Christmas 2010

for today's Christian doctor

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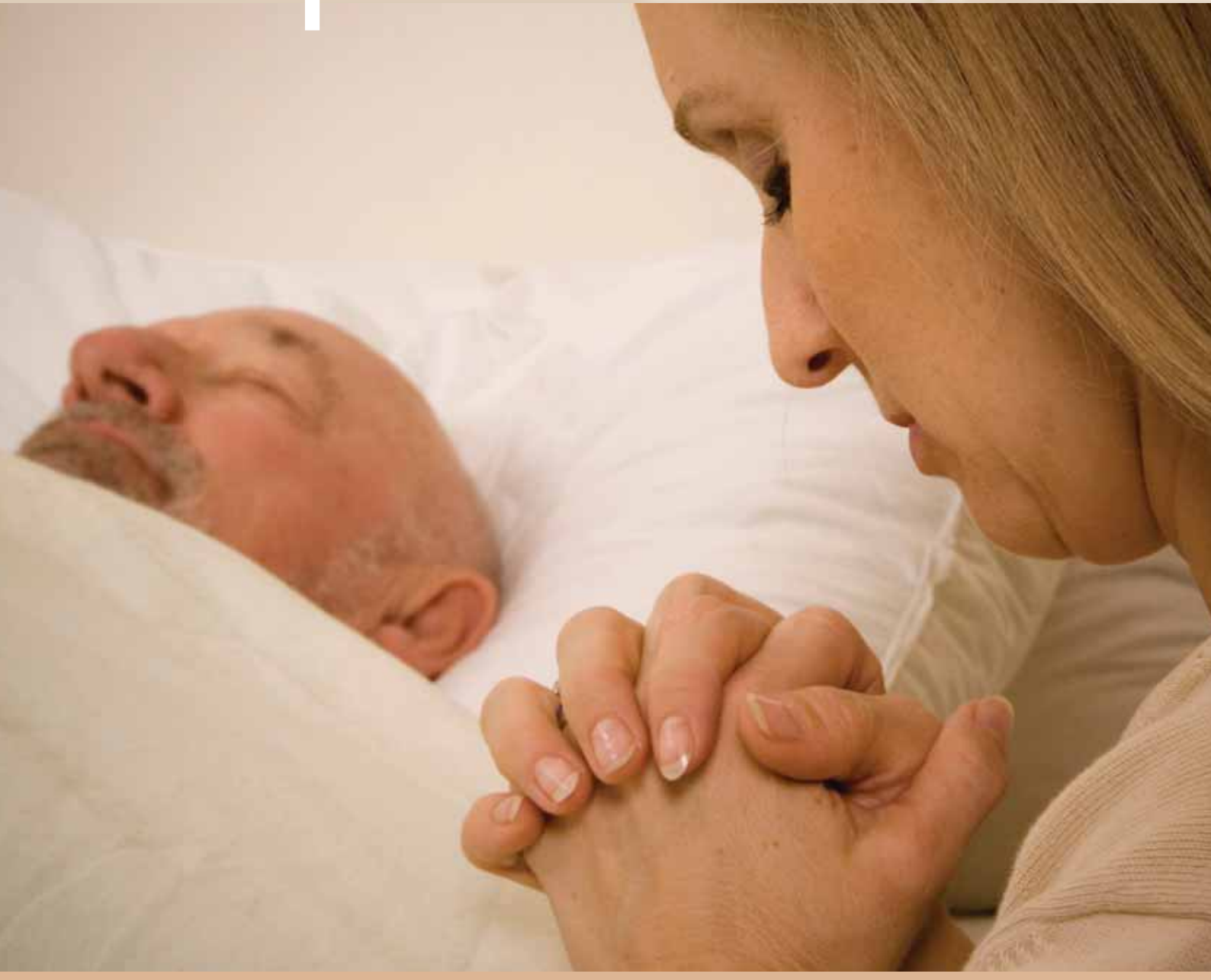

time to let go?

healthy doctors, the vulnerable, praying with patients, healing miracles, ultra-short term mission, commitment, wider horizon, reviews

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contents

Cape Town 2010

A foretaste of heaven and a ringing call to the church

Photo: © lausannemovement

The Third Lausanne Congress on World Evangelization[1] closed in Cape Town on 25 October with a ringing call to the church. The event, perhaps the widest and most diverse gathering of Christians ever held, drew 4,000 selected participants from 198 nations. Organisers extended its reach into over 650 GlobaLink sites in 91 countries, and attracted 100,000 unique visits from 185 countries to its website.

It was an extraordinary privilege to be involved. The overall theme was 'the whole church taking the whole gospel to the whole world' with two days on each of the three parts. We were treated to Bible exposition on Ephesians by some of the world's most gifted expositors; along with state of the art multi-media presentations, drama, and cutting-edge teaching on every possible aspect of world mission through plenaries, multiplex sessions and up to 40 different parallel seminars (dialogues) every day. The worship, led variably by a full piece orchestra, a contemporary worship band and once by 30 African drummers, was culturally diverse and awe-inspiring – a real foretaste of heaven.[2]

Professor John Wyatt and I jointly led a 'multiplex' session for over 400 leaders on 'Ethics, Emerging Technologies and the Human Future'.[3] It was well received and left us feeling the huge need throughout the global church to help leaders think through issues at the interface of Christianity and medicine, steadily impacting every nation.

A 'rest day' allowed scenic or historic tours, or viewing 'mission in action' projects. I visited an HIV/AIDS project called Living Hope[4] launched ten years ago by one moderate sized Baptist church. It employed 180 staff and 400 volunteers and was engaged in schools education, homeless work, and economic empowerment in addition to running a 20-bed hospice, a clinic and community nurse scheme. It was impressive. People were being converted, lives changed and rebuilt, and a community transformed. I was left wondering why my own church in the UK was not embodying the same sort of holistic ministry to our local community.

The First Lausanne Congress (1974) gave rise to The Lausanne Covenant, a new awareness of the number of unreached people groups; and a fresh discovery of the holistic nature of the biblical gospel and of Christian mission. The second in Manila (1989), spawned the Manila Manifesto and more than 300 strategic partnerships in world evangelisation.

The Cape Town Commitment[5] will be complete by the New Year. Its first part is a Trinitarian statement, fashioned in the language of love, and is already available. The second will call for action on critical issues facing the church over the next ten years.

I was struck most powerfully by: testimonies of God's faithfulness through immense suffering by delegates from Rwanda, Nigeria and North Korea; explosive church growth in the Global South; the emphasis on the 'integral gospel' – preaching, mercy and justice as the church's mission; the exponential progress in Bible translation and in taking the Gospel to every people group; and Chris Wright's challenge that the major obstacle faced by the Gospel is not other faiths, persecution or resistant cultures, but rather the sin and idolatry of Christians.

I leave you with a quote from Richard Stearns'[6] address on 'the hole in our gospel'. His challenge to the American church about its attitude to wealth, poverty and power applies equally to us:[7]

I believe that the (American) church stands at a crossroads. The world we live in is under siege. Three billion are desperately poor, one billion hungry, millions are trafficked in human slavery. Ten million children die needlessly every year. Wars and conflicts are wreaking havoc. Pandemic diseases are spreading and ethnic conflict is flaming. Terrorism is growing. Most of our brothers and sisters in the developing world live in grinding poverty. And in the midst of this stands the church (in America) with resources, knowledge and tools unequalled in the history of our faith.

I believe we stand on the brink of a defining moment and have a choice to make. When historians look back… will they say that these authentic Christians rose up courageously and responded to the tide of human suffering to comfort the afflicted and douse the flames of hatred? Will they speak of an unprecedented outpouring of generosity to meet the needs of the world's poor? Will they speak of the moral leadership and compelling vision of our leaders? Will they write that this, the beginning of the 21st century, was the churches' finest hour?

Or will they look back and see a church too comfortable and insulated from the pain of the rest of the world, empty of compassion and devoid of deeds? Will they write about a people who stood by and watched… of Christians who lived in luxury and self indulgence while millions died….

Sometimes I dream and I ask 'What if?' What if we actually took this Gospel seriously? Could we, might we, actually be able to change the world?

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

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news reviews

DFID and maternal health

Multi-level interventions and recognising faith are the real answers

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

After noting recently the appalling level of maternal mortality in the developing world[1] some good news was welcome. This August came a long term meta-analysis of global maternal mortality statistics that showed a nearly 30% drop over the past two decades.[2] The UN annual report likewise found the mortality rate had fallen from 500,000 to 350,000 maternal deaths per annum.[3] Both surveys found these reductions were due to multi-level interventions, including addressing social attitudes, educating and empowering women and girls, good obstetric and midwifery care, and better birth spacing.

This coincided with a major consultation by the UK Department for International Development on their new strategy for maternal health. DFID states it wants to support evidence based, multi-level interventions,[4] giving prominence to the provision of 'safe abortion' as an effective intervention. However, the two meta-surveys indicated that of all the interventions, this had the least impact – in part at least because addressing the other issues minimises the demand for abortion. DFID have been criticised for tying overseas aid to legalised abortion for ideological reasons.[5]

Another major lacuna is the role of religion. Historically DFID has been criticised for marginalising faith,[6] an issue they have sought to rectify.[7] However their Western secular perspectives fail to understand that for most developing world communities, faith shapes values and choices as much as, or more than, poverty. Only by working from within religious traditions (in particular with faith based organisations) can we transform attitudes and values that devalue women and set their health needs low.

CMF has made a detailed submission challenging DFID on these two issues.[8] Drafted by obstetricians, midwives and paediatricians with developing world experience, it shows that Christian health professionals have a great deal to contribute to global health policy, giving a voice to the voiceless and standing up for the needs of the poor.[9]

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Human Fertilisation and Embryology Authority

HFEA to join the bonfire of the quangos?

Review by **Josephine Quintavalle**
Director of CORE, Comment on Reproductive Ethics

After 19 years of controversial existence there is a real possibility that the Human Fertilisation and Embryology Authority (HFEA) will be axed. It has rarely been remembered during two decades of relentless embryo destruction that the original HFE Act 1990 came into being with the primary objective of protecting the special status of early human life. Licences for treatment or research involving the human embryo could only be authorised if shown unequivocally to be necessary or desirable.

With the Authority in the hands of an unelected, unrepresentative committee overtly on the side of the fertility and libertarian scientific communities, it is hardly surprising that respect for the human embryo has rarely been upheld. Almost every licence application landing on the HFEA's desk gets approval. Human embryos can now be used as practice tools by embryologists simply to improve biopsy techniques.[1]

So three cheers for the forthcoming 'bonfire of the quangos', a phrase used in 1995 by Gordon Brown, then Shadow Chancellor, in an attack on 'over-centralised, over-secretive and over-bureaucratic' government.[2] The present government's bonfire is principally aimed at increased efficiency and economy, but it is nevertheless a joy to find the HFEA high on its list of 177 doomed quangos, or 'Arm's Length Bodies' as they prefer to call them. If all goes well the HFEA's functions are to be parcelled out by the end of the current Parliament to the Care Quality Commission, the Health and Social Care Information Centre, and a new research regulator.[3]

Whether or not the HFEA will actually end up on the pyre is still cause for heated discussion. Some argue this is unlikely as it would require an Act of Parliament to rescind existing provisions in the Act which govern the HFEA. It is hard to imagine the current government not anticipating this problem. Experts suggest that a specific piece of overarching preliminary legislation could govern the disbanding of all targeted quangos, and the necessary changes could then be effected without need for primary legislation.

At the last public meeting of the HFEA (8 October 2010), Chairman Lisa Jardine was taking possible closure very seriously. While bravely stating that in the interim they would 'carry on carrying on', it was anticipated that significant changes would be effected before the end of 2013. The demise of the HFEA is a possibility and there should be no tears. The ethical responsibility for unbiased defence of the human embryo must be entrusted to a competent representative body independent of the fertility industry, with final decisions determined democratically in Parliament.

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More quangos for the bonfire?

Time for some truly independent advisors

Review by **Trevor Stammers**
Director: MA in Bioethics and Medical Law, London

Among the quangos due for dissolution are the Teenage Pregnancy Independent Advisory Group (TPIAG) and the Independent Advisory Group on Sexual Health and HIV (IAGSH). Since TPIAG was set up in 1998 to halve the national under-18 conception rate by 2010, it has put most of its efforts into the promotion and provision to teenagers of the very contraceptives which, when they fail, then constitute the commonest reason for requesting abortion. The IAGSH (March 2003) equally adopted an ideological approach which consistently ignored evidence-based practice, such as studies indicating that abstinence-only education programmes can reduce both teenage conception, abortion and STI rates.[1,2]

The IAGSH published many inaccuracies. In September 2003, they claimed those who took a US 'abstinence pledge' were 'at higher risk of STIs…because they have often had little or no information about contraception and safer sex'.[3] Not only was no evidence presented to support the reason given, but even the purported 'higher risk' of STIs was not shown by the actual research which consistently showed lower rates of STIs (though not statistically significantly so) among pledgers.[4] A more recent study has since confirmed the lower STI rates in another type of abstinence programme.[2]

The membership of both TPIAG and IAGSH raises questions about their independence from the contraceptive and abortion industries. The vast majority of members had declared interests in these fields. Baroness Gould, the chair of both, was President of the fpa and chaired a pro-abortion lobby group in Parliament. Like Baroness Gould, many of the members of one of these 'independent' groups were also members of the other;[5] whereas there were no representatives at all with any experience of alternative strategies such as the highly successful ABC programmes in Uganda[6] or *Love for Life*[7] programmes in Northern Ireland, where teenage pregnancy and STI rates are far lower than in England, Wales and Scotland.

If indeed 'wisdom is vindicated by its outcomes'[8] Christians need to pray that those bodies taking over from these two failed quangos will indeed be independent and have some fresh approaches. We might see some improvements by investing in encouraging primary behavioural changes such as later age of first intercourse and greater parental involvement with teenage sex education. Let's start introducing what we know actually works, instead of wasting yet more millions on what does not.

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New medical group advocates assisted suicide

But doctors supporting a change in the law still constitute a minority

Review by **Peter Saunders**
CMF Chief Executive

A new group of 'health professionals' has recently joined the growing number of 'societies' and 'forums' seeking legal permission for doctors to assist with suicide.[1]

Healthcare Professionals for Change[2] follows Libby Wilson's FATE[3] (Friends at the End), Michael Irwin's SOARS[4] (Society for Old Age Rational Suicide), Philip Nitschke's EXIT International[5] and the Secular Medical Forum[6] (also founded by Irwin) in pushing for a change in the law. Perhaps not surprisingly, HPFC is sponsored by the pressure group Dignity in Dying (formerly the Voluntary Euthanasia Society).

Prominent among the group's supporters are several well known medically qualified campaigners for liberalising the law on assisted suicide and abortion, including former MP Evan Harris, Simon Kenwright, Wendy Savage (who leads a similar doctors' pressure group on abortion[7]), David Paintin and Ray Tallis.

Evan Harris has campaigned for the legalisation of assisted suicide both through the British Medical Association and also as a Liberal Democrat backbencher in Parliament, but without success. Interestingly, he lost his Oxford West and Abingdon seat on a large swing in the general election this year to a candidate who opposed his views on a number of ethical issues.

Ray Tallis held the influential Chair of the Ethics Committee of the Royal College of Physicians (RCP) when that organisation briefly went neutral on the issue in 2005. After he had vacated the chair, and just before the debate on Lord Joffe's Assisted Dying for the Terminally Ill Bill in May 2006, the RCP reverted to opposing any change in the law after seeking the opinions of its members, a position it has held ever since. Responding to the launch, Sir Richard Thompson,[8] currently RCP President, recently outlined eloquently the reasons why a clear majority of the College's members still do not support a change.

They are in good company. Other official doctors' bodies opposing any change include the British Medical Association (BMA), the Association for Palliative Medicine (APM), the British Geriatric Society (BGS), the Royal College of General Practitioners (RCGP) and every other Medical Royal College that has expressed an opinion on the matter. The BGS earlier this year issued a strong statement[9] on assisted suicide about how a change to the law would remove protection from vulnerable elderly people. Christian doctors, in continuing to promote palliative care and oppose any change in the law, need to remember that those doctors who support so-called 'assisted dying' remain only a minority.

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Ian Donald believes we must recognise life has a natural end

A time to LET GO?

key points

Pressure for physician-assisted deaths is driven by a culture of individualism and choice, but also by many people's fears of what their last days or weeks of life will be like.

The author, a geriatrician, argues that therapeutic and symptomatic care must go hand-in-hand, and that we must also recognise the onset of natural death. Many deaths in Old Age Medicine departments are uncomplicated and undramatic.

He concludes with the Physician's Prayer, which ends '*from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us*'.

The growing public support for physician-assisted dying is driven by many factors, including a consumer-driven culture of individualism and choice. This is essentially self-centred, and undervalues our interdependence – the essence of a caring and loving society demonstrated by strong intergenerational ties and the commitment to care for the most dependent.

Christians are called to be like Jesus, demonstrating love and compassionate care and travelling with those who approach the end of life, while seeking to minimise their suffering in that journey.

One factor determining the views of so many regarding euthanasia is the fear of what those last days or weeks of life will be like. For many, their view will be formulated by witnessing another's death – family or close friend, or perhaps, for those in healthcare, at work. Paul Badham has written a Christian apology for physician-assisted dying,[1] and his views were shaped by witnessing distressing family deaths. How is it that during the generation that has discovered palliative medicine, in a country that arguably leads the world in palliative care, public clamour for euthanasia has still grown? I believe some of the blame must belong to modern medicine – many now fear that doctors will keep them alive long beyond their natural life, and beyond what they would wish.

Fear of dying badly

It is untrue that medicine is the principal reason for longevity today – it is of course more related to public health and nutrition. Although old age may make little sense to strict 'survival of the fittest' evolutionary theory, we appear to be programmed to live into old age, and a few have always done so. Survival to 65 has changed dramatically in the last 150 years – from 5% to around 90%. The continuing improvement in life expectancy in the UK over the last 50 years of around 2.5 years each decade relates partly to public health changes and partly to better medical care of long term conditions.

The Bible has vivid descriptions of old age – notably that of Solomon in Ecclesiastes 12, where the realities of frailty are even more explicit than Shakespeare's seven ages of man. The biblical view appreciates the wisdom of the aged,[2] and many societies acknowledge the contribution of the elderly to leadership, while in Britain we poke fun at any political leader over 65. The Bible also emphasises our duty to respect older people and support them, either through the family structure or the church – some churches today need to be reminded of this important way we can demonstrate God's love in our community.

Yet for most people it is not the fear of growing old *per se* that worries them – life free of significant disability is also lengthening,[3] witnessed by productive retirement for many. The alternative of a premature death is hardly attractive! Rather it is the prospect of a prolonged period of disability, followed by undignified suffering, culminating in a hospital bed wired up to machines.

In reality, death in the UK through switching off life-support is uncommon. Many more though will experience a hospital admission when we are striving to save life, followed by a period of palliative care. Ideally palliative (or symptomatic) care should go hand-in-hand with therapeutic care, but the impression to the public will often be a sudden switch from a therapeutic to a palliative

approach. Junior doctors naturally find this change difficult, with their strong desire to save and prolong life whenever possible. They will have seen the times when intravenous diuretics or powerful antibiotics have brought someone back to life.

Life's natural end

Patients and their families often know when life is coming to an end. Hospital doctors who know them less well may find this more difficult to recognise. As Christians we want to enable our patients to live their full life, and that includes recognising its natural end.

The experience of dying involves letting go – for the patient and for the family – and clearly it also requires the doctor to let go. We naturally cling to life, and, as doctors, will always seek therapeutic options that might be offered. But there will be many times when we can only relieve symptoms. We must be comfortable with the withdrawing or withholding of treatments which are ineffective, when almost certainly the burdens of treatment clearly outweigh the limited or non-existent benefits. Judging whether the treatment is still offering benefit can be difficult, and requires team working and experience. Recent GMC advice on treatment, including hydration and nutrition towards the end of life, has been very helpful here.[4]

Some doctors may feel uncomfortable judging quality of life – 'Is her life worth saving?' – in determining when they might 'switch' from therapeutic to palliative care. For the non-Christian this may become a very utilitarian judgment, which allows them to be somewhat dispassionate. The Christian doctor will naturally run a mile from this, and may feel that the 'sanctity of life' commits them always to prolong life for as long as possible using whatever means they can. Yet this would be a wrong understanding of the sanctity of life, which principle is better termed *Imago Dei*, made 'in the image of God'. This conveys the unique and special value of each human, treasured by their Maker. We should treasure, honour and respect that life from its beginning to its natural end. We cannot deny that we are mortal. Our respect for that life cannot then be warped into prolonging parts of that person artificially.

A better way

Yet there is a better way, which takes us away from 'playing God'. It is about listening – using all our skills to look for the signs that tell us this person's life is coming to an end. We can embrace this in the same way that Jesus cried 'It is finished'.[5]

Many people know for themselves. Some will 'turn their face to the wall', and we need to learn to distinguish this from clinical depression. We will not always know or be right, but can always give treatment to relieve symptoms. As we listen and give symptomatic relief, we can be honest in where we think the journey is going, yet humble enough to admit we cannot know for sure.

I believe the vast majority wish to live their natural lifespan. They want medicine to try and cure their ailments, and they want to live into old age and see the generations following them. Today the average age at death for women is 82 and still increasing. But people also want a peaceful end when life is over. Death will always be sad regardless of the age when it comes. In old age, many deaths witnessed in Old Age Medicine departments are uncomplicated and undramatic.

Releasing and letting go

So both healthcare staff and family need to understand the importance of releasing and letting go, and handing over to God's sovereignty. Yet this should not lead to pointless waiting – rather it can be a time of continued listening, a time of healing of relationships, as well as a time of preparation for death. 'Show me O Lord, my life's end and the number of my days; let me know how fleeting is my life.'[6]

How often today do we see someone dying 30-50 days after an admission and feel ashamed at how much they have suffered in their last illness? Of course we are right always to give someone a chance, either at their request or acting in their best interests. But we must do so humbly and sensitively, always listening. Our passionate concern for our patient should not blind us to when things are not working out – as if it was our own reputation at stake that the patient should leave the hospital well.

The public remain confused about euthanasia – many will believe that without it, doctors are committed to attaching tubes and sticking in needles right to the last minute of life. Our junior doctors are also confused, with the power of modern medicine deceiving them to believe they must make God-like decisions on who is worth treating. If modern medicine is partly to blame for the clamour for euthanasia, we now must not only strive for the very best in palliative medicine available to all, but also reduce excessive unwanted medical care.

When doctors routinely combine therapeutic and palliative medicine in their dealings with older people, then perhaps we will create the setting where patients can express their wishes more clearly, and death can be discussed more openly. The most heartfelt thank you letters to an elderly care department in the hospital come from bereaved families.

The physician's prayer[7]

From inability to let well alone, from too much zeal for the new, and contempt for what is old, from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases and from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us.

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As Christians we want to enable our patients to live their full life, and that includes recognising its natural end

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John Holden considers a pre-eminent issue for Christians

Photo: PA Photos

THE VULNERABLE: their quality of care

key points

Care for the vulnerable dominates medicine, both clinically and ethically, and Jesus endorsed Old Testament obligations.

In contemporary Britain, vulnerability extends beyond poverty and it is a lack of strong relationships with reliable people which makes many especially vulnerable, particularly when they have to turn to the NHS for help.

The author makes practical suggestions for serving the vulnerable in personal and spiritual ways, and concludes that care for the vulnerable is a God-ordained task, in work and beyond work.

I have worked for 25 years as an NHS GP in the north west of England. Care for the vulnerable is the main purpose of my job, and the direct or indirect professional concern for most of us each day. Aspects of vulnerability are also the main ethical issues we encounter most often in our work.

The Old Testament Law and Prophets had a great concern for the poor. For example: 'Do not take advantage of a hired man who is poor and needy'.[1] Isaiah urges God's people to practise true fasting, such as setting the oppressed free and 'not to turn away from your own flesh and blood'.[2]

Ezekiel has this interesting comment: 'Now this was the sin of your sister Sodom. She and her daughters were arrogant, overfed and unconcerned: they did not help the poor and needy.'[3] Micah 6:8 tells us: 'He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God.'

This teaching was wholeheartedly endorsed by Jesus, who characterised his mission as being to preach good news to the poor.[4] And the care of needy widows was an early church priority,[5] led by those especially 'full of the Spirit and wisdom'. Biblical teaching implies, and instructs us, that our care for others is the expected way of thanking God for our salvation.

The vulnerable: who are they?

Christians have always been concerned for the poor and victims of injustice. In Britain today a simple lack of money seldom causes hunger or ill-health, so viewing poverty merely in material terms misses the point. *Vulnerability* is a far better word to use. Although people who are materially poor are vulnerable; most of the vulnerable people I meet are not materially poor.

For many, it is a lack of strong relationships with reliable people rather than material poverty which makes them especially vulnerable. This is often clearest when illness removes independence and patients have to turn to the NHS for help. Indeed vulnerability and powerlessness sum up the state of the sick people most dependent upon us.

The vulnerable: what should our attitude be?

Jesus' expression of thanks to his disciples at the end of his life, 'You are those who have stood by me in my trials' strikes me forcefully.[6] So often our greatest need is for people to stand by us, especially when the pain will not go, the vomiting will not stop, the depression will not lift, and fear is still gnawing. I particularly find this quote, from a retired doctor about the care of his terminally ill wife, a helpful summary: 'The essential concept is that the doctor (or at least the practice) will stay firmly with the patient and relative at their time of need and not desert them'.[7]

For most *Triple Helix* readers the vulnerable are right here with us each day in our surgeries, clinics and wards. The issue is 'how can we care for these people as well as possible'? Unfortunately we cannot assume NHS care of patients is universally good, since a series of scandals has shown the opposite. NHS care, as known to me, ranges from excellent through mediocre to dangerous, and I have reported care that I and others consider dangerous, as the General Medical Council's *Good Medical Practice* requires us to do.

The vulnerable: how can we best serve them practically?

We would give Jesus excellent care if he were our actual patient, so the question is 'how can we deliver excellent care to the vulnerable people we serve?' Often this will be through the best achievable technical care, which evidence based medicine has helped us to understand better.

In general practice the Quality and Outcomes Framework, 'QOF', has delivered unprecedented high levels of chronic disease management.[8] Indeed this quantum leap forward has been directly observable, a rare phenomenon when advances are usually slow and piecemeal. In hospital too, the two week cancer targets and 18-week referral to treatment goals have, at least from the outside, transformed performance.

But we will also want to give excellent non-technical care too, which may be less obvious but is an equal challenge. Since starting a new practice in 2004 we have sought to create systems that serve vulnerable patients in particular. We started by trying to be very efficient, stripping out unnecessary tasks whenever possible so that the pace of work never becomes frenetic, which inevitably damages staff and patients if sustained for long. Here are some examples.

- **Access**. Impersonal telephone systems can be hard for the vulnerable to navigate. Many NHS phone numbers are not answered directly, and people who are unfamiliar with appointment systems become confused and just give up, later entering 'did not attend' statistics. A local mental health service requires patients to complete a questionnaire before even giving them an appointment, a gross example of discrimination against those most in need of the service.
- **Personal care**. It is heart-warming to observe staff knowing patients and their needs personally and individually. This is a true mark of quality and one that is easily taken for granted. The combination of friendliness and taking people seriously is enormously therapeutic in itself.

  When we started our practice I was prayed for in church. A few days later the impersonal patient-call system was not working! Ever since we have called patients from the waiting area individually and by name, something that is appreciated enormously more than the effort it requires.

  My experience of well over 100,000 consultations leads me to suspect most people are hardly ever taken seriously. The case then for 15 minute, rather than 10 minute, appointments in general practice is almost unanswerable and increasing numbers of practices are now offering this. Once achieved it quickly becomes a necessity.

  Vulnerable patients, such as those with a psychosis, need people whom they can know and trust and who know their values. Indeed the rapport that can develop with many psychotic patients has been a particular source of professional satisfaction for me.
- **Planned care**. For the most vulnerable, screening and monitoring of chronic disease needs to be largely opportunistic. Skill is needed to meet patients' wishes while ensuring safe and effective delivery of the good therapeutics which can significantly improve their symptoms. In my view many QOF targets *are* worthwhile just as long as they are not seen as an end in themselves.
- **Spiritual care**. Christians should not be dazzled by a reductionist, solely biophysical model of health. While we are not nihilistic we also see that death is natural and usually not a failure. Indeed people become tired at the end of their lives and it requires considerable experience and wisdom to realise someone is terminally ill, the final state of vulnerability.

Values and preferences

Vulnerable people are less able to articulate their values and preferences but are certainly not, in my experience, averse to risk. Indeed they may be particularly sceptical of screening and other aspects of my agenda, and sometimes able to reject sharply what is offered. I recall one elderly man with advanced COPD telling me, with humour, 'The difference between you and me is this Doc: you want me to go on and on, and I don't!'

Values are a central part of spiritual care, and these may clash sharply with our own. It is tough to 'stand by' people whom we can see destroying themselves by substance misuse.

Conclusion

Vulnerability affects us all. We start life as vulnerable children, and usually end our lives in vulnerable old age, once again dependent on others for our welfare. Abortion and euthanasia are important not least because they affect the vulnerable unborn, vulnerable parents, vulnerable terminally ill people, and vulnerable families.

But care for the vulnerable is seldom one-way. We are told that God has chosen the poor in the eyes of the world to be rich in faith.[9] Their care for other vulnerable people warms and challenges my heart, I trust making me less self-satisfied than I otherwise would have been. And of course care for the vulnerable extends beyond our work, and almost all of us will have vulnerable relatives, friends, neighbours to care for in complementary ways. Care for the vulnerable is a God-ordained task, in work and beyond work.

Yet this is not a detailed argument about why vulnerability should be pre-eminent. It is merely an invitation to consider it, and if it resonates with your understanding of what Jesus' invitation to follow him means, then be encouraged in all you do for the vulnerable, and ask how we can all do this better.

***John Holden** is a GP in Wigan*

Photo: PA Photos

Care for the vulnerable is a God-ordained task, in work and beyond work

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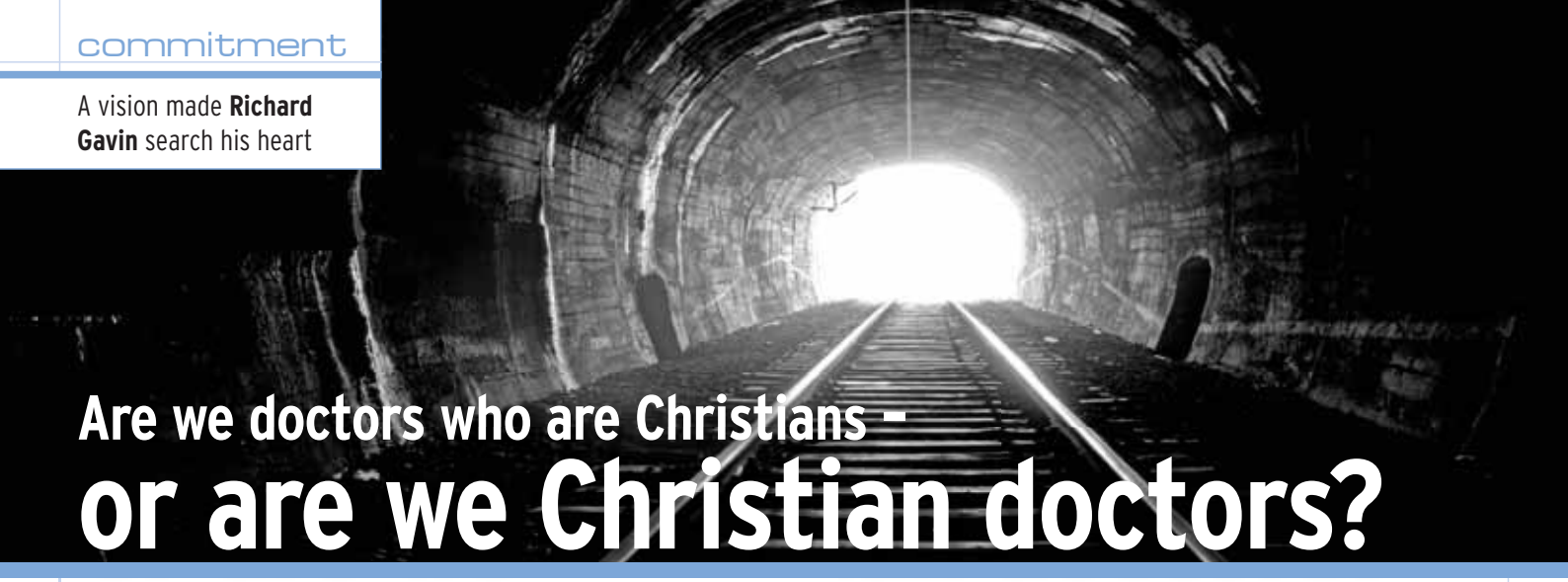
A vision made **Richard Gavin** search his heart



Are we doctors who are Christians – or are we Christian doctors?

God gave me a clear instruction: 'Follow me'. Have I dropped everything and done just that? Do I love him first and foremost in my life, forsaking everything, even my closest relationships? I know a true disciple is prepared to forsake his family and his career for him alone. Am I a Christian doctor bearing spiritual fruit in serving Jesus, or simply a nominal Christian serving my title as a doctor?

Two trains

At the 2008 ICMDA conference in Austria a prophetic word was shared that truly touched my heart. There were two trains heading in opposite directions. The first was filled with many people, hurrying off to do their business. It was crowded and busy. The second train was practically empty with only a few people entering inside: those who wisely considered their way.

The vision was not about the lost and saved. The vision was, and is, for us as God's people. It vividly describes our need to enter by the narrow gate. It is a prophetic warning from the Holy Spirit to us all. It speaks of busyness, dead works, and going in the wrong direction.

Busyness or disobedience?

Medicine may be a noble, self sacrificing and demanding career but are we truly vessels ready and available for the Master's use? Am I busy building my career, pursuing my ambitions, concerned for my reputation? Am I busy being a good, successful and respectable doctor? Yet no-one is good but God alone. All my works are but filthy rags if they are not the works of love wrought in faith.

How often do I find myself busy doing many seemingly worthy things, diligently doing them, but am I serving, have I perceived the higher calling? To listen and obey him as Mary did, sitting at the Lord's feet.[1] Have I been so busy and distracted that I have neglected to stop, to listen and to obey? I may be on the Christian platform but am I in the train marked 'God's ways'?

My achievements: dead works?

God's view of my life's work is certainly sobering and refreshing. '..All labour and all achievement spring from man's envy of his neighbour. This too is meaningless, a chasing after the wind.'[2] He wants me to seek first his kingdom and his righteousness before all other things. He wants me to do his will, serving wholeheartedly in all that I do, whether seen or unseen, appreciated or not. I now realise that unless I surrender my present life I cannot ever hope to find eternal life.

Many turn away because what the Lord asks will be too much of a sacrifice. It will be too difficult to accept his life and let go of our own. We are to exchange our lives for his life so we can experience life in all its fullness. Could it be that what I do or say in my professional life could be 'evil' even though it has all the appearances of good? Even the most fastidious and well meaning work can be abominable in the sight of our God if it is not done in faith for his glory.

Amos bewailed the ritualistic worship of God by his people. For them, religion was only something to be practised in the presence of a priest, on specific days or in a special place. The rest of the time they violated God's commandments, utterly disregarding justice, righteousness and purity. God's reaction to such conduct was disgust and rejection: 'I hate, I despise your religious festivals; your assemblies are a stench to me. Even though you bring me burnt offerings and grain offerings, I will not accept them. Though you bring choice fellowship offerings, I will have no regard for them.'[3]

> He wants me to do his will, serving wholeheartedly in all that I do

God does not want our dead works, our empty sacrifices. He wants to live in us and for us to live our lives through him. This is the acceptable sacrifice.

Reputation and the wrong direction

Why am I concerned about my reputation when Jesus 'made himself nothing, taking the very nature of a servant, being made in human likeness'?[4] Shunning reputation and becoming a servant is a choice. I need to decrease so that he may increase.[5] I need to be prepared for humble service as I progress in my medical career and into a role of godly leadership. Only then will I begin to head in the right direction: God's way, the way of Life.

He knows our deeds and our reputations for being alive but warns some of us that we are spiritually dead. I may have all the hallmarks of being a good doctor who is a Christian, but what does the Lord say? 'Wake up!' I need to awaken from a busy agenda with its attitudes of self justification and proud works. I need to listen and obey his words of instruction because the way that seems right to me may lead to death. May God help me to hear the warning signals, not being so preoccupied with my own life nor so proud of heart that I fail to acknowledge I just might be on a crowded train going in the wrong direction.

***Richard Gavin** is a GP in Drogheda, County Louth, Ireland*

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Victoria Parsonson
on the challenges of
praying with patients

To pray or not TO PRAY?

The subject of praying with patients received much media scrutiny after nurse Caroline Petrie was suspended in 2009 for offering to pray with a patient.[1] Spiritual health is an important aspect of holistic care. The British Medical Association 2009 conference recognised this, but failed to carry a motion reassuring doctors that they would not be penalised for offering to pray with patients.[2]

During my vascular surgery rotation, I met a patient who challenged me and made me reflect on praying for patients in difficult circumstances. The patient had been admitted for high-risk surgery and necessitated a post-operative HDU stay. I had come to know her well during the preceding week and on the eve of her surgery she talked about being fearful of her own mortality. I asked her about her spiritual beliefs and whether she was a prayerful person. Following some discerning questions and with her permission, I prayed with her, after which she felt more peaceful. The following day on the HDU ward round she explained to the assembled medical and nursing team that I had prayed with her, she had found it very helpful, and would like me to pray with her again. She looked at me expectantly, intending that I would pray with her immediately, before the ward round moved on. I struggled to know how to react. On one hand, I was aware that I was the most junior doctor present, there was a busy ward round to be done, and some of my colleagues were clearly very uncomfortable. I too felt uncomfortable not knowing how my colleagues would react to knowing I had prayed with her previously, even though many of them knew I was a Christian.

I have to admit I felt awkward at the thought of praying openly in such a situation and before so many people. Many of the reasons why we choose not to pray with patients were highlighted: lack of privacy, questioning its appropriateness, fear of colleagues' reactions and whether we may be reported, and also perhaps fear of rejection on the patient's part. However, I also realised that despite the difficult and busy environment of intensive care or high dependency, with the close observation and high numbers of staff, these patients are some of the sickest, facing the biggest physical health challenges, and are arguably therefore the most in need of spiritual care.

General Medical Council. Personal Beliefs and Medical Practice. March 2008

Patients' personal beliefs may be fundamental to their sense of well-being and could help them to cope with pain or other negative aspects of illness or treatment (Para 5)

For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care (Para 9)

What did I do?

I acknowledged we had prayed together the previous day, even though it would have been easy to have said nothing. I didn't pray there and then, but explained, in front of my colleagues, that I would return and pray later, but if she would like someone sooner then I would contact the chaplain.

How did my colleagues react? When I returned the HDU nurses were supportive and respectful, and managed to afford us as much privacy as they could. It brought spontaneous discussion among my fellow juniors, who thought it positive that someone had been able to give a patient the holistic care she needed. Others argued that since we were so busy, it would be better to call in a chaplain. The impression given was that they felt it was time wasted for which everyone else had to pick up the slack, that spiritual care was an extra nicety but certainly not a necessity. More senior colleagues chose not to acknowledge it with me either at the time or afterwards.

Nothing in the GMC's guidance Personal Beliefs and Medical Practice (2008) precludes doctors from praying with their patients. It says that the focus must be on a patient's needs and wishes.

Any offer to pray should follow on from a discussion which establishes that the patient might be receptive. It must be tactful, so that the patient can decline without embarrassment – because, while some may welcome the suggestion, others may regard it as inappropriate.

Jane O'Brien, Assistant Director, Standards and Fitness to Practise, GMC.
Telegraph Letters. 7 February 2009

One of the most rewarding moments of my career to date was in Madagascar, where I was able to hold the hand of a child and pray with him as he died. In the Bible the elders are instructed to pray with the sick[3] and Jesus spent significant periods of time ministering to the sick.[4,5] We should not be put off but we need to show wisdom and discernment in the way we approach spiritual care. Questions such as 'Do you have a faith that helps you through difficult times?' and 'Are you a prayerful person?' can be very helpful. Listen to God and to his prompting. Always ask permission and be humble if a request is refused. Praying with patients enables God to minister through us to show his children his love and peace and, at the same time, serves as a reminder of just how much God loves his people, our patients.

Victoria Parsonson *was an FY1 at the time of this account. She is now an FY2 in the West Midlands*

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Richard Scott and others evaluate a recent mobile medical mission in Maasailand

Ultra-short term medical mission: IS IT WORTHWHILE?

key points

In March 2010 seventeen UK health professionals took part in a two week mobile medical mission to the Maasai people of rural Kenya. The Kent GP/evangelist who organised it describes the medical and the Christian aspects.

3,500 patients were treated, and 737 made commitments to Christ after watching the *Jesus* film. Asking 'was it all worthwhile?' the author concludes that 'saving the soul is ultimately far more important than mending the body'.

Three independent experts with developing world experience comment. A cautious 'medical' assessment adds to concerns the author expresses, but all three acknowledge that God can work – and does.

This March, 17 UK health professionals formed the medical arm of a two week mobile mission in rural Kenya, in response to an invitation from a prominent Maasai pastor, David ole Kereto. The itinerary included two days' work in each of four places, running clinics in primary schools, a church and a health centre. Reflecting on the trip back home, I ask the question – ultra-short term medical mission: is it worthwhile?

Background

3.5 million Maasai inhabit southern Kenya and northern Tanzania. Known for their distinctive dress and nomadic lifestyle, their desire to maintain traditional practices has slowed tribal conversion to Christianity. Pastor Kereto estimates that while approximately 70% of Kenyans regard themselves as Christians, the comparative figure for the Maasai is 1-2%.

Cambridge-based 'Through Faith Missions' have been sending evangelistic teams to Maasailand since 2002, as well as raising money for education, wells, and famine relief. Now we were invited to bring a medical team – aware that work done would not be in isolation but part of a bigger, co-ordinated picture.

Challenges

Bringing a team is only the start. Would rural patients hear about it and attend? Which diseases, what kit, and how many medics would we need? In such a short mission, the need to 'get it right first time' was clear. In addition to our team costs, we needed £10,000 to buy medicines and fund some projects abroad – could busy people raise this amount?

It was to be as much a Christian mission as a medical exercise – would the team be at ease with prayer and evangelism at work? Local evangelists would be showing the *Jesus* film by night, and our medics would be giving testimonies at the beginning of each clinic. With only two regular preachers but eight preaching slots and church services to cover, would the team rise to the occasion?

The team

So – before recruitment – prayer! Several of those approached commented on God's remarkable timing in their lives. Some came via a CMF conference or the website, others through church. The team of 17 was made up of eight doctors, four nurses, two dentists, an occupational therapist, a physio and a laboratory technician. Nine had been

to Africa before – six had worked there – and eight were first timers.

The trip

We treated 3,500 patients over the eight days, with hundreds of teeth extracted and spectacles dispensed. Postnatal ladies and a suicidal woman were visited at home as well as a Maasai evangelist who'd just lost his son. 2,640 people watched the *Jesus* film and 737 made commitments to Christ.

Unused medicines and equipment were distributed between two health centres – one thriving, the other struggling. Some of the funds we had raised were allocated to medical projects and evangelism – providing a laptop and projector for schools work, and contributing to vehicles and training for local pastors.

Is ultra-short term medical mission worthwhile?

Beyond the feel-good factor, was the cost in time and money worth it? Medically, some immediate benefits were obvious, particularly following practical procedures. Local feedback reported that our medicines were also powerful! One Sunday at a remote church, the chief asked for a future medical team, commenting that they'd been late to receive the Gospel and had never had medical aid. For Maasai Christians, both were clearly important.

For the team members, it was medically challenging and great fun. Seeing needs first-hand and using funds raised is more satisfying than merely sending money. It was spiritually challenging as well, stimulating us to pray and depend on God, and to develop skills such as preaching, leading and praying for patients – skills which can be used back in the UK.

In medical terms, clearly one can do far less on a short mission trip than if working long-term in an established hospital, but the little that one can offer is still highly appreciated. However, I believe that saving the soul is ultimately far more important than mending the body. Paul writes 'I have become all things to all men so that by all possible means I might save some'.[1] Medicine is a means by which communities receiving healthcare also receive something more vital – the Gospel.

***Richard Scott** is a part-time GP/evangelist in Margate and a former Medical Superintendent in Tanzania*

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1 1 Corinthians 9:22
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Three independent experts comment

Richard Scott's question is an important one for the 21st century, as short term teams become more and more part of the mission scene. They can be a blessing but in 12 years' work in Africa I have also seen some negative consequences. The standing of local clinicians and health centres can be diminished, as they do not have the drugs and equipment that the team brings.

Short term visitors cause a lot of work for hosts and there are many mission spouses who groan inwardly when they hear of another group coming! On the spiritual side there can be a failure to integrate with local church work unless there is good planning for follow-up, and careful preparation beforehand. This needs to involve more than an invitation from a keen individual. And there will never be a lack of invitations as there is always someone in a poor country ready to welcome rich visitors!

Having said that, God is sovereign and in his world can use any person or organisation in any place, sometimes in unexpected ways. There are many who subsequently give long term service as a result of short term 'taster' visits, and there are also those who become regular short termers, visiting the same place each year, and their usefulness grows each trip. Through Faith Missions have been visiting Maasailand since 2002.

My advice to those thinking of short term mission trips is: don't go unless there is clear evidence that your visit will support local medical or church work. Ideally one member should do a reconnaissance trip first. And don't go unless at least some members of the group are considering a longer term relationship – there are too many one-off shows in life.

***Professor Chris Lavy**, consultant orthopaedic surgeon*

The health needs of a semi-nomadic people will never be easy to meet, and the impact of a one-off medical mission is likely to leave a limited health legacy. It can only reach a snapshot of those with chronic disease and opportunistically help those who fall ill on the day the team appears. As an alternative to existing services, overstretched and under-resourced, the team will be welcomed and certainly see and help a large number of people. Opportunities to work alongside national staff and for skills to be transferred will be limited, if not next to impossible.

'Lord, help us to see as you see' was our prayer on the recent short overseas trip I made with a team from our church. Richard Scott asks us to see this medical mission in the context of a bigger picture, of an ongoing relationship with a proud and noble people where gospel opportunities exist. Both sowing and reaping took place. If this mission becomes part of the narrative of these communities and nudges some towards transformational change, it becomes less relevant to calculate a cost per health benefit, and more important to reflect on the eternal value of lives made right with their Creator.

***Dr Andrew Mortimore**, consultant in public health*

What mission really means is shown to us in the life of Jesus – God willing to become a man, just like us. He felt hunger and pain, joy and sorrow. He left us with the words: 'As the Father has sent me, I am sending you'.[2] What a challenge!

Medical mission is not so much an action but a lifestyle, bringing Christ to where he has called us to be. It is feeling the need of others and being there for them, speaking their language and learning their culture so that we can understand their strengths and values. It is respecting them and including their resources in meeting their needs. At the end we will see that it is Christ who will work the miracle in their hearts and change their lives around, and ours.

Medical mission that does not only see diarrhoea or malnutrition, the cleft palate or the Kaposi sarcoma, but brings health and wholeness, restoration and reconciliation will cause transformation of people and society and be truly part of God's mission in this world.

***Dr Gisela Schneider**, Director of The German Institute for Medical Mission*

Peter May revisits biblical characteristics of healing miracles

Cardinal Newman's MIRACLE

key points

Starting with the much publicised beatification of Cardinal Newman during the recent British visit of Pope Benedict XVI, the author reviews the medical evidence for the claim that Jack Sullivan had experienced miraculous healing after praying to the late Cardinal.

He compares this evidence with the biblical criteria, upon which the Catholic Church has based its criteria since 1795, and having commended Catholic openness in making material available in a *Positio*, concludes that the Jack Sullivan case falls far short of being a miracle.

In a brief 'apologetic' consideration of biblical accounts of Christ's healings, he emphasises that the resurrection is a miracle that is open to critical investigation today.

The making of a Saint?

In September 2010, at a much publicised ceremony during the British visit of Pope Benedict XVI, the late Cardinal Newman was beatified. There are two stages in the making of a Catholic saint, beatification and canonisation, and each stage requires evidence of a miracle resulting from prayers being made to the individual in question.

A television film about Newman was seen by an American man called Jack Sullivan, who at 61 years was training for the Catholic diaconate. The film urged people, who had prayed to Newman and believed their prayers to have been answered, to inform the Catholic authorities.

Mr Sullivan had severe back pain. An MRI scan confirmed that there was pressure on the root of his femoral nerve.[1] So in the summer of 2000, after seeing the TV film, Sullivan prayed to Newman and apparently had immediate and lasting relief of his pain. Now all that is impressive enough, except for the fact that ten months later, the pain returned. This temporary relief of pain can be explained medically, in that investigations had demonstrated a slipped lumbar disc to be the cause, rather than degenerative bone disease.[2] Most slipped discs shrivel up with time.

When the pain returned, Sullivan was re-examined, confirming the earlier diagnosis. He was consequently seen by a neurosurgeon, who performed a laminectomy on 9 August 2001. This common operation carries a good success rate and pain relief is dramatic as soon as the pressure on the nerve is released. Most patients are usually encouraged to walk within 24 hours of the operation, and most leave hospital within five days.

However, Mr Sullivan suffered a complication during the operation, in that there was a large tear of his dural sac.[3] To suture it required a more extensive removal of bone than had initially been indicated.[4] As a result, he was restricted to bed rest for four days post-operatively to allow the tear to heal.[5] On day 5, Mr Sullivan had both pain and anxiety when a physiotherapist tried to mobilise him. On the 6th day however, he put his feet on the ground and he prayed again to Newman. He says that he immediately had a warm feeling in his body and felt 'a surge of strength and confidence that I could finally walk'.[6] He then began to walk and found that his pain had vanished. Later that day he was allowed home. Since his original episode of pain had recurred, causing him to have surgery, it is this second relief of pain after a successful, albeit complicated, operation, which the Catholic hierarchy are calling a miracle, justifying the 'beatification' of Newman.

What is 'miracle'?

'Miracle' is a word we are all liable to use rather casually to speak of entirely natural events, such as childbirth. When Christian people speak of healing

miracles, we tend to imply that we are talking about Christ-like gospel miracles. We do not just mean that their prayers were answered in the natural course of events.

Cardinal Lambertini, who went on to become Pope Benedict 14th, has been the Catholic Church's guiding authority on this subject. In 1795 his study of the Gospels enabled him to publish five defining characteristics of Christ's healing miracles:[7]

1. They were complete cures
2. They included frankly incurable diseases
3. They happened instantaneously
4. There was no other treatment involved
5. They were not self-limiting conditions

Examples showing all five characteristics are found in all four Gospels. They include a man who was born blind (John 9:1ff), a woman who had a fixed curvature of her spine for 18 years (Luke 13:10ff), a paralysed man who was able to take up his bed and walk (Mark 2:1-12), a deaf-mute (Mark 7:32-37), a man with a shrivelled hand (Matthew 12:9-13) and the raising of Lazarus, who had been dead for four days (John 11:1-44; 12:1, 2, 9-11).

To unpack these criteria further, there is no suggestion that the blind man could only partly see or that the paralysed man staggered off home leaning on the shoulder of a friend, who had to carry his bed! These diseases were incurable then and remain so today. The healings were immediate in that they occurred there and then in full view of the watching crowd. That Jesus touched the deaf-mute cannot be said to have been physically therapeutic in natural terms. None would have got better on their own and neither would any of them need a physician's certificate to confirm that they had been healed. That was entirely obvious to everyone present.

It is important to note that none of these conditions were psychosomatic. These were frankly physical diseases and the examples I have listed above certainly would not have resolved with placebos.

Jack Sullivan's pain was relieved immediately but this was fully expected to resolve as a result of the operation. It is difficult to exclude a psychological effect, given what we know about placebo responses. What we do know is that he had definitive surgery for the cause of his pain, and the operation notes gave every indication of a good result.[8]

Evaluating Gospel accounts

Of course, sceptics doubt that the Gospel events actually happened. However, testimony to such healing miracles is given in all four Gospels, while the Jewish historian Josephus also described Jesus as 'a doer of wonderful works'. Historian Hugo Staudinger has written 'It is from a historical point of view impossible, that these miracle stories as a whole are the result of a free-roaming imagination. One must continually call to mind that the oral fixation of the reports already began shortly after the actual happenings and that the final written fixation of the first Gospels was brought to a conclusion at a time when the greater part of the witnesses were still living.'[9]

It seems to me that we cannot investigate these healings today and must therefore take a general view of them on other grounds. Our conclusions about Christ will be pivotal to our view of his reported deeds. That view will take into account his teaching, character, claims and resurrection (a miracle that is open to critical investigation today). The Christian will argue that there is plenty of evidence there to support the view that God confronts us in Christ. And as Jesus said, 'If I drive out demons by the finger of God, then the Kingdom of God has come to you' (Luke 11:20).

Evaluating contemporary claims

It is not difficult in Britain to investigate miracle claims. The *Access to Medical Records Act 1990* allows all patients to obtain copies of their medical records or specialist letters upon request. So if a patient claims to have been healed of blindness, for instance, we can establish whether they had been formally registered blind and whether they were completely or partially blind. We can also compare the visual acuity scores before and after any claimed healing. The only caveats are that their doctors may request an administration fee and they retain the right to decline to give reports, if they feel that it is not in the patient's best interests to see these details.

It seems to me that anyone claiming to have experienced a healing miracle should do the decent thing and obtain medical verification. If that is true for individuals making claims, it is also true for any potential publisher to see such reports before telling the world about it.

A new Vatican openness?

Dr Jacalyn Duffin, a Canadian haematologist, was given access to the Vatican secret archives to research her 2009 book on the Vatican miracles. She wrote that she was not allowed to see any of the Vatican records since 1939.[10] 'Positios' of the saints are kept secret in Vatican archives for the next six papacies – a period of approximately 70 years.

My details of the Newman miracle story however come from the official Vatican document called a *Positio*, a copy of which I have been able to purchase! This came as a complete surprise to me. If this represents a new openness by the Catholic authorities, it is very much to be welcomed. It is quite clear to me that the so-called miraculous healing of Jack Sullivan falls far short of the biblical criteria, and indeed the Catholic Church's own criteria, for what constitutes a miracle.

Peter May *is a retired GP in Southampton with a long term interest in the evidence for miraculous healing*

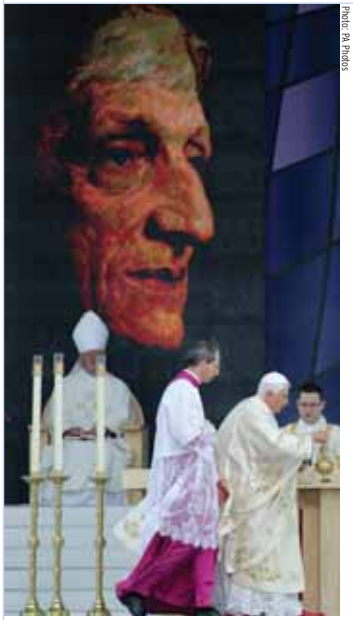

Photo: PA Photos

'Miracle' is a word we are all liable to use rather casually to speak of entirely natural events

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Rhona Knight summarises her 2010 RCGP Breakfast talk

Healthy doctors, healthy patients[1]

key points

Doctors are generally very bad at looking after their own health. This lack of self care impacts negatively on us as individuals, but also impacts on our families, our colleagues and our patients.

We need doctors for our own physical and emotional health needs, but as Christian doctors, we need more. The author points us to Jesus, and his prescription for our health found in loving God totally, and loving our neighbours as ourselves.

As Christian doctors we must take time to consult with the greatest physician, so that we can become truly healthy.

What is heath?

The World Health Organisation definition of health tells us *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*[2] Bearing this in mind, it is hard to imagine anyone could be completely healthy. One small twinge, one tiny anxiety, one miniscule regret will all serve to compromise wellbeing as defined by the WHO.

Yet even the WHO definition is lacking, for as our palliative care colleagues eloquently point out, the causes of pain are multiple. Pain can arise from physical, social, emotional and spiritual causes. Spiritual pain can occur as a result of fulfilling the obligations of a chosen worldview. It can develop when contemplating the more general meaning of life, the universe, and everything. It can arise more specifically as a result of an individual considering and reflecting on the meaning of their own life. The term often used here is 'existential angst', encompassing the spiritual *why*? questions of life which can have such a powerful impact on health, and the answers to which form the view of the world we have.

For example, look at the impact on health in those with a nihilistic worldview, captured well in the descriptions of meaninglessness in the book of Ecclesiastes, or in the existentialist view, where to give life perceived meaning, suicide has to become an option. Consider the impact on health of those with a hedonistic worldview, as described in Isaiah: 'Let us eat and drink...for tomorrow we die!'[3] Assuming death is not tomorrow, this sounds like a recipe for liver disease.

Doctors as patients

As doctors we are generally very bad at looking after our own health.[4,5,6] We often are not registered with a GP, we have corridor consultations, we self-diagnose, manage and treat. This lack of self care impacts negatively on us as individuals, but as John Donne says, no man is an island and our health and ill health also impact on our families, our colleagues and our patients.

Then there is the job. The sad fact is we have a job or vocation that appears by its very nature to make us more likely to become ill; be that stress, depression or burnout, or substance and alcohol misuse and suicide. Caring is costly, and Christians are not exempt. Maybe Christians are more at risk, as not only are we busy at work and home, but at church as well. We can spend so much time doing, there is little time just to be with God.

Doctoring doctors

There is then the question of doctoring. How do you doctor doctors? Many doctors find doctor patients more difficult to consult with, especially if they can be perceived as having greater clinical expertise. An interesting poem[7] reported by Lipsitt and Schneck perhaps crystallises this problem:

If a doctor is doctoring a doctor,
Does the doctor doing the doctoring
Doctor the doctor being doctored
The way the doctor being doctored
Wants to be
Or does the doctor doctoring the doctor
Doctor the doctor being doctored
The way the doctoring doctor usually doctors?

As doctors we need a doctor

As Christian doctors we need doctors to go to when we are unwell, to check our BP and Ischaemic Heart Disease risk factors. We need them to guide and care for us if depressed and stressed. We need them to look after our physical and emotional health needs, and while possibly not from the same background or faith perspective, to be aware of the importance of our social and spiritual health.

Yet as Christian doctors we need more. We are more than physical, emotional and social beings. We are spiritual beings and need to take care of and be cared for in the area of spiritual health, where our key focus is on loving God with all our heart, soul, mind and strength and in loving our neighbours as ourselves. As Christian doctors we need a doctor. The beauty is that we do have a doctor, a great physician, we can turn to. Jesus tells us that he came for us, those who are not healthy, for after all it is not the healthy who need a doctor, it is the sick. [8]

Jesus the physician

Jesus, our physician, gives us a prescription for health from Deuteronomy [9] and repeated in various forms in Matthew, Luke and Galatians. [10] 'Hear, O Israel: The Lord our God, the Lord is one.' We are to listen to the God who is trinity, yet also unity, the God in whose image we are made. We must then *love the Lord our God* with all our heart and with all our soul and with all our strength. To this in Matthew is added a second commandment: 'Love your neighbour as yourself'. [11] Love God, the greatest commandment. The next is to love neighbour as self. As Christians we do need to love God, and from this, to love our neighbours as we love ourselves.

This is where Christian doctors often face a rather concerning problem, for if we look around at ourselves and our colleagues, we may begin to feel very sorry for our neighbours, if the standards set are so low. Do we really want to love our neighbours the way we love ourselves – by expecting them to work all hours, to compromise on time with God, family, fun and relationships? Or do we not rather want them to have a healthy work life balance, where time with God and neighbour is a priority and not squeezed out as life is too busy?

David Short in an article on vocation entitled 'More than just a job' tells us this. [12] 'The budgeting of time, essential for all doctors, is absolutely crucial for the Christian who is determined to glorify God at work. Time must be allocated for recreation, for spouse and family, and for communion with God. All are vital, particularly the last.' Psalm 1 would back this approach. Blessed is the man, we are told, whose delight is in the law of the Lord and on his law he meditates day and night. Blessed – healthy in the fullest sense of the word. If we do this we will automatically, on a daily basis, put on the armour of God, [13] and we will bear the fruit of the Spirit. [14]

Good doctors

Take the fruit of goodness. What is goodness like in medical practice? Micah 6:8 guides us:

He has showed you, O man, what is good.
And what does the LORD require of you?
To act justly and to love mercy
and to walk humbly with your God.

God has shown us what is good, and goodness is not just about doing, it is also about being. It is about acting justly, whether it be in speaking up and acting to address health inequalities locally and nationally, or in target data submissions, tax returns and claim forms. It is about trustworthiness and integrity. Goodness is about loving mercy. This can be demonstrated in the intuitive and often gut wrenching feeling of compassion and mercy that God develops in us for others. This mercy arises from our being, and is a way God uses to touch the patients we meet and care for – even the ones we find more difficult.

In this way we become good doctors. Justice and mercy help us maintain good relationships with both colleagues and patients, thereby loving neighbour. They also support us in demonstrating the General Medical Council duties of a doctor. *Good Medical Practice* [15] tells us: 'Good doctors make the care of their patients their first concern: they … maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity'. The guidance of scripture and the fruit of the Spirit are a pretty sure way of fulfilling these duties. The only way by which all of this becomes possible is by walking humbly with our God.

The recipe for healthy doctors

In scripture we therefore have a 'recipe' for truly healthy doctors who in turn can have a positive impact on the health of their patients. This recipe does not guarantee physical, emotional or social health the way the world defines it. However it does promise a more holistic view of health, which includes our spiritual health.

Love God and walk with him humbly. Love your neighbour as also you love yourself. As Ezekiel tells us, God, by giving us a new heart and putting a new spirit in us, moves us to follow his decrees and keep his laws – a sure way to spiritual health. [16]

As doctors we need doctors. We need to see them for our own physical and emotional health needs. But as Christian doctors let us make sure we take time to consult with the greatest physician, so that we can become truly healthy.

Rhona Knight *is a portfolio GP in Leicestershire*

As doctors we are generally very bad at looking after our own health

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Floods in Pakistan

'It was terrible – people were just lying beside the road, with nowhere to go. Children were on the ground, scraping up bits of rice that someone had dropped. People were drinking the flood water.' Dr Nadeem Hidayat described the scenes he witnessed the day the flood swept through Pakistan's Khyber Pakhtunkhwa Province.

Nadeem is the Medical Superintendent of Pennell Memorial Christian Hospital (PMCH) which CMF supported during the initial crisis this summer, and we were privileged to meet him during his November trip to the UK. He went on to tell us: 'Three days later we ran our first clinic in the camp. People were suffering from diarrhoea and vomiting, there was a lot of malaria and typhoid fever. Many had terrible wounds – we were asked to help a woman whose house had collapsed on her. Falling beams had crushed her and I had to amputate both her hands. She is still in the hospital with her six children as she has nowhere to go – some of the staff are bringing her food. We don't know how many others there are like her.'

The worst humanitarian crisis

The floods have created the worst humanitarian crisis in recent times, with 20 million people affected – more than the 2004 tsunami and the earthquakes in Kashmir and Haiti put together. In September we considered whether there was anything CMF could do to help in this devastating situation. We are not an aid agency, but as part of a worldwide fellowship of Christian doctors we are in the unique position during health crises of being in direct contact with doctors living and working on the frontline.

Dr Nadeem at PMCH and Dr Haroon Lal Din at Kunhar Christian Hospital in northern Pakistan are both CMF members in flood-affected areas. We launched an appeal within the membership to support these two hospitals and were amazed by the response – we reached our target of £20,000 in five days. Even after the appeal was closed, members continued to send donations and altogether we have raised £28,700 which will enable us to help in other places as well. The £16,000 we have sent to PMCH has provided two months' food, water and drugs for 200 families – almost 2,000 people. It has been a great privilege to stand with our Pakistani colleagues in this way, and through them to help some of those who have suffered from this tragedy.

Pennell Memorial Christian Hospital

PMCH has a long legacy of service since it was founded 117 years ago by pioneer missionary Dr Theodore Pennell. But it is not an easy place to work – near the border of the lawless Federally Administered Tribal Area where the Taliban are active, the area has been a victim of extremism, terrorism, military operations and natural disasters for the last couple of decades. Nadeem explained:

'Many NGOs are afraid to work in these areas. Due to security issues, it's difficult for me to leave the hospital – I am visiting flood victims with a van full of army guards. The former Medical Superintendent was kidnapped by the Taliban. But by the grace of God we are safe and it is my pleasure that we treat many war wounded Taliban in our hospital so we have a good reputation in this area.'

'Our province of Khyber Pakhtunkhwa is a divided community – the social and economic lives of the people are almost crippled due to economic uncertainty and political instability. The 'War against Terror' has further aggravated the peaceful lives of the local people, and there are divisions between liberals and extremists, East and West, Muslims and non-Muslims. Most Christians are unskilled and poorly educated, living in slum areas. Economically they are the poorest of the poor. Christians in Pakistan are regarded as second class citizens.'

In the crisis of the flood, the hospital has tried to build bridges between the divided communities by providing food and gifts for Muslims at the end of Ramadan. Hospital staff gave two days' wages to provide the gifts, which included a portion of the Bible for any who wanted one. Ninety copies of the New Testament and 250 Gospels of John were given out.

Where no other doctor would go

I asked Nadeem why he has chosen to work in this difficult place, when he could have chosen easier and more profitable options. He replied 'It has always been my aim to work in a mission hospital. I wanted to work where no other doctor would go. I pray with every patient – these people really need God. I want to stay longer – as long as God can use me there.' Praise God for doctors like Nadeem, willing to bring the love of God and the light of the gospel to hard places – places where other doctors won't go.

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

eutychus

Clampdown on Dutch 'coffee shops'

The Dutch have traditionally tolerated selling small amounts of cannabis through licensed 'coffee shops', which first emerged in the mid-1970s with the idea of creating a safe environment where adults could smoke cannabis but other illegal substances would be banned. Licensing laws limiting the social harms caused by drug tourism have put them under increasing pressure since the 1990s, and the number has fallen from around 1,200 to 700. Under a new agreement the coffee shops will become private clubs – so no tourists allowed.
(*www.bbc.co.uk/news/world-europe-11647189*)

Alcohol and school children

A study of 3,641 children aged 11-14 at 15 secondary schools in the north west showed that a third of 11-year-olds, rising to two-thirds of 14-year-olds, had drunk alcohol. Children happier at school, 'with positive school wellbeing', had lower odds of ever drinking alcohol, drinking often, engaging in any sexual activity, and of having sex. 'General wellbeing' had a smaller effect. The more often 13-14s drank alcohol, the more likely they were to engage in sexual activity: Children drinking once a week or more had 10-fold higher odds. (*Substance Abuse Treatment, Prevention, and Policy* 2010, 5:27)

Almost 500,000 new STIs

With young people most affected, there were 482,696 new cases of sexually transmitted infections in the UK in the year to August, a 3% rise from 2008 figures and continuing a 'steady upward trend'. More testing, and the use of more sensitive tests more likely to detect infections are said to explain part of the increase, but 'experts believe unsafe sexual behaviour is also part of the story'. Perhaps the new coalition government will at last bring in some truly independent advisors.
(*www.bbc.co.uk/news/health-11072853*)

48 hour week

The European Working Time Directive has suffered two – perhaps fatal – blows. The *BMJ* reports that the Department of Health has stopped monitoring doctor compliance with the 48 hour week, and the European Commission has stopped proceedings against Greece which broke the regulation. The President of the Royal College of Surgeons of England said: 'The inevitability of change is in the political air. Why is it taking so long?'
(*BMJ Careers* 30 October 2010: GP136)

NHS locum costs almost double

Under the Freedom of Information Act the Royal College of Surgeons asked for data on locum spending from 164 trusts, getting results from 96. These figures were then extrapolated to the whole of England, and suggested spending rose from £384 million in 2007-8 to £758 million last year. A third of the £758 million figure related to surgical posts. The President linked this to the EWTD and the Health Secretary added: 'The scale of increase in the cost of agency staff in the NHS is unacceptable. There is also a practical concern about continuity of care for patients.'
(*www.bbc.co.uk/news/health-11722478*)

Breaking the death taboo?

A feature helpfully asks whether traditional British 'reserve' is spoiling the chances of a good death? Professor Mayur Lakhani, GP and chair of the Dying Matters Coalition and The National Council for Palliative Care, said: 'When a significant majority of people say they want to die at home, but around 60% end their days in a hospital bed, it's clear this so-called 'reserve' is preventing a large number of people from dying how they want'. CMF would welcome greater recognition of the inevitability and often the rightness of natural death. (*www.bbc.co.uk/news/health-11642250*)

How many of us are gay?

The Integrated Household Survey produced by the Office for National Statistics (ONS) consists of core questions from six current household surveys including data from nearly 450,000 individual respondents – the biggest pool of UK social data after the census. 1.5% of adults in the UK identified themselves as Gay/Lesbian or Bisexual; 71% of people in Great Britain stated their religion was 'Christianity', 8% 'any other religion' and 21% 'no religious affiliation'. Eutychus understands the next census due in 2011 will enquire about religion, but not sexual orientation.
(*www.statistics.gov.uk/pdfdir/ihs0910.pdf*)

Civil partnership dissolutions increase

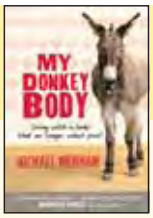
New ONS data reveals a substantial increase in the number of civil partnership dissolutions. In 2009, 351 were dissolved, almost double the 180 in 2008. This increase is in the context of a decrease in the number of couples entering into a civil union. The number of civil partnerships peaked at 4,869 in the first quarter of 2006, as long-standing same-sex couples took advantage of the change in the law, but last year 6,281 civil partnerships were formed in the UK, a decrease of 12% on 2008 figures. (*www.statistics.gov.uk/pdfdir/cpuk0810.pdf*)

The average woman would spend £15,000 on IVF

A survey by the women's fashion and lifestyle magazine *Red* asked 2,000 women aged between 30 and 45 about fertility treatment. British women are prepared to spend an average of £15,000 in order to conceive, with one in ten willing to spend over £50,000 on fertility treatment. 38 per cent of women had struggled to conceive. One in ten had sought some form of fertility treatment, with the average amount spent being £8,678. (*BioNews* 13 September 2010. *www.bionews.org.uk/page_70346.asp?dinfo=evYYbiC4InfTh85o4zzmkIA5*)

Human rights in China

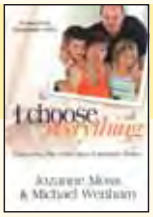
Ending a two-day UK trade mission to China in November the Prime Minister said 'There is no secret we disagree on some issues, especially around human rights. We don't raise these issues to make us look good, or to flaunt publicly that we've done so. We raise them because the British people expect us to – and because we have sincere and deeply-held concerns.' He emphasised that, were he not in Beijing, he would have been preparing for Prime Minister's Questions. Such scrutiny forced leaders to listen to criticism and adapt their policies in response.
(*www.bbc.co.uk/news/business-11723838*)



My Donkey Body

Living with a body that no longer obeys you
Michael Wenham

- Monarch Books (Lion Hudson) 2008
- £7.99 Pb 160pp
- ISBN 978 1 85424 889 3



I Choose Everything

Embracing life in the face of terminal illness
Jozanne Moss and Michael Wenham

- Monarch Books (Lion Hudson) 2010
- £7.99 Pb 192pp
- ISBN 978 0 85721 012 8

These two books are linked by a common author, Michael Wenham, an Anglican priest. He has never met Jozanne Moss, only communicated by email. There is a CMF link, as they were introduced by Peter Saunders.

What the authors have in common is that both are living through the progressively disabling and ultimately fatal condition of Motor Neurone Disease (MND). Both books contain honest, moving accounts of this experience and the interplay between it and the authors' Christian faith.

In *My Donkey Body* Wenham tells his own story of disease onset, diagnosis and progression. He tells it straightforwardly with gentle humour, tackling along the way an array of challenging issues including his personal relationship with God, maintaining faith in the power of prayer that yet does not bring about healing, and his approach to the ongoing push to legalise assisted suicide when many would see him as a prime example of a person who might 'benefit' from it.

Wenham's contribution to *I Choose Everything* (a quotation from St Therese of Lisieux, who died aged 24 from tuberculosis) is also informed by his experience of MND but takes the form of theological counterpoints to Jozanne Moss' description of her own journey. Her MND began when she was only in her thirties, a mother of two young children, and is moving faster than his.

She too tells the story of her physical deterioration and the frustrations and fears it brings about, as well as the intense sadness of realising she will not live to see her children grow up. Yet at the book's recent launch in her home town in South Africa, Jozanne said: 'This book is not about me or my illness, but about God's faithfulness and love to us as a family'. And it is.

Filtered through their different characters and circumstances both authors show how, despite everything, they remain convinced of God's love in Jesus Christ, and perceive their own and their families' needs met through that love, shown in small, unexpected but numerous ways.

Michael and Jozanne's stories deserve to be read by health and social care workers but also by any Christian who has ever contemplated disabling or terminal illness and thought: 'I wonder how I would cope it that were me…?'

***Nigel Sykes** is a consultant in palliative medicine at St Christopher's Hospice*

A time to care

Loving your elderly parents
Emily Ackerman

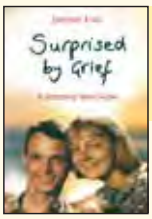
- IVP 2010
- £7.99 Pb 190pp
- ISBN 978 1 84474 487 9

There is plenty of help in our churches for parents of young children – toddler groups, parenting courses, crèche on Sunday. This book is an excellent resource for the increasing number of us who are at the other end of family care. Each thoroughly biblical and accessible chapter closes with thought-provoking questions and quotations, so that the hard-pressed carer will benefit from just considering those even if they can't find time to read a chapter at a sitting. The appendix provides a very helpful list of books, websites and support group details.

Carers certainly need encouragement and sympathy but Emily is not afraid also to challenge unbiblical thinking and 'tell it like it is'. She helpfully points out the many unlooked-for positives of the caring role – for instance learning new skills, and the opportunity for spiritual growth.

I highly commend this book and hope it will find a wider readership than simply those already committed to caring for their parents. To quote another reviewer, it is 'honest, down-to-earth, spiritually sensitive, encouraging and realistic'.

***Jen Watkins** helped care for her mother who had Alzheimer's and Parkinson's diseases*



Surprised by grief

A journey into hope
Janine Fair

- IVP 2010
- £7.99 Pb 143pp
- ISBN 978 1 84474 472 5

Starting at the moment of her husband's unexpected death, Janine Fair, mother, doctor and vicar's wife, explores the impact of this tragic event on herself, her young family and her faith. In a direct and punchy style, she examines her spiritual and psychological weaknesses, dissecting how God uses events to change her. She lays bare emotions of overwhelming grief, anger, bitterness, self-pity and despair in the context of the daily struggle to survive.

This book is not a theological treatise but is run through with a golden thread of faith. Janine shows how God used Psalms, Bible verses, songs and pictures to bring her to repentance for the times she had distanced herself from people and refused to accept the help God was offering. Using the metaphor of a butterfly emerging from a chrysalis of suffering, she finishes in a place of surprising joy and hope. While acknowledging that aspects of grief will often be present, she thanks God for the grace he has given her over four years.

I would recommend this book for any Christian who has not experienced the loss of someone close. It may prove helpful for those taking their own journey through grief.

***Claire Stark Toller** is a specialist registrar in palliative medicine in the Oxford Deanery*

Incapacity and Care

Controversies in Healthcare and Research
Edited by Helen Watt

- The Linacre Centre 2009
- £11.95 Pb 146pp
- ISBN 978 0 90656 111 9

It was winter 1983, while doing obstetrics at medical school, that I witnessed the sterilisation of a young woman with mental disability. We met her at the hostel one day and she was operated on the next. This always felt questionable, but it was only while reading this book that I understood why.

Drawn from the Catholic tradition, this collection of essays explores contemporary ethical problems, which are instantly recognisable to those involved in clinical practice. All the contributions examine aspects of care for people without capacity. There are profound insights into PEG feeding in dementia; research on those who lack capacity; sterilisation of people with intellectual disability; and the Mental Capacity Act. The chapter on non-voluntary euthanasia is a mine of information on the Dutch experience, unequivocally exposing the 'slippery slope'.

The contributions are of a uniformly high academic standard, giving integrity to the arguments crafted. The authors each explain the rationale for Christian values which we otherwise grasp only intuitively much of the time. This book takes one by surprise. Not obviously a best seller, but giving the reader a new perspective on human dignity and worth framed by the love of God. Worth the read.

***Steve Sturman** is a consultant neurologist in Birmingham*

Just the two of us?

Help and strength in the struggle to conceive
Eleanor Margesson and Sue McGowan

- IVP 2010
- £7.99 Pb 191pp
- ISBN 978 1 84474 475 6

This is a gentle, sensible walk through issues that appear when infertility crushes your identity, written by two women whose infertility had different outcomes. They discuss questions of concern to Christian couples longing for a child, some of whom may have suffered miscarriages or stillbirth. The book is also meant for those who support such couples, giving positive suggestions and revealing ways in which friends and family can cause pain by thoughtless remarks or questions.

Sections explore the biblical perspective, what makes a family, marriage, men's advice and experiences, adoption, and medical treatment. Personal stories are included and helpful reflections end each section. A poignant chapter talks about letting go of the dreams you had for your future. Maybe the dreams have taken you over.

We are made in the image of a Father God and thus with the 'stamp' of a parent. Therefore we naturally love and nurture others and find childlessness hard. The authors note that in the New Testament Paul shows this father love for fellow Christians, and today we can use this grasp of parenting in a much wider sense than with our own children. This is a book of encouragement, comfort and strength to face whatever the future may hold.

***Clare Cooper** is an early-retired doctor in Sussex*

Turning the World Upside Down

The Search for Global Health in the 21st Century
Nigel Crisp

- Royal Society of Medicine Press 2010
- £12.95 Pb 228 pp
- ISBN 978 1 85315 933 6

Five reasons to buy. First, it is short. Secondly, it is packed with facts about the health status of the world. I personally will be using the many powerful quotations and facts in future talks. Thirdly, it is written by the man who for five years ran the NHS – the world's biggest healthcare organisation.

Crisp knows the issues facing healthcare in the richest and poorest countries. Commissioned by Tony Blair to visit as many places as he could, to talk to healthcare givers, receivers, planners and managers, he has listened to the needs and stories of hundreds, and quotes them widely. He is able to take a sensitive issue, eg the emigration of doctors from poor to rich countries, look at it from all sides, then discuss it concisely and objectively.

Fourthly, he does what the title promises: he rejects constraints inherent in traditional methods of delivering healthcare and turns the donor-recipient relationship upside down. Finally, he offers suggestions as to how all countries in the 21st century can work together, learning from each other as we address global need in healthcare, and the social, political and economic inequalities that accompany it.

***Chris Lavy** is a professor of orthopaedic surgery in Oxford*

Healing is a way of life: *Practical steps to healing*

Talks: Canon Jim Glennon
Compiled & Edited by Zillah Williams

- Zillah Williams 2009
- £14 Pb 261pp. Available from CMF
- ISBN 978 0 64651 862 6

After experiencing healing following a nervous breakdown, Canon Jim Glennon became well known for his healing ministry, from 1960 until he died in 2005. This compilation preserves his teaching as a practical resource for today's reader. Set out as daily readings (five/week for a year), each day has a Bible verse, a reading, the sermon notes, a key thought, and a sentence prayer.

Many helpful topics relate to faith and healing, and I was challenged over the need for discipline and persistence in prayer. I found myself reviewing my capacity to pray in faith without doubting, to truly forgive, to let go of the burden, and to remember the reality of the Kingdom of God. He clearly believes in working alongside medical care, but I do worry that some who remain unwell might feel accused of lack of faith. Some faith-enhancing ideas expressed (believing for others and accepting Christ for others) raise eyebrows.

Although I understood his arguments better by the end, they needed further reflection. Some parts I found repetitive and a little tedious, and I was uneasy about some dogmatic statements and biblical interpretation. The book should be used both with an open mind and with discernment.

***Jean Maxwell** is a retired palliative care consultant in Essex*

letters

Language for leprosy

C Ruth Butlin *has advised the Danish Bangladesh Leprosy Mission. She enjoyed the article* Drugs and Alcohol: Why should we care? *(Easter 2010: 10-11) but makes an important comment about language:*

I regret I am late in sending this comment as I only read the Easter *Triple Helix* recently (having been stranded in Bangladesh for a month by the ash cloud). The author makes a comparison between the situation of leprosy-affected people and that of those who are suffering from substance abuse. He makes some good observations and I sympathise with his point of view. However, I take exception to his use of the word 'leper'.

The word 'leper' has too many unpleasant and unfair associations to be acceptable nowadays in a Christian medical journal. It is considered by leprosy patients' organisations and also by NGOs like The Leprosy Mission which help individuals and communities affected by leprosy – and even by WHO – to be unduly derogatory and stigmatising for referring to individuals who have been affected by leprosy.

I feel that if authors use the word in manuscripts submitted to CMF they could be asked to reword the material, or alternatively the editor could amend it. Of course, if quoting an old book (including older translations of the Bible) the word may occur and be reproduced in that context, but in commenting on a Bible passage the author can surely use other phraseology.

For example, in the AV version of the Leviticus passage, Derrett Watts correctly quotes 'and the leper in whom the plague is…' But afterwards he could say 'In this passage we see the leprosy-affected people have had their dignity removed…', then later 'How did Jesus respond to people affected by leprosy?'

I am very sure that Jesus would never have offended suffering people by using words like 'leper' to speak to them. Nowadays none of us talk about mongols, spastics, cretins… We say 'patients or people with Down's syndrome or cerebral palsy or hypothyroidism'. Similarly we can speak of 'leprosy patients' (when they are under medical care) or 'leprosy-disabled people' in the appropriate context or (especially for those who have been treated and are no longer 'patients') we can use a term like 'person affected by leprosy'.

The author and the editors say 'Thanks. Point taken.'

Christians and medical research

Retired missionary and GP ***Peter Pattisson*** *appreciated the Summer* CMF File *(No 42 Christians and Medical Research):*

Thank you for the latest *CMF File* – one of the best for a while. Sam says in his conclusion: 'It is widely accepted that religion and science are mutually exclusive, but it is part of our task to show this is not true'. Space doubtless prevented Sam expanding on this, but I am reminded of words I heard first from the lips of Francis Schaeffer in the 60s to the effect that both science and biblical religion deal with both facts and faith.

Science requires faith because no one has personally been able to do all the basic research on which scientific advances are built; it has to be taken on trust – trusting the integrity of those who did the research and the reliability of the records of their findings.

Likewise, as biblical Christians, we know that faith is founded on the facts of salvation history and the reliability of the record of those events in the Bible.

Thank you, Sam and Helen, for an excellent *File*.

What is the right model of medicine?

Matthew Jackson*, an ST3 in anaesthetics, comments on the critique of QOF (Summer 2010: 6-8):*

David Misselbrook's discussion of the Quality and Outcomes Framework (QOF) is a welcome addition to the wider debate regarding targets, guidelines, care pathways, protocols, checklists, targets and computer records in healthcare. While sharing many of the discussed objections to 'tick-box medicine', I maintain that such practices need not be to the exclusion of broader 'care'.

Healthcare is increasingly characterised as a complex set of interventions. Because as humans we cannot always be relied upon to perform perfectly, technology has increasingly come to aid our practice – both in paper and computer formats. David Misselbrook quotes examples where the QOF has mechanised the patient-doctor relationship at the expense of 'softer' aspects of care.

An important consideration is whether protocols and such should aid or define practice. Perhaps Jesus' words in Mark 2:27 offer some insight: 'The Sabbath was made for man, not man for the Sabbath'. The error of the Second Temple establishment was to idolise the Sabbath, as opposed to recognising that it was made for holy rest (Genesis 2:3). Its observance became a distraction. Analogously, current medical practice may be said to idolise protocols and check lists. Tools designed to enhance care have paradoxically become a barrier to that goal.

The solution then is not to dismiss protocol, but to reflect on the way it is used. If true care is to be offered, the patient, not the protocol, must become the centre of the encounter. There is no choice offered between care or protocol, but rather a realisation that care may occur through protocol.

Andrew Drain faced death in the confidence of the resurrection

NOT MADE FOR TIME, BUT FOR ETERNITY

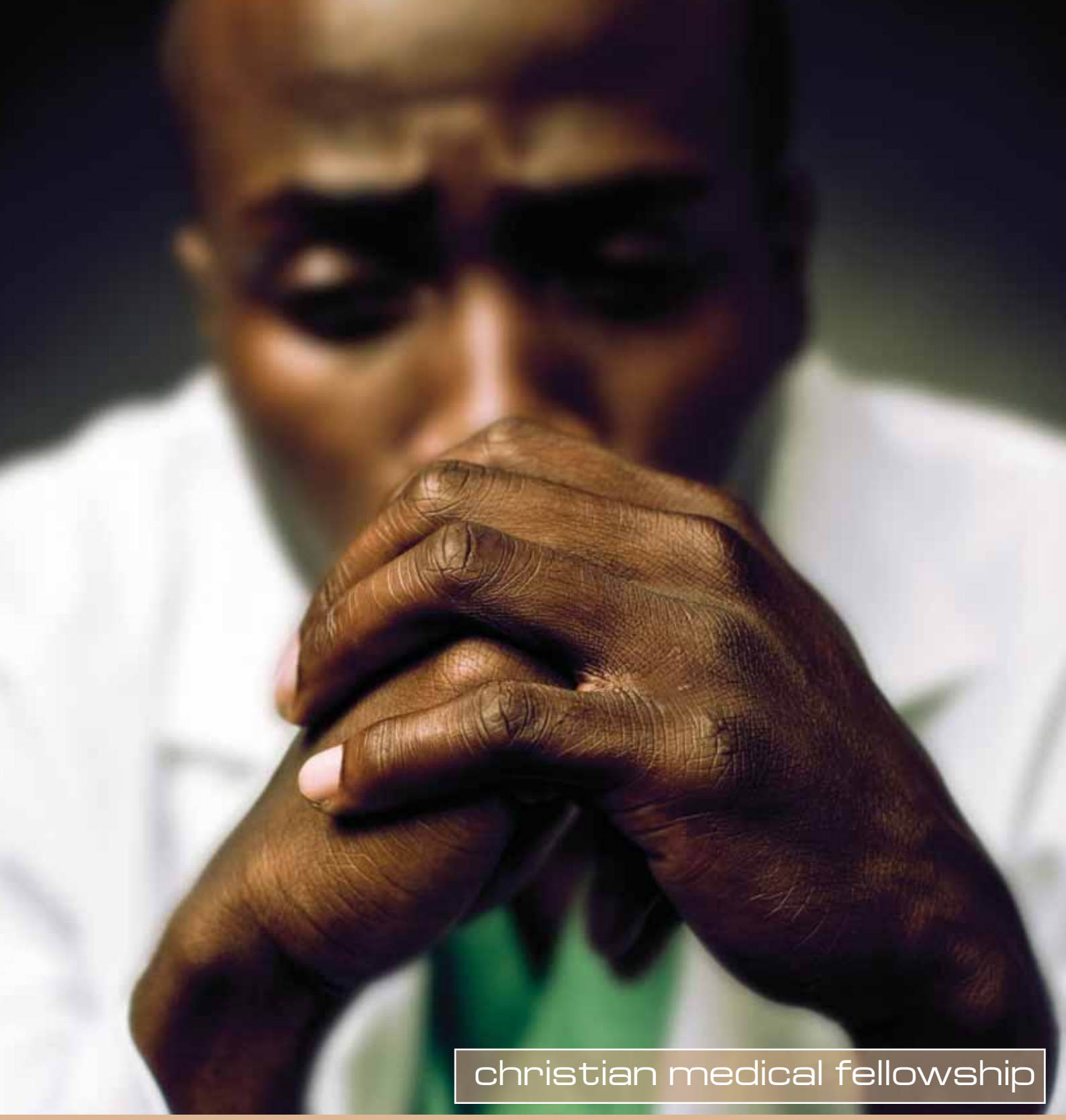
I recently received an email from a friend in Cambridge. He suggests that all of us have a certain frustration from being confined within time. We cannot hold on to time...but our frustration with time suggests that perhaps we are not meant to be confined by it. CS Lewis writes: 'We are so little reconciled to time that we are even astonished at it. 'How he's grown!' we exclaim, 'How time flies!' It's as strange as if a fish were repeatedly surprised at the wetness of water. And that would be strange indeed; unless of course, the fish were destined to become, one day, a land animal'.[1]

Our frustration with time is a reminder that we were not made for time, but for eternity. We are all meant to become (in CS Lewis' image) land animals – to emerge out of time into a greater dimension...but that is only possible because of the resurrection. It is the resurrection that gives us the courage not to fear time, or tomorrow, or whatever may happen to us in this world. Even before it happened, it was the resurrection that gave Job a hope beyond the here and now and into eternity. It was the resurrection that changed the disciples from deserting cowards into men and women of faith, conviction and courage, and it is the resurrection that can change us and our suffering into something more glorious than we will ever imagine.

This is an extract from **Code Red**, *published posthumously in October by CMF and available online or from the office for £5.* ***Andrew Drain*** *was a young cardiothoracic surgeon who died of leukaemia in July 2010. His exposition of Job is illuminated by his own experiences and the book is already a CMF best-seller*

reference

1 CS Lewis. *Reflections on the Psalms*. Harcourt, Brace, 1958. Chapter 12 'Second Meanings'



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