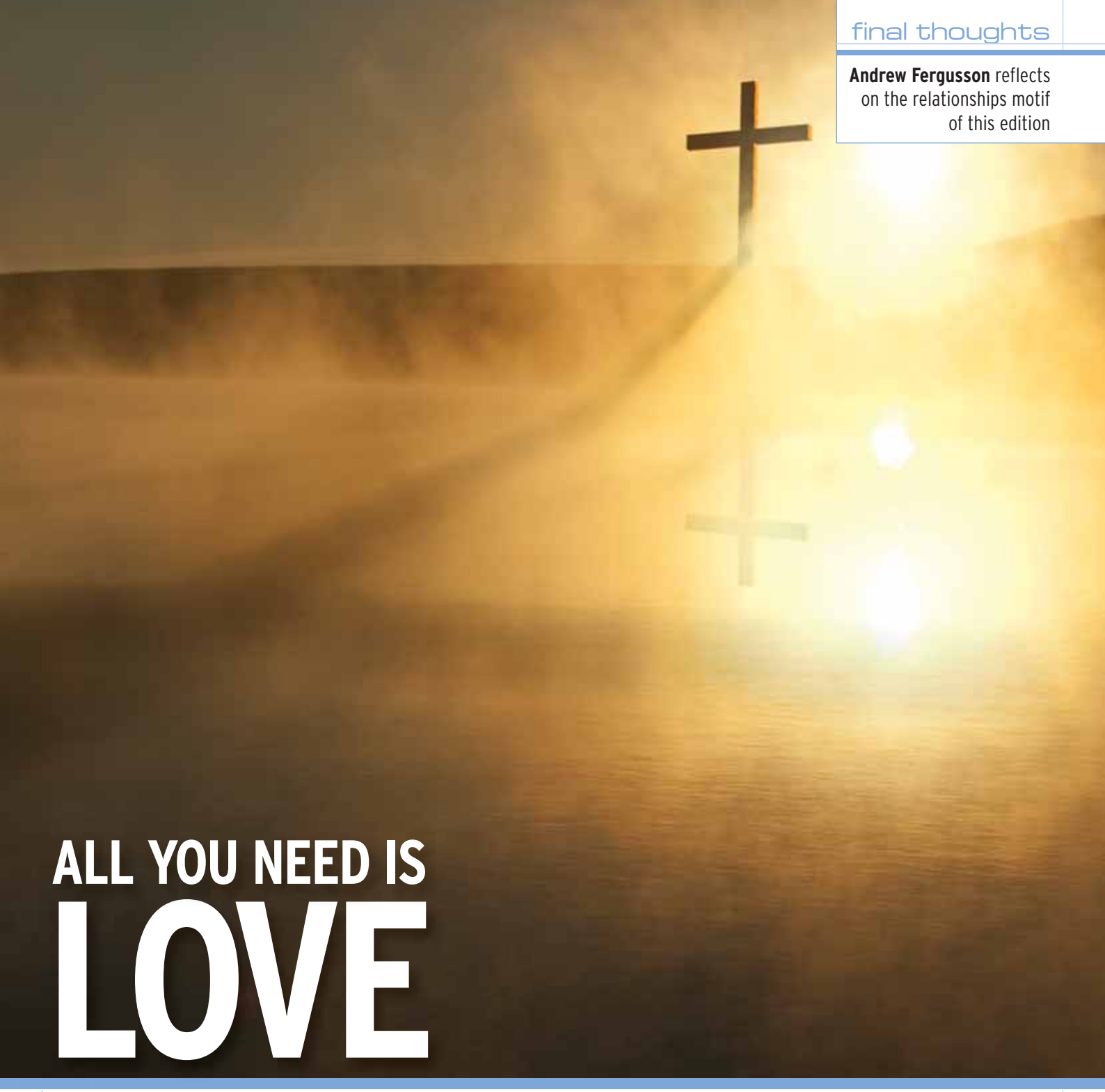
## references


1. Engel J. Meeting Dr Right. *Triple Helix* 2006; Autumn: 14-15 *www.cmf.org.uk/publications/content.asp?context=article&id=1863*
2. Names changed
3. *www.friends1st.co.uk/StephJamesmarriagestory.htm*
4. Genesis 15, 16, 21
5. Genesis 24

**Andrew Fergusson** reflects on the relationships motif of this edition



# ALL YOU NEED IS LOVE

We never consciously set out to have a theme for this edition of *Triple Helix*, much less one about relationships. But that's how the material – commissioned and contributed spontaneously – came in.

We've considered whether QOF's box-ticking damages the doctor-patient relationship, what really matters in parent-professional relationships when a baby is dying, teacher-student-patient interactions in education, doctors supporting students, shorter term service across the world, the stress of interruptions, social networking, and 'meeting Dr Right'. What ties these together but relationships?

A lawyer once asked Jesus: 'Of all the commandments, which is the most important?' and he replied: 'The most important one…is this: "Hear, O Israel, the Lord our God, the Lord is one. Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength". The second is this: "Love your neighbour as yourself". There is no commandment greater than these.'[1]

It is sometimes said that the symbolism of the cross recognises these love relationships – the upright the one which puts us back in touch with a loving God; and the horizontal arms represent love extended to our fellow humans.

The apostle Peter tells us that 'love covers over a multitude of sins'[2]. Perhaps we should substitute 'love' for 'kindness' in the question quoted in *Eutychus*: 'Could kindness heal the NHS?'

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## references


1. Mark 12: 28-31
2. 1 Peter 4: 8


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