Winter 2012

for today's Christian doctor

triple helix

feeding the poor

Christian Dental Fellowship at 60, withdrawing and withholding care, the Liverpool Care Pathway, Is the gospel good news for healthcare?, changing direction, dispatches from abroad

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contents

Assisted suicide: victories and challenges

2013 will bring more pressure to legalise assisted suicide in Britain with two new parliamentary bills and an ongoing court case to threaten further the lives of elderly and disabled people. But there is also good cause to look back with thanks to God for victories in 2012.

Lord Falconer's 'Commission on Assisted Dying', which reported on 5 January 2012, predictably recommended a change in the law to recommend assisted suicide (and not euthanasia) for mentally competent adults with less than twelve months to live. CMF, as a leading member of the Care Not Killing Alliance (CNK), played a prominent role in discrediting the Commission's findings and exposing its funders and backers.

David Burrowes MP headed up a Westminster Hall debate [1] in Parliament in January on the Commission report which highlighted MPs' desires to frame the debate around the provision of excellent palliative care rather than any measure to introduce assisted suicide. On 13 February members of the House of Lords blocked [2] a move (which would have weakened the application of the law) to fetter the Director of Public Prosecutions in his judgements by placing his prosecution policy on a 'statutory footing'. A later debate [3] in the House of Commons on 28 March defeated a similar move by Richard Ottaway MP, further endorsed palliative care and rejected any weakening of the Suicide Act.

In June the British Medical Association defeated an attempt to move it to a neutral position on assisted suicide which was spearheaded by a new pressure group called 'Healthcare Professionals for Assisted Dying'. [4] This underlined the fact that majority medical opinion remains opposed to assisted suicide.

The First European Symposium on the prevention of euthanasia in Europe took place in Edinburgh on 7-8 September and was attended by around 100 delegates from twelve countries. It strengthened ties between Christian doctors and others all over the continent who oppose current threats.

Whilst the conference was going on two newly appointed health ministers, Anna Soubry and Norman Lamb, aroused controversy by announcing their support for legalising assisted suicide but a poll released shortly afterwards showed that seven out of ten MPs would not support such a measure. [5]

Three High Court judges in August rejected challenges by two men with conditions resembling 'locked-in syndrome' to change the law.

Tony Nicklinson had argued that the principle of necessity should allow a doctor to end his life without fear of prosecution for murder, and that the current laws interfered with his Article 8 right to his private life. 'Martin' had also argued under Article 8 and wanted the DPP, the Solicitors' Regulatory Authority and the General Medical Council to make clear in advance the extent to which solicitors and doctors could assist his suicide. CNK intervened successfully in both cases.

Lord Falconer has now published a new draft bill calling for doctors to have the power to help mentally competent adults with less than one year to live to kill themselves. This will be debated in the House of Lords next year.

In addition Margo MacDonald MSP has announced that she is going to try again to legalise assisted suicide in Scotland, just over a year after her last failed attempt. We expect the bill to be debated next spring.

Meanwhile reports from jurisdictions that have legalised euthanasia and assisted suicide continue to heighten concerns about incremental extension. According to the Dutch media, [6] euthanasia deaths in the Netherlands in 2011 increased by 18% to 3,695. This follows increases of 13% in 2009 and 19% in 2010 with euthanasia now accounting for 2.8% of all Dutch deaths.

In the US state of Washington assisted suicide cases increased 40% in one year, [7] whilst there has been a 450% increase in neighbouring Oregon and 700% increase in Switzerland since 1998. [8]

Meanwhile others face similar battles abroad, especially in Canada, the US and Australia where the battle is as intense as that in the UK. The recent referendum in Massachusetts (see News Reviews), however, has been a particular encouragement in showing how broad-based coalitions can be successful in turning public opinion and resisting a change in the law.

Under this relentless assault on the laws of our own country and others, Christian doctors need to continue to lead the way in promoting good care and opposing a change in the law.

'Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy' (Proverbs 31:8, 9).

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

references

1. http://bit.ly/QpwxxW
2. http://bit.ly/XmgG6k
3. http://bit.ly/HeJ8u4
4. *Triple Helix* 2012; Summer:4 http://bit.ly/Xmj8d2
5. http://bit.ly/Rf4IgO
6. http://bit.ly/S2EOxh
7. http://bit.ly/Jg4UE1
8. http://bit.ly/HH7pss

news reviews

All change at the Department of Health

Mixed reactions

Review by **Helen Barratt**
Clinical Research Fellow in Public Health in London

In September, Andrew Lansley was replaced as Secretary of State for Health by Jeremy Hunt, the former culture secretary, as part of an extensive government reshuffle. Three of the department's other ministers have also been replaced. The reshuffle saw Liberal Democrat Paul Burstow replaced by Norman Lamb; junior minister Anne Milton by Anna Soubry; and minister Simon Burns replaced by Dr Dan Poulter. Only Lord Howe stayed in post.[1]

Lansley was the architect of controversial reforms to the NHS in England, having been health secretary since the coalition government was formed in 2010. Prior to that he was shadow health secretary for seven years. Hunt will oversee the changes to the health service resulting from the Health and Social Care Act. Many of these come into force in April 2013, including the abolition of NHS primary care trusts and strategic health authorities.[2]

Observers have said the Prime Minister believed Hunt would be better placed than Lansley to present NHS policy to the public in the run-up to the 2015 general election. However, Hunt's appointment prompted mixed reactions from commentators. Some described it as 'disastrous,' whilst others perceived it as a fresh opportunity for discussions about the challenges facing the NHS. Hunt's most prominent previous involvement in the health service was leading a high-profile campaign five years ago to stop the closure of services at Royal Surrey County Hospital. This has sparked concern that he will try to delay planned NHS service changes in his new role.[3]

Increasingly many commentators regard the reform of social care as a priority. The government is being urged to adopt the recommendations of the commission chaired by the economist Andrew Dilnot in 2011.[4] Norman Lamb, the new Minister of State for Care Services has a strong interest in this subject having been the Liberal Democrat party's health spokesman before the 2010 election. The cost of the Dilnot proposals is estimated to be around £1.7 billion. However, in an interview with *The Spectator*, Hunt suggested that he would be seeking 'other versions that might not be quite so expensive.'[5]

Hunt caused controversy ahead of the Conservative Party conference in October. *The Times* reported him as saying that he would favour a change in the law to halve the legal limit on abortions from 24 weeks of pregnancy to 12. Theresa May, the Home Secretary, said she would 'probably' back a change to 20 weeks, and the Prime Minister David Cameron is known similarly to favour a 'modest' reduction. A Downing Street spokesman insisted that Hunt was expressing purely personal views and there were no plans to change the law.[6]

references

1. West D. Jeremy Hunt replaces Andrew Lansley as health secretary. *Health Service Journal* 2012; 4 September
2. Roberts M. Mixed reception of Hunt as new health secretary; *BBC News* 2012; 4 September
3. West D. Concern about service change delay as Hunt replaces Lansley. *Health Service Journal* 2012; 4 September
4. Barratt H. Social care funding. *Triple Helix* 2012; Spring: 5
5. Jeremy Hunt: no promises on the NHS ringfence. *The Spectator Coffee House Blog* 2012; 3 October *http://bit.ly/T1yOzi* (Accessed 10 October 2012)
6. Abortion limit reduction favoured by Jeremy Hunt; *BBC News* 2012; 6 October

Contraceptive jabs and implants for 13 year olds

Neither ethical nor evidence-based

Review by **Peter Saunders**
CMF Chief Executive

School nurses have given implants or jabs to girls aged between 13 and 16 more than 900 times in the past two years.[1] Girls aged 13 have been given contraceptive jabs and implants on more than 20 occasions and a further 7,400 girls aged 15 and under have been given contraceptive injections or implants at family planning clinics.

The implants are effective for up to three years and the injections for up to three months. Under patient confidentiality rules, nurses are prevented from seeking the permission of parents beforehand, or even informing them afterwards, without the pupil's permission.

Sex under 16 is not only illegal, it can also be profoundly damaging – physically, emotionally and spiritually. Children under 16 are judged to be too emotionally immature to drink in a pub, drive, vote or watch certain films, and parental consent is required for any other medical or surgical procedures. Why then is this issue being treated so differently especially when contraceptive implants pose health risks?

Young people who feel that they are secure and protected by contraception will take more risks sexually, a phenomenon known as 'risk compensation'[2] and the claim that this strategy will decrease pregnancy rates *in a given population* is not actually evidence-based. By contrast, there is real evidence that making the morning-after pill more widely available does not reduce unplanned pregnancy rates in a population and may actually increase the incidence of sexually transmitted infections.[3]

Contraceptive implants or jabs also offer no protection against sexual exploitation. If a young teenage girl is in an abusive relationship or has pressure put on her to have sex then she can be very easily manipulated especially if she is emotionally involved with the boy or man who is trying to coerce her. The fact that she is taking contraception may well intensify that pressure and make it harder for her to say no. It is ironic that this story broke around the time of the Jimmy Savile enquiry.

Contraceptive provision alone will never address Britain's epidemic of promiscuity and its consequences. More needs to be done to dissuade young people from having sex and promoting abstinence as a good lifestyle choice. By contrast the government's strategy for sexual health seems to be based on the two false premises that contraceptives are safe and that abstinence is impossible.

There are ethnic and faith communities in the UK – including Christian communities – which have relatively low levels of promiscuity and accordingly very low levels of unplanned pregnancy and sexually transmitted disease, divorce and broken relationships. The government would do better to learn from them and base their strategies on godly wisdom rather than an untested worldly ideology.

references

1. *Telegraph* 2012; 28 October. *http://bit.ly/U8fjR5*
2. *Wikipedia*. *http://bit.ly/2CWVzD*
3. *Telegraph* 2011; 30 January. *http://bit.ly/eEGwl0*

Where to next with the Millennium Development Goals?

Health goals unlikely to be met

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

With only two years left before they are supposed to be met, it looks like a mixed bag of results for the Millennium Development Goals (MDGs). The major goal of halving the number of people living on less than $1.25 per day by 2015 looks well on track – but mainly because of the meteoric rise in living standards in China (and, to lesser extents, in India and Brazil).[1]

MDGs 4, 5 and 6 which focused on health goals (covered in depth in *Triple Helix* in 2006-2007) look far from being met. Even where progress has been made, the current economic climate has reduced the funding to global health programmes.

The focus of the international community is now on what comes next. While the MDGs have had their faults, they have galvanised and focused world attention and resources. But they have also tended to separate issues artificially. For instance, reducing extreme poverty, increasing access to clean water and providing primary education all have significant health benefits. Improving maternal health benefits child health and can have a major impact on HIV and other communicable diseases.[2]

The current buzz is around Universal Health Coverage (UHC) – making effective health services available to all and introducing some kind of local or national universal health insurance. The problem is there are no universally agreed definitions or ways of measuring what constitutes universal health coverage and its outcomes. There is growing research that universal insurance and provision of good quality medical care can have a significant (if modest) impact on the health outcomes for the poorest communities, but only if there is also good government, sound social institutions and a vibrant civil society.[3]

Wherever the world goes next with high level goals, it does seem that the world is slowly realising a principle long expressed in scripture, that our lives are a whole and not a divided set of self-contained areas. Obedience to God goes along with longevity and prosperity;[4] but obedience includes adhering to provisions for social and economic justice,[5] hygiene,[6] dietary practices and care of the land[7]. Health and healing go hand in hand with God expressing his salvation amongst his people. The Bible makes it clear then that good health starts with a right relationship with God, from which all other right and healthy relationships flow.[8]

A set of goals that embody this understanding are unlikely to arise out of the current post-MDG process, but this understanding will continue to inform Christian responses to local and global health needs.

references

1. Sustainable development for health: Rio and beyond. *Lancet*, *http://bit.ly/KglGU5*
2. Positive Gains: Promoting Greater Impact On Health Through HIV And AIDS Programming. *UK Consortium on AIDS & Development policy paper* 2012. *http://bit.ly/RtERaW*
3. Glassman *et al*, A post 2015 development goal for health–should it be universal health coverage? *BMJ Blog* 2012; 25 September. *http://bit.ly/PkOZEK*
4. Deuteronomy 30:16
5. Leviticus 25
6. Leviticus 13:47ff
7. Leviticus 25:11-12, 18-22
8. 1 John 2:1-11

Good news from Massachusetts

A significant defeat for the assisted suicide lobby

Review by **Peter Saunders**
CMF Chief Executive

On the night of the US presidential election on 6 November the state of Massachusetts voted 51% to 49% in a referendum to reject the legalisation of assisted suicide.[1]

The question considered read 'Should a doctor be legally allowed to prescribe medication, at a terminally ill patient's request, to end that patient's life?'[2]

This was a hugely significant result given the medical influence and prominence of Massachusetts itself (the home of Boston and the *New England Medical Journal*) and despite the small margin, it is a huge defeat for the pro-euthanasia movement given that the strongly Democrat state has a reputation for being one of the most liberal in the country.

The measure was defeated after a strong campaign by a diverse coalition called 'No On Question 2' drawn from both sides of the political spectrum and comprised of disability rights organisations, doctors, nurses, community leaders, faith based groups and patient rights' advocates. Alex Schadenberg[3] and Wesley Smith[4] give helpful analyses of how the campaign was won.

The Massachusetts Medical Society issued a statement[5] saying it was opposed to Question 2 and cited insufficient safeguards, the uncertainty of predicting life-spans and the profession's historic opposition to assisted suicide. The Society also reaffirmed its commitment to provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient's family.

They were backed by a group of 15 disability rights organisations.[6] John Kelly, Executive Director of Second Thoughts and former Chair of the Advisory Board to the Boston Disability Commission, argued as follows:

'We already have seen serious cost cutting pressures. We constantly hear about the costs of caring for people in the last year of their lives. We can point to examples in Oregon and Washington, where assisted suicide is legal, of these implicit and explicit cost pressures. Ballot Question 2 legalizes a $100 lethal prescription and that sends a terrible message to people living with serious illness or disability.'

Currently only two US states, Oregon and Washington, have legalised assisted suicide, each on the basis of a referendum. This has led to an annual increase of assisted suicide in each state.[7]

By contrast, whenever a bill has been brought before a US state parliament it has been defeated. This has happened over 120 times in the last 20 years. It is clear that assisted suicide is an issue Christian doctors are not alone in opposing.

references

1. Massachusetts 'death with dignity' initiative. *http://bit.ly/S91X6B*
2. Question 2: Prescribing Medication to End Life. *http://bit.ly/QblUZc*
3. *http://bit.ly/SUHAek*
4. *http://bit.ly/T3y35M*
5. *http://bit.ly/T30XSO*
6. *Life News* 2012; 1 October. *http://bit.ly/PoXdlU*
7. *Christian Medical Comment* 2012; 24 September. *http://bit.ly/TpeYPE*

Valerie Rowe helped start a foodbank in her area

FEEDING THE POOR

key points

The Trussell Trust is the only UK Christian charity running a network of foodbanks.

The rising cost of food and fuel combined with static incomes, high unemployment and changes to benefits, is forcing people into crisis where they cannot afford to eat.

Doctors can play a key part by distributing vouchers to hungry people.

'For I was hungry and you gave me something to eat.'[1]

'As you shop do you think you could buy just one extra item—a tin of fruit, some sugar, a jar of jam?' Have you ever been greeted by those words as you rush into a supermarket intent on quickly doing the shopping? I have, but now often it will be me asking you the question.

Why? About two years ago a member from the church I attend in Lambeth felt that the Lord was calling her to start a local foodbank. As she shared her passion, more church members caught the vision.

We could see increasing numbers of people in Brixton, Norwood and the surrounding areas in dire need of help to survive in tough economic times. Today, about 13 million people in the UK live below the poverty line. That is one in every five people.

We contacted the Trussell Trust, a Christian charity that runs the only network of foodbanks in the UK. It partners with local churches and communities to launch foodbanks in their towns. As I wrote this article there were 265 foodbanks across the UK with about three new foodbanks being launched every week. Trussell Trust receives no government funding and relies entirely on the generosity of the general public, businesses and charitable trusts.

Getting started

We invited a speaker from the Trussell Trust to explain how we could set up a local foodbank in Lambeth. He arranged training days for volunteers. Other local churches were approached and as they caught the vision the numbers of volunteers gradually increased. We visited other local foodbanks, receiving tips on what works well and potential problems to avoid.

Our foodbank is now a partnership with more than 18 participating local churches – a cause for praise in itself. An area of the church was set aside for food storage. We produced leaflets and made a large banner to hang outside the church. By September 2011 the Norwood Foodbank was ready to open its doors. But would anyone come?

We didn't need to wait long for the answer. It soon became widely known that on Tuesday and Friday mornings the Norwood Foodbank was open. Increasing numbers of people with various needs came through the church doors. Not all were looking for food. Seeing the church open, some came for a cup of tea, for prayer, for a friendly chat. But in the first six months from September 2011 to March 2012, Norwood Foodbank fed more than 1,000 people and gave away over seven tons (6350 kg) of food.

Demand continued to increase. In January 2012

UK Foodbank Clients

- 2008-09: 26,000
- 2009-10: 41,000
- 2010-11: 61,468
- 2011-12: 128,697
- 2012-13: 200,000 (predicted)

Source: Trussell Trust

a decision was taken to open another foodbank in Brixton. Currently the Norwood and Brixton Foodbank is feeding more than 100 people per week and giving out over 1100lbs (500kg) of food.

Hunger in the UK

Nationally, UK foodbanks fed 128,697 people in crisis in the 2011-12 financial year. That is up from 61,468 in 2010-11. The rising cost of food and fuel combined with static incomes, high unemployment and changes to benefits, have forced these people into a crisis where they cannot afford to eat. Other reasons for referrals include delayed wages, domestic violence, sickness, debt and refused crisis loans. The single biggest reason that people were referred to foodbanks was benefit delay (40% in Norwood and Brixton). This is followed by low income.

To receive emergency food, clients must be referred by front-line care professionals such as doctors, social workers, other healthcare professionals, head teachers, faith-workers and debt advice agencies. Clients bring with them a voucher from a recognised professional and this is logged on to the database.

Without a voucher they will be welcomed, given a warm drink and some cake, then given advice as to where they can access help. Once a week we have a specialist advice worker based in Norwood Foodbank.

Since opening, vouchers have been sent to as many appropriate professionals as possible. Hopefully many of you reading this article will have seen the vouchers issued by your local foodbank. If not, and if there is a foodbank in your area, ask them to send you some. Have them to hand when you are seeing patients and use them prayerfully. Our experience is that not many of our vouchers have been completed by doctors and I wonder why not.

Charlotte's story

One exception, though, was a referral from a hospital where a pregnant woman came in. She was malnourished due to various reasons. We were able to give her immediate nourishment and provided her with at least three more days' worth of food and arranged for a key worker to continue to support her.

We have had several mothers with new-borns who have had trouble feeding babies due to lack of food. Charlotte, with baby Peace, is one example. We were quite concerned when we first saw Peace. She was more limp than expected. With the food and support given her and her mother, Peace is now a bright alert little baby. Another client is a sofa-surfer with little access to benefits. He has several medical conditions including being diabetic and having had a CVA. He requires appropriate food for his dietary needs.

Where the food comes from

All the food given out is donated by the public. Schools, churches, businesses and individuals donate non-perishable, in-date food. Supermarket collections are another way food is donated. Volunteers give shoppers a foodbank shopping list and ask them to buy an extra item or two for local people in crisis. Very few are unsympathetic and many drop off not just one item but a bagful. If someone wants to find out more, or even become a volunteer themselves, we have leaflets. On a recent Saturday at a local supermarket we collected one and a half tons of food.

At the church the food is weighed and stored, ready to be given out. When a client comes, they are given nutritionally balanced, non-perishable food to last three days. It might include tinned fruit, vegetables, meat, fish, pasta, cereal UHT milk, sauces, tea, coffee and long-life juice. Foodbank clients can receive a maximum of three foodbank vouchers (each voucher is redeemable for at least three days' food). Longer term support is available in exceptional circumstances.

If it would help (and this is often the case) we try to signpost clients to agencies able to help resolve the underlying cause of their crisis. A client struggling with debt, for example, would be referred to CAB or Christians Against Poverty. We receive clients from these agencies as well. More than 120 agencies now refer people to the Norwood and Brixton Foodbank.

As one of our volunteers said, 'A foodbank is not just about food. That is a starting point and a real practical help. But just as importantly it's about empathy: listening, advice, love, care and referral to outside agencies.

'These agencies can provide long-term practical support and solutions to enable people to regain control, confidence and self-esteem. It's a privilege to be able to serve our community in this way and meet so many amazing people, all with a different story to tell if only someone is willing to listen.'

As we are helping the clients who come to foodbank we are ministering to Jesus himself and what we give them is a gift from him. Some are finding Jesus personally for themselves through speaking and praying with volunteers, joining Alpha groups and attending church. As Isaiah said, the duty of faithful people is to 'share your food with the hungry and provide the poor wanderer with shelter'.[2]

Valerie Rowe *trained as a GP and works part-time as palliative care consultant in Dartford, Gravesend and Swanley*

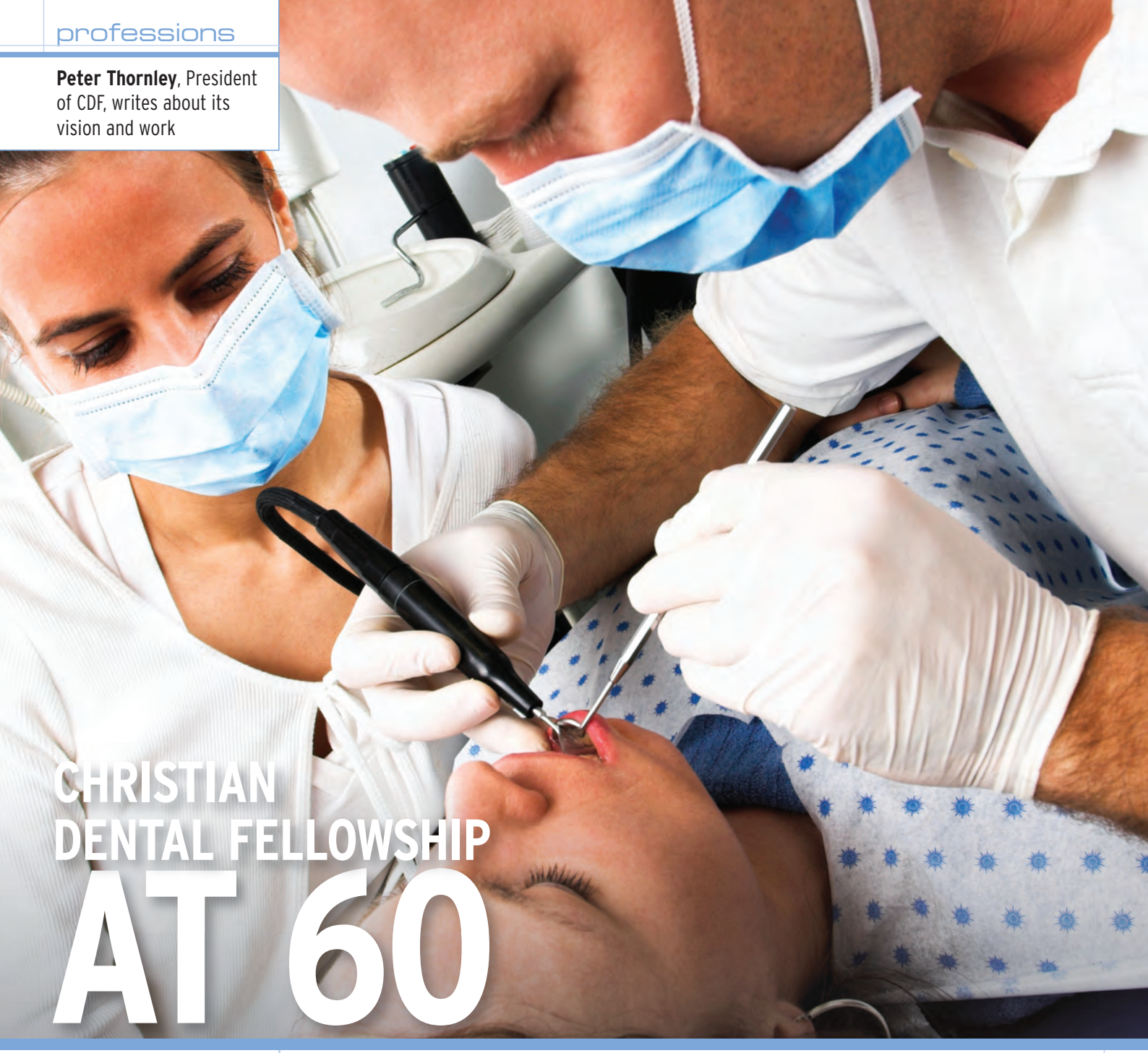
Vouchers: have them to hand when you are seeing patients and use them prayerfully

Trussell Trust
Tel: 01722 580 180
enquiries@trusselltrust.org

references

1. Matthew: 25:35
2. Isaiah 58:7

Peter Thornley, President of CDF, writes about its vision and work



CHRISTIAN DENTAL FELLOWSHIP AT 60

key points

The Christian Dental Fellowship has always had close links with Christian medics and nurses.

Dentists face many day-to-day issues which can lead to ethical dilemmas.

High suicide and divorce rates among dentists are well known.

The year: 1952. The scene: a dentist's waiting room in Wimbledon, south west London. Present: eight Christian dentists, members of the Inter Varsity Fellowship (later to become the Universities and Colleges Christian Fellowship). The outcome: the Christian Dental Fellowship (CDF) was founded.

Right from those early days the aims of CDF have remained constant:

- To unite all those who try to follow high standards in their Christian professional life;
- To support students and those who have recently qualified;
- To give practical support to members who are overseas partners and to help them meet specific needs;
- To help all members of the dental team share their faith in Christ and his ethical teaching within the profession.

From its inception CDF has had close links with Christian medics and nurses. Douglas Munns, the first secretary, arranged day courses on emergency dentistry for doctors and nurses. They were held at missionary training colleges and participants received a manual to take with them overseas.

The CDF and CMF partnership

These links continue today. CDF and CMF partners work together on projects such as Mercy Ships, providing oral surgery and dentistry for people with no access to basic health care. CDF has trained many health workers overseas in safe extraction techniques and preventative dentistry, with partners such as Dentaid and Bridge to Aid.

Although CDF is not a sending agency, it encourages its members to support international dental work as well as making members aware of opportunities to work overseas, both on a short-term and long-term basis. CDF is affiliated to the

International Christian Medical and Dental Association (ICMDA) and continues its links with CMF and the Professional Groups section of the Universities and Colleges Christian Fellowship.

At home CDF has many regional groups which hold informal meetings to build friendship and support members in their Christian and professional lives. Dentists are privileged to see large numbers of generally healthy people at approximately six monthly intervals; the average 35 to 55-year-old man sees his dentist much more frequently than his doctor.

Relationships matter

This long term care allows relationships with patients to grow and provides insight into their lives. (Dentists can discuss holidays and much more with patients, despite filling their mouths with various instruments and making their lips numb.) As with many GMP practices, dental practices often become a source of social and pastoral support for patients in areas where there are few other professionals.

Some regional CDF members have been working with CMF colleagues and other Christian healthcare workers to run Saline Solution courses. These provide information and training on bearing witness to Christ in the healthcare setting, whilst following the guidance of the GMC and GDC to use sensitivity, gain permission and to respect patients when discussing spiritual issues. Saline courses are an opportunity to network with colleagues from a variety of healthcare disciplines, providing mutual support and allowing the exchange of ideas.

A great feature of CDF has always been the annual conference, usually alternately south and north of the country. The conference is family-friendly and the format usually consists of excellent Bible exposition by a well-known preacher, a clinical session, reports from our mission partners and a relaxing Saturday evening get-together. This year it was Salsa dancing.

Active in Scotland

Scottish CDF is very active and holds an annual conference. The fellowship has been involved with the British Dental Association conference. This year it hosted a seminar, 'Faith Matters in Dentistry'. The Care Quality Commission is the regulatory body responsible for Quality Assurance and patient safety for healthcare providers. One of its requirements is that health professionals should take into account patients' beliefs and views when providing treatment. The Faith Matters seminar invited other faith groups to inform the profession about patients' beliefs and provided an opportunity to present the gospel.

Although dentists do not usually face the life and death ethical issues that doctors have to deal with, there are many day-to-day issues which can lead to ethical dilemmas. Dentistry is not free at the point of delivery for many patients in the health service. Dental practices are, in effect, small businesses and dentists have to deal with costs directly and charge patients for their services.

Dentists have been subject to several reformations of their NHS contracts in recent years. They have to deal with the tension between providing universal care affordable to all and the desire to produce high quality care with the best techniques and materials available; this may be very difficult within the health service budget.

Living with stress

These tensions inevitably produce stresses and strains, together with the high intensity and invasive nature of dentistry. There are similarities with medicine in the effects this has on the work force. High suicide and divorce rates among dentists are well known. CDF has developed a pastoral support network to assist members facing difficulties. This can include the challenges of working ethically in the NHS, dealing with complaints, returning from overseas, coping with retirement and facing mental health and alcohol dependency problems.

Students are seen as the life-blood of CDF and although we are a small organisation we have two student representatives. Regional groups invite students to their meetings and offer the opportunity to meet with practising dentists and share a meal.

Facing the future

Dentistry faces many challenges in the future. Many things have changed since the fellowship was founded in 1952. The gender balance and ethnicity of the work-force has changed. There is a much greater skill mix in dental practices. Inter and intra-disciplinary team-working has become the norm and the role of the dentist continues to change. CDF hopes to equip and help colleagues with the spiritual resources and support to meet these challenges and face changes. If you would like to know more about CDF, have involvement with dentistry or a friend who may be interested, contact details and more information are available on the website: *www.cdf-uk.org*.

Peter Thornley *is the President of the Christian Dental Fellowship*

Although dentists do not usually face the life and death ethical issues that doctors have to deal with, there are many day-to-day issues which can lead to ethical dilemmas

Alex Bunn on faith in the workplace

IS THE GOSPEL GOOD NEWS FOR HEALTHCARE?

key points

The Christian faith is increasingly marginalised in the NHS and this is not good for patients or practitioners.

A culture of targets and perfectionism negatively impacts care.

Work is a gift of the Creator who invites us to engage in his work of bringing order out of chaos. We find the toil of work frustrating and difficult because we live in a fallen world.

Even so, God is at work in his world and offers a hope and a future.

Christians are rarely persecuted in the NHS but there is increasing marginalisation of faith in the workplace. More and more we are subject to secular imperatives that are detrimental for people of faith and atheists alike.

In October 2011, CMF participated in a day conference on work and faith at All Souls, Langham Place in London. A multidisciplinary group of healthcare workers (HCWs), including psychologists, students, managers, researchers, nurses and doctors, considered the challenges for Christians, and how the gospel is good news for the situations we face. We identified several secular trends:

Naturalistic reductionism: bad news for patients

Science works by breaking big things into small ones to see how they work. But we can dehumanise patients if we see them merely as complex physiological problems to be solved. Many of us will have innocently talked of the 'pyelonephritis in bed number 5'. X-ray vision is great for diagnosis, but looks through the person and misses their godlike dignity. A recent example is Joy Tomkins (opposite top right), a pensioner who got a tattoo to prevent futile CPR:

X-ray vision is great for diagnosis, but looks through the person and misses their godlike dignity

Targets, perfectionism, legalism: bad news for HCWs

As a result, healthcare is increasingly task-orientated, based on a utilitarian approach to ethics. We are increasingly judged on measurable aspects of care, *targets*, even when they mean little to our patients. 'If you can't score it ignore it!' When a patient presents with lack of hope after a relationship breakdown, the doctor may feel under pressure to record a depression score for QOF before he really listens or makes eye contact. Micromanagement from above leads to algorithmic medicine. Hence, both the patient and professional are dehumanised by an industrial approach, mere body mechanics on a conveyer belt of 'care'.

Christians are no less prone to basing their identity and worth in their productivity, driven by *perfectionism*. Even worse, when mistakes are made, healthcare workers can feel the curse of a codified law, and unforgiving *legalism*. Increasingly patients

are turning to law to take health staff to task. Whilst guidance on best practice can improve clinical excellence, it can be difficult for flawed human healthcare workers to measure up, and forgive themselves for inevitable imperfections.

These trends have roots in a rejection of the Christian story, and the God who, contrary to popular opinion, is good news in all these areas. We traced the story in four episodes:

Creation

Work is a gift of a working God [1] who desires that humankind follow in the family firm. Wherever healthcare workers bring order out of chaos we image our creator. [2] That might include helping a dying patient put his house in order, treating an arrhythmia or implementing measures that improve communication for clinical safety. God launched science when he asked Adam to name and order creation, [3] and planted natural resources to be developed. [4] Wherever we harness the potential of the world for good, we continue his work. [5] That might include choosing the right medication for contraception, cancer or depression, most of which are still modified natural ingredients. Work was always personal, working to please a loving father who was more concerned with the health of our hearts than our merit awards. [6]

Fall

But sin tore apart the family and the firm. Work today is beset by futility and frustration. [7] Every patient we see is a terminal case, and much of the time we are only partially correcting degenerative processes, merely delaying entropy and apoptosis. A patient whose defibrillator repeatedly alarms or discharges is a chilling reminder that we are all living on borrowed time. [8]

Redemption

Yet the Bible uses a wonderful obstetric image to show how even now God is working:

'We know that the whole creation has been groaning as in the pains of childbirth right up to the present time. Not only so, but we ourselves, who have the first-fruits of the Spirit, groan inwardly as we wait eagerly for our adoption to sonship, the redemption of our bodies.' (Romans 8:22-23)

Despite appearances, God does have purposes in a groaning and degenerating world. He is making a people for himself, and he delays out of mercy, as he holds out the offer of relationship with him through Christ, and renewed resurrection bodies. As we work in the gap between a broken world and a gracious God, we might even experience the privilege of the 'fellowship of sharing in Christ's sufferings', 'filling up what is still lacking as regards Christ's afflictions'. [9] Just as he shared the suffering of creation, Christian healthcare workers may be called to participate in our patients' suffering, and overcome it in some measure, that we might also share glory.

Future hope

How does this affect our work in the NHS in the meantime, and how is the gospel better news than the secular alternatives above?

Firstly, contrary to *naturalism*, we are not merely hairless apes with degenerative diseases. We came from eternity and we have a future there:

'It is a serious thing, to live in a society of possible gods and goddesses, to remember that the dullest and most uninteresting person you talk to may one day be a creature which, if you saw it now, you would be strongly tempted to worship, or else a horror and a corruption such as you now meet, if at all, only in a nightmare. All day long we are, in some degree, helping each other to one or other of these destinations.' [10]

Secondly, we can put *targets* in perspective. Managers use algorithms because they set a high standard for care. Whilst the law is good when it restrains evil, ignorance or laziness, it doesn't change the heart. As Paul pointed out, the law is only weakly therapeutic, but it is certainly diagnostic of our fallen and needy state. [11] *Legalism* and *perfectionism* are natural reactions to our failures, and even high fliers feel the need to prove themselves:

'Every time I accomplish something I feel like a special human being, but after a little while I feel mediocre and uninteresting again. I find I have to get myself past this again and again. My drive in life is from the terrible fear of being mediocre. I have to prove I'm somebody (Madonna).

But thankfully our Creator is not a slave driver manager who expects perfection. Rather he is the God who releases his people from slavery, literally in Egypt, and now Christ's work releases us from the fear of law and the need to prove ourselves. [12] In fact there's nothing we can do to make him love us less, because he already sees us as we are. And there's nothing we can do to make him love us more, because he loved us first in Christ. The gospel is good news!

So we are called to please God not *appease* God. He is not a utilitarian obsessed with measurable outcomes but a loving father who asks for faithfulness, not success. As the Puritans put it, our God loves adverbs: will we follow him faithfully, expectantly and lovingly, whatever the outcome?

Alex Bunn *is CMF Associate Head of Student Ministries (field) and a GP*

Joy Tomkins... tattooed instruction to prevent CPR

Despite appearances, God does have purposes in a groaning and degenerating world

We are called to please God not appease God. He is not a utilitarian obsessed with measurable outcomes

references

1. John 5:17
2. Genesis 1:2 onwards
3. Genesis 2:18-19
4. Genesis 2:10-12
5. Genesis 1:28
6. Genesis 4:7
7. Genesis 3:17
8. *www.ncbi.nlm.nih.gov/pmc/articles/PMC1892472/*
9. Colossians 1:24 and Philippians 3:10
10. Lewis CS, *The Weight of Glory*: London: SPCK, 1942
11. Romans 3:20
12. 'There remains, then, a Sabbath-rest for the people of God; for anyone who enters God's rest also rests from their works.' Hebrews 4:9

Peter Phillips reflects on appropriate care of frail patients

WITHDRAWING & WITHHOLDING CARE

key points

Withholding or withdrawing care not in a patient's best interests is different from acting to end a life.

Diagnosis of terminal illness needs careful scrutiny and discussion with experienced colleagues since recognising the dying patient may prove difficult for less experienced doctors.

The peace of mind of relatives has to be satisfied.

This is a very emotive topic for healthcare professionals, patients and their families taking place against the backdrop of the debate on assisted dying. However, I hope to demonstrate that withholding or withdrawing care which is no longer in the patient's best interests[1] is quite a different scenario from a deliberate act to end life.

As Christian doctors and healthcare workers, we seek to provide the best possible care for our patients following the principle taught by Jesus Christ of loving our neighbour as our self. This love, and faith in God's ability to heal, is combined with evidence-based medical and surgical treatments.

However, those patients who are terminally ill, frail, disabled or without mental capacity are the most vulnerable and require the most scrupulous care to ensure that we are acting in their best interests rather than the interests of the family or healthcare providers. Any decision on best interests should be inspired by Christ's love for us all and our love for each other.

I start from a position of opposing any deliberate act to end or shorten a patient's life, that is assisted dying or euthanasia, on the basis that this is contrary to the sixth commandment '*Thou shalt not kill*'. In a secular society we have also to argue that assisting another person to die is wrong for a number of reasons:

- None of us is autonomous and the act of assisted dying will adversely affect other people drawn in to the act.
- Assisting mentally competent people to die is one end of a slippery slope which threatens vulnerable, mentally incompetent individuals.
- A cultural shift in favour of euthanasia would leave disabled and vulnerable people feeling that they are a burden and should be expected to volunteer for euthanasia.

Having dismissed euthanasia as an unacceptable practice, the next question is how far we should go along the spectrum of diagnostic and therapeutic interventions in each case. This ranges from 'pulling out all the stops' for a patient with an acute,

Best Interests Principle:
Featured in the Mental Capacity Act (MCA) and promulgated by the GMC to provide guidance on what can be reasonably considered to be in a patient's best interest where the person lacks the capacity to provide informed consent to undergo or refuse to undergo a procedure. Decisions should take account of:

- Options for treatment which are clinically indicated
- Any evidence of previously expressed preferences
- The doctor's own and the healthcare team's knowledge of the patient's background
- Views about the patient's preferences from a relevant third party (eg spouse or family)
- Which option least restricts the patient's future choices where more than one option (including non-treatment) seems reasonable

potentially reversible medical problem on the one hand and, on the other hand, limiting that intervention for another patient with terminal illness because of very low probability of benefit. Whether or not an intervention is offered will depend on the potential benefits for the patient in terms of quality and quantity of life as agreed between the healthcare team and the patient and family.

For example, in the case of a frail elderly patient with multiple comorbidities, undergoing active medical treatment after a stroke, myocardial infarction or pneumonia, it may be considered that, in the event of cardiac arrest, attempted cardio pulmonary resuscitation would be unlikely to produce survival or benefit for the patient. Such a decision should not be made without obtaining the approval of the patient, if mentally capable, and family. In cases such as this there is usually agreement that we should not embark on an intervention which would simply'prolong the dying process'. Of course, patients agreed to be not for attempted resuscitation are not be abandoned by their medical and nursing attendants. They continue to be treated actively in the hope of some improvement while every attempt is made to maintain comfort and dignity.

We are left with the scenario of the dying patient, with no prospect of recovery in the opinion of the medical team. This may be due to uncontrolled malignancy, or irreversible failure of multiple organs eg heart, lungs, kidney, brain, liver, bone marrow etc. The diagnosis of terminal illness should always be scrutinised and discussed with experienced practitioners as less experienced doctors may have difficulty recognising the dying patient. If in doubt, a further medical opinion should be obtained. When the diagnosis of terminal illness has been agreed, we should review the appropriateness of certain diagnostic or therapeutic interventions and aim mainly at improving quality of life rather than quantity of life. This scenario should always be discussed with the patient if possible and family members, especially those with Lasting Power of Attorney.[2] Provided all are in agreement, a referral for palliative care may be the best way to demonstrate to all concerned that the care plan has changed from active treatment to palliation. If a patient is assessed to be imminently dying, within hours or the next few days, offer of the Liverpool Care Pathway[3] or equivalent may be appropriate.

Within the context of end of life care, the question of withholding or withdrawing care usually applies to medication or food and fluids. There is a view that, as long as the doctor offers every possible intervention, including medication, food and fluids, he or she cannot be accused of negligence. However I would suggest that such defensive medicine is not necessarily in the patient's best interests. Instead we should be doing our best to discern what is most likely to keep the dying patient comfortable. Palliating may include relief of pain and other distressing symptoms and offering food and fluids by mouth according to the patient's willingness or ability to accept them. However this may not extend to tube feeding, intravenous or subcutaneous fluids, which are artificial medical interventions, unless it can be demonstrated that these will make the patient more comfortable. Sometimes it is the relatives' peace of mind which has to be satisfied by giving parenteral fluids even though there may be no benefit to the patient. However this would not normally extend to feeding by nasogastric or gastrostomy tube unless there was clear benefit to the patient. The experience of gastrostomy feeding in patients with severe dementia or very severe disability from stroke, for example, has not shown benefits in terms of quality or quantity of life.[4] There is no evidence that parenteral fluids improve the biochemical status of dying patients.[5]

With this in mind, it is possible to understand scenarios when it may be appropriate to withhold or withdraw ***artificially*** administered food or fluids towards the end of life. However, oral food and fluids should ***always*** be offered provided the patient is conscious, willing and able to accept them. More rigorous testing of swallowing ability may sometimes be relaxed in the context of palliative care.

So what may appear to the layman as a callous neglect of the patient's needs may, in fact, be an act of Christian love on realising that artificial medical interventions are no longer of benefit. They may amount to a futile prolongation of the dying process. This should be sensitively explained to colleagues, relatives and carers with time given for reflection and further discussion among the family before the decision to withhold or withdraw medical treatment is made.

I would welcome any comments or reflections from personal experience to further explore this important question which faces many of us in daily practice.

Peter Phillips *is a Consultant Geriatrician and Stroke Physician at Ipswich Hospital NHS Trust, Suffolk*

Lasting Power of Attorney
A means under the MCA where someone, unable to make decisions, can appoint a person or persons to make these on their behalf. There are two types of LPA and a person may invoke one or both:

- health and welfare
- property and financial affairs

In the fields of health and welfare, persons appointed under a Lasting Power of Attorney can make decisions about:

- the daily care routine (eg eating and clothing)
- medical care
- moving into a care home
- refusing life-sustaining treatment

What may appear to the layman as a callous neglect of the patient's needs may, in fact, be an act of Christian love

references

1. GMC. *http://bit.ly/VHSvOk*
2. HM Government. *http://bit.ly/TvHV5P*
3. End of Life Care Network, Cumbria and Lancashire. *http://bit.ly/TPukGE*
4. Sanders DS *et al*. Survival analysis in percutaneous endoscopic gastrostomy feeding: a worse outcome in patients with dementia. *American Journal of Gastroenterology* 2000; 95: 1472-1475
5. Stewart TL. Intravenous fluids in end of life care. *Journal of Palliative Medicine* 2006; 9(5): 1230-1231

Jeff Stephenson addresses issues about care at the final stages of life

THE LIVERPOOL CARE PATHWAY

key points

LCP is widely used and probably the best known of such pathways. The onus is still on clinical teams to assess and review patients.

Misconceptions about LCP risk scaremongering and detracting from the real benefits.

The LCP encourages professionals to consider the needs of patients and families, current and anticipated.

Exemplary palliative care for dying patients and their families was pioneered in hospices, and end of life (EOL) care pathways were developed as a means to extend such care into other settings. The Liverpool Care Pathway for the Dying Patient (LCP) is widely used and probably the most well known of such pathways. However, it has been the subject of controversy. Concerns have been expressed over its inappropriate use and association with practices akin to euthanasia. This article looks at its background, addresses these concerns, and suggests some biblical perspectives.

Developed by the Marie Curie Palliative Care Institute Liverpool in the late 1990s, the LCP is recognised as a model of best practice,[1] was recommended in the End of Life Care Strategy (2008)[2], and is now identified as a quality marker for EOL care.[3] The current Version 12 emerged in 2009 after two years of consultation and evidence from two rounds of auditing of its use in hospitals.[4] Latest figures suggest that around 150,000 people a year are dying on the LCP, amounting to about a third of annual deaths in the UK.[5]

The LCP encourages professionals to consider the needs of patients and families, both current and anticipated, and guides them through the key areas of assessment and provision of care. As well as an initial assessment and after-death care covering twelve goals, it entails daily assessments in which patients are checked every four hours to ensure comfort.

There is a diverse range of evidence to suggest that EOL care pathways can improve care in a number of ways, including symptom control and bereavement experience of relatives.[6,7] The second national audit of the LCP concluded that where it is used people are receiving high quality clinical care for the last days and hours of life.[8]

Periodically there has been adverse press about the LCP, including headlines in national newspapers suggesting it is being used to hasten death.[9,10,11] Criticisms usually focus on: inappropriate use in those who are not dying; excessive use of sedation, encouraged by the prescribing of anticipatory medication and the use of syringe drivers; withholding of food and fluids; and the perception that it is a 'one-way street' to death.

Inappropriate use

The LCP is intended for use in people who are in the last days or hours of life. Diagnosing dying can be difficult and more so in some conditions than others. While in cancer patients it is usually evident when someone is entering the last few days, it is often more difficult to discern in patients with dementia and other non-malignant conditions. If there is any doubt about whether a patient is imminently dying, and these decisions should ideally be arrived at within a multidisciplinary team, then the LCP should not be initiated.

Excessive sedation

The LCP aims to prevent situations where a patient

is dying with uncontrolled symptoms, and without easy access to medication to relieve those symptoms. Hence there is guidance on the anticipatory prescribing of injectable medication, and the use of a syringe driver if necessary medication needs to be continued up to the point of death. If doses need to be increased, practice in the UK is that of incremental titration to match symptoms, with the primary intention being not to induce sleep but to achieve symptom control with the minimum necessary dose. When medication is used in this way there is no evidence that such practice shortens life.

This is to be contrasted with the practice of 'terminal sedation' where the intention is to reduce consciousness as a last resort in a dying patient with refractory symptoms.[12] In my experience the need to resort to the latter is rare. Unfortunately, misunderstanding about the use of morphine and sedatives at the end of life has led some to equate practice in the UK with that of 'continuous deep sedation' as practiced in the Netherlands, where there has been a progressive rise in the number of patients dying by this route, as well as a progressive increase in deaths by euthanasia.[13] Indeed, one study suggests that a greater proportion of deaths in the UK involve continuous deep sedation than those reported most recently in the Netherlands (18.7%[14] vs 12.3%[15]), but I believe this is due to misunderstanding around definitions.

The LCP has been described as 'the UK's main clinical pathway of continuous deep sedation'[16] but this is simply not something that the LCP promotes. The second national audit of its use found that drugs prescribed for agitation and restlessness were given in only 37% of cases, and the median dose of midazolam, the most frequently used drug for this indication, was 10mg/24hrs.[17] This contrasts markedly with guidance on continuous deep sedation from the Royal Dutch Medical Association[18] which recommends a starting dose of 1.5 – 2.5 mg *per hour*, with progressive escalation until unconsciousness is achieved, up to a maximum of 20mg *per hour*. Interestingly, the use of the LCP in the Netherlands has been reported to reduce the extent to which physicians use medication that might hasten death.[19]

Food and fluids

The LCP encourages the offering of food and fluid for as long as the patient is able to take them. When patients are dying there usually comes a point when they stop eating and drinking, and for most patients initiating clinically assisted hydration (CAH) or nutrition is not appropriate and may be detrimental to their quality of dying. The LCP explicitly encourages consideration about whether or not CAH should be initiated or continued. There is no blanket discouragement from continuing treatments in those patients for whom it might be appropriate, and particularly so if there is some uncertainty about the diagnosis of dying. The most recent national audit of the LCP found that for those patients receiving it CAH was continued in 16% after initial assessment.[20]

A one-way street?

While the LCP is a useful tool, the onus is still on clinical teams to assess and review patients, and if there is any suggestion that they may be improving, the decision to continue the LCP must be reviewed. The LCP recommends an assessment whenever the patient's condition changes, and at least every three days. In my own practice there is a proportion of patients who come off the LCP, albeit usually only for a short while before they deteriorate again.

Biblical perspectives

Fundamental to a Christian approach to any ethical challenge is the principle that human beings are made in the image of God.[21] Their lives are to be valued in and of themselves, and they are to be protected from harm. There is a particular expectation to protect the vulnerable, and the cry for justice resonates throughout Scripture.[22] The law of love[23] constrains us to act with compassion towards those who are suffering, just as Jesus was moved with compassion repeatedly throughout the Gospel accounts of his ministry.[24] Death is a reality[25] but it is not the end.[26] High quality EOL care should not be restricted to a select few, and a tool that facilitates better care for those who are suffering should be welcomed and championed.

We have a responsibility to seek justice and speak out against injustice.[27] The biblical injunction against the killing of the innocent upholds the law of love and the inherent value of lives made in the image of God.[28] Where the LCP is being misused or abused, then we need to confront that, and we need to be vigilant in the years ahead as demographic changes may increase pressure for moral drift and economic expediency in healthcare. Sensational published misconceptions about the LCP risk scaremongering and detracting from the real benefits it can bring.

Conclusion

The LCP represents a pragmatic and effective response to some of the suffering experienced by many in the last days of life. It remains, however, a tool and it is only as good as those who use it. There is always potential for misuse and abuse and there are undoubtedly instances where this occurs. Where these arise by intention then those involved should be held to account, but more often they occur through poor understanding and inadequate training. Successful roll out of the LCP needs much education, both initial and ongoing, and this may sometimes be underestimated or under-resourced. We owe it to patients to not only furnish the means to better care, but also to equip adequately those who provide it.

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references

1. NHS Beacon Programme (2001)
2. End of Life Strategy Care Strategy: promoting high quality care for all adults at the end of life. DOH 2008
3. End of life care strategy: quality markers and measures for end of life care. DOH 2009
4. National Care of the Dying Audit - Hospitals. Rounds 1 (2006-7), 2 (2008-9) and 3 (2011-12). Marie Curie Palliative Care Institute Liverpool-Royal College of Physicians
5. *Ibid*
6. Chan R, Webster J. End-of-life care pathways for improving outcomes in care of the dying. *Cochrane Review* 2009
7. Watts T. End-of-life care pathways as tools to promote and support a good death: a critical commentary. *European Journal of Cancer Care* 2012; 21: 20-30
8. National Care of the Dying Audit, *op cit*
9. Sentenced to death on the NHS. *Telegraph* 2009; 2 September
10. Top doctor's chilling claim: The NHS kills off 130,000 elderly patients every year. *Mail Online* 2012; 20 June
11. Hospitals 'letting patients die to save money.' *Telegraph* 2012; 8 July
12. Sales JP. Sedation and terminal care. *European Journal of Palliative Care* 2001; 8: 97-100
13. Onwuteaka-Philipsen BD *et al*. Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet* 2012; 380: 908-15
14. Seale C. Continuous deep sedation in medical practice: a descriptive study. *Journal of Pain and Symptom Management* 2010; 39: 44-53
15. Onwuteaka-Philipsen. *loc cit*
16. Treloar A. Dutch research reflects problems with the Liverpool Care Pathway. *BMJ* 2008; 336: 905
17. National Care of the Dying Audit, *loc cit*
18. Guideline for Palliative Sedation. Royal Dutch Medical Association (KNMG), 2009
19. Van der Heide A *et al*. End-of-life decision making for cancer patients in different clinical settings and the impact of the LCP. *Journal of Pain and Symptom Management* 2010; 39: 33-43
20. National Care of the Dying Audit, *loc cit*
21. Genesis 1:27
22. Amos 5:24; Zechariah 7:9-10
23. Matthew 7:12, 22:39
24. Matthew 9:36, 14:14, 15:32, 20:34; Mark 1:41, 6:34, 8:2; Luke 7:13
25. Ecclesiastes 3:2
26. Hebrews 9:27 and John 14:2-3
27. Isaiah 1:17
28. Genesis 9:6; Exodus 20:13

Vicky Lavy highlights news from four CMF members

CHANGING ATTITUDES BRINGING HEALING CHANGING LIVES

Nepal: fistula camps

Watch the CMF video of Shirley Heywood tranforming lives in Nepal online at *cmf.org.uk/media*

Shirley Heywood *went to medical school because she felt called to work as a doctor in Nepal. She arrived there nine years ago, via Liverpool, London, Pakistan and Papua New Guinea. She works with International Nepal Fellowship (INF) in district hospitals to support and train local surgeons, as well as running camps to treat women with obstetric fistula. She writes:*

Thank you for your prayers for the fistula camp this year. We saw many answers to prayer. Patients came in numbers we could manage and roads stayed open for them to come and return home. We had a wonderful team of nurses and the tent was a place of peace and fellowship as the women became friends and encouraged each other. God gave strength to keep going and wisdom to manage difficulties. 52 patients attended from 17 different districts. Some were new patients; some friends from last year who came for a check-up or needing further surgery.

One of the first to arrive was Khinti. She has had a very hard life; she married and had her first baby at 15, labouring for three days. The baby was still-born and she was left with a fistula. Her husband took a second wife after she had delivered three more babies born too early to survive. He has children now, but Khinti lives with her in-laws, sleeping in an outhouse and caring for the goats. Her mother-in-law opposed her coming to the camp last year but a health worker brought her.

The fistula is healed but her life isn't much better. She lost her place and respect in the family 13 years ago when she failed to produce a living child and became incontinent. She is still the family servant, sent back to care for the goats only days after she returned following the operation. Yet she is grateful and she brought a gift for me, a chicken, still half grown. I remember Khinti when I look out over my back garden and watch my little red hen scratching around. I pray that one day there will be fruit from our efforts to raise awareness of obstetric fistula, and no more women will suffer as Khinti has, losing her babies, her husband, her health, her place in society, her dignity and self-respect.

Somaliland: new arrival

Becky Hammond *is a surgical trainee from Norwich. She did the CMF Developing Health Course this summer, during which she signed up to work with Medair, a Christian humanitarian organisation. She has just arrived in Somaliland for 18 months where she will be the manager of a nutrition project in Burao. She writes:*

Working in Africa is a dream I have held since the age of six when my heart was touched by images of the 1984 famine in Ethiopia, which shook the world at the time. Sadly, similar tragedies exist today and so I find now the dream of a six year old becoming a reality.

Thanks to the Developing Health Course, I arrived in Somaliland with a good social network. On my second evening I went out for dinner with a friend from the course. Yesterday I had lunch with two others. The teaching on the course was great, but I am even more grateful for the friendships I formed. To find yourself in a country that most people have never heard of and to have friends here is absolutely amazing. We all seem to be settling in well and slowly adjusting to the heat and dust. And there is so much dust.

Mozambique: latrines and paediatrics

***Sam Dunnet** trained in general practice but has worked overseas for several years in a number of African countries. She is now in Mozambique, managing community health programmes in Zambezia province for Save the Children Fund. As well as this, she is setting up a health project with her church there to improve the health situation in the local area and working in the provincial hospital at weekends. Her latest newsletter describes some of the challenges:*

The health situation in the area is dire with very poor sanitation and a high incidence of disease. As far as I know, there is not a single latrine in the entire area so people go in the bush or the mangrove swamp. Many families do not have 'bathrooms' – usually just an open structure with four straw-covered walls where you can have a bucket bath – so they have to wait until it's dark. Washing up is done squatting on the ground using ash and rice husks or a piece of sacking and occasionally washing powder; then the dishes are left to dry on the ground with the chickens, goats and dogs all around.

Our first step was to train people from the church in hygiene and sanitation so they could work to change attitudes and encourage healthy habits. Nine volunteers were trained and they are just starting their activities. A major challenge is keeping them motivated since they are not receiving any payment. We had a graduation ceremony at church to show that we value their work in the community.

> CMF has over 150 members living and working overseas. They are in a variety of settings and have many different roles

I'm thoroughly enjoying doing clinical work in the hospital on Saturdays. The paediatric ward is large with about 60 beds and usually two children per bed. This hospital serves a provincial population of four million and yet there seems to be only one blood sugar metre in the entire hospital and the biochemistry machine stops working for days at a time. This week the observation charts ran out and on Saturday I was shocked to discover that no obs (temp, pulse) were being done at all since there was nowhere to write them down. Infection control is a disaster. Haemoglobin levels of two are a daily occurrence and it can be a struggle to get blood. However, I am enjoying it!

Madagascar: Good News Hospital, Mandritsara

***Vic Parsonson** finished foundation training a year ago and set off to work in a mission hospital in Madagascar. She is in charge of paediatrics, but in a rural hospital you end up doing a bit of everything, as her Facebook posts vividly describe:*

Have discovered one of the many disadvantages of being the only doctor in the hospital overnight: 4am, was donating a pint of blood for the massive GI bleed I'd just admitted as there were no donors and we don't have a blood bank. Blood bag was half full when a nurse comes running to the lab, 'You have to come now, there is a paediatric resus and another patient is fitting...' Err... I wait a further five minutes till bag full, needle out of arm and run back to the ward.

You know it's going to be a bad day on call when you've already done five lumbar punctures before 10am, and three have been confirmed as bacterial meningitis. Hospital bursting at the seams, considering introducing bunk beds...

Today the med students here on elective announced the nurses told them they should do all their on-calls with me 'because I attract disaster and crazy things'. Hmmm...

Will never fail to be amused by African mechanisms of injury. 'So how did you get your head injury?'
'I was having a nap under my palm tree when a coconut fell on me...' Ouch.
Only in Madagascar – results from the lumbar puncture I did today: white cells three, red cells ten, spiders one. No-one is quite sure how the spider got there, but the lab assistant came to show me that quite clearly, there WAS one...

I wish that all consultations were this simple. Patient: 'I can't see very well, doctor.' I ask the patient to pass me his glasses, remove the price tag off the left lens and hey presto, he is cured, and as a bonus he thinks I did something amazing!

Monday morning ward round chaos. Apparently 8am on a Monday is a good time for spring cleaning. Items tripped over: a relative sleeping on the floor, three buckets of water, an oxygen concentrator, and a chicken. Catastrophes during ward round: five. Lizards that dropped on my head whilst doing lumbar puncture: one. Doctors in the hospital: only me. Just another average Monday morning then.

'My child has been vomiting up large 6cm worms all night,' said mum. Small child then proceeds to wretch and chuck up said worms all over my desk. 'Yes, just like that!' said mum, jubilantly. Could have done without the practical demonstration.

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

Sarah Maidment shares the experience of changing specialties

CHANGING DIRECTION

'I think you'd be better suited to General Practice.' My mother's words hung heavily in my mind. I had received offers of specialty training in paediatrics from two different deaneries. Not one but two doors had opened for me in paediatrics. I felt this was where God was leading me. The question in my mind was not, 'which specialty?' but rather, 'Which deanery?'

'*Trust in the LORD with all your heart and lean not on your own understanding; in all your ways submit to him, and he will make your paths straight*' (Proverbs 3:5-6).

My parents, both doctors, inspired me to study medicine. I had always thought I would follow in their footsteps, training in general practice. Throughout medical school and my Foundation jobs, I discovered I enjoyed paediatrics. Having been encouraged by a number of influential, enthusiastic paediatricians, a medical school prize and a publication, I started to consider seriously a career in this specialty.

Ultimately, I wanted to serve God and glorify him in my work – whatever I ended up doing – and to train in a specialty that I could usefully take abroad to a developing country.

'*For I know the plans I have for you,' declares the LORD, 'plans to prosper you and not to harm you, plans to give you hope and a future. Then you will call on me and come and pray to me, and I will listen to you. You will seek me and find me when you seek me with all your heart*' (Jeremiah 29:11-13).

Specialty training applications

I applied for Paediatrics in the two most competitive deaneries in the UK, so I thought it would be wise to apply for general practice as a back-up option.

This was a stressful time for my peers but I had a real sense of peace, knowing that God was in control and that whatever happened the outcome was safe in his hands.

'*And we know that in all things God works for the good of those who love him, who have been called according to his purpose*' (Romans 8:28).

Paediatrics ST1

I found the transition to specialty training particularly difficult. I had moved to a new deanery, leaving behind all of my friends, church and a hospital where I was known, trusted and 'knew the system'.

I found paediatrics stressful: screaming children, anxious parents. Even a simple task such as taking blood became a mammoth undertaking, requiring several pairs of hands, a box of toys and a great deal of nerve. I struggled to 'perform' to the level of perfection expected of me.

It was a busy hospital in a deprived area, with a demanding, exhausting rota. I felt unsupported by my seniors. There were times when I arrived at work in tears. This wasn't me. It was a real challenge to be a shining light for Jesus in the workplace when I was struggling to be joyful in my work.

'*Rejoice always, pray continually, give thanks in all circumstances; for this is God's will for you in Christ Jesus*' (1Thessalonians 5:16-18).

Thankfully, God had prepared the way for me. Despite leaving behind my 'social network' I quickly settled into a local church and joined a home group. My new church family gave me a tremendous amount of support through this difficult time.

A change of direction

It was becoming clear that paediatrics was not the career for me. I was going to have to make some important decisions. Training in paediatrics would mean at least seven more years of shift work. I would still be working night shifts as a consultant. It would be a challenge to combine this career with my extra-curricular interests. I had just started racing for a women's cycling team and longed to serve more actively at church.

I had to consider the 'contextual' factors. Would things have been different if I had started my training in a different hospital, or with friends and family nearby? Would the grass really be greener on the other side?

After much prayer, I talked things through with a consultant whom I trusted and decided to apply for GP training.

Specialty training applications: take 2

Interviews came round. I was more nervous the second time round but I felt better prepared, having had an extra year of experience. I trusted that God had a plan and I was open to the fact that this might be to struggle on and serve him in paediatrics.

I was overjoyed to be offered a place on the Oxford GP training scheme. Rather than rushing into a decision, I spent time praising God and seeking his guidance.

So where was God in all of this? Why would God open doors into a career in paediatrics and then seemingly close them again? Did I spend enough time praying and committing everything to the Lord the first time round? Could this year in paediatrics be preparing me for something in the future? I felt God was leading me into general practice, so I accepted the offer.

And so to Oxford...

Changing specialties was the best decision I could have made and I don't have any regrets. Once I had settled into another new hospital and overcome my fear of relatively enormous cannulas, I started to enjoy work again, arriving with a smile on my face and a spring in my step, overflowing with joy that only comes from the Lord.

'*Consider it pure joy, my brothers and sisters, whenever you face trials of many kinds, because you know that the testing of your faith produces perseverance*' (James 1:2-3).

'*I press on towards the goal to win the prize for which God has called me heavenwards in Christ Jesus*' (Philippians 3:14).

***Sarah Maidment** is a GP trainee in Oxford and a member of the CMF Junior Doctors' Committee*

James May on the place of the arts in healthcare

FAITH, ART & HOLISTIC MEDICINE

'There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy.' Hamlet Act 1, Scene 5

Our age idolises the gods of economics, technology and science. Debates and decisions within the health service, as in society at large, tend to revolve around them. In a time of economic austerity the arts and the humanities tend to be overlooked in favour of science and technology. After all, they are seen as the drivers of the economy.

Should Christians be content with such a limited view of reality? Christians often share with society at large a diminished view of the arts and humanities. Rather than seriously engaging with them, they are more likely to relegate them to be mere light entertainment.

This is all background to a discussion of the role of the arts in 'holistic' medicine. There is a pietistic strand in British Christianity which sees our faith as being principally about our personal and individual lives. So faith has less and less to do with culture 'out there'. But true holistic health is not merely a combination of physical health and spiritual concerns. It is when every aspect of our existence is submitted to the lordship of Christ.

Consider what CS Lewis writes about our natures:

'They (people) propound mathematical theorems in beleaguered cities, conduct metaphysical arguments in condemned cells, make jokes on scaffolds, discuss the last new poem while advancing to the walls of Quebec, and comb their hair at Thermopylae. This is not panache: it is our nature.' [1]

And consider this from the Christian thinker Calvin Seerveld:

'I know that the Lord shall save some without a cultural deed to their name, as if by fire...but...Creaturely life is what the Lord wants redeemed... bearing fruit in obedience in all facets of our existence...I am talking about sanctification that is gritty and concrete.' [2]

Seerveld believes aesthetic health is as vital to our well-being as physical health. Of course we should check what the Bible has to say about this. It is striking, for instance, when considering the humanities and literature, to observe that the Bible contains many if not most forms of literature, with the notable exception of scientific discourse.

The Old Testament scholar John Walton notes that people in the Ancient Near East didn't have a 'material ontology' like we do, but a 'functional ontology'.[3] They were less interested in what things were made of, than what things were for. Our world has different priorities.

We are influenced by Enlightenment rationalism. So when we read poetry in the Psalms we are prone to try to abstract some systematic theology, or a doctrinal statement, rather than let the words and idioms wash over us. Poetry reaches our emotions through our imaginations, not analytic logic. The Bible reflects imaginative and intuitive ways of thinking as much as analysis.

Indeed, when we think thoughts we find it difficult to conceive of anything other than words and language. We so favour words with definitions, and sentences with precise meanings, that we fail to see that this is only one way that the world is represented to us. But this is by no means the main way. Can you think about a melody, or an image?

> We need to find ways of helping people comprehend their experiences in a way that is both real and profound using the arts and humanities

As clinicians presented with the problems of life we can feel hopeless and helpless if we can't give answers. But what if we thought differently? When there is not practical help that we can offer, maybe we need to find ways to help people comprehend their experiences in a way that is both real and profound using the arts and humanities.

Albinoni's Adagio in G Minor expresses to me a sorrow that I often repress in day-to-day life but which I know is there. How do I make sense of my sin and the relationships I have harmed? How do I feel about starving children who I do not help? What should the human race feel about the environmental crisis? Maybe listening to music can help us face these realities rather than hiding them beneath a cacophony of chaotic daily chores.

What about a sense of joy or longing that can't be satisfied by material pleasures? Can poetry help us to transcend our momentary troubles? Can a Rembrandt self-portrait or a Dostoevsky novel reveal something of the troubles of our own hearts? Can the playfulness of a rhyme or poem, or a piece of chocolate, lift us out of drudgery and help us enjoy spending time with our children?

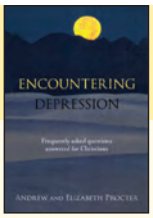
How do we evaluate whether or not someone should start taking a statin? Is it a pure statistical consideration of risks and benefits, or do we as a society need to reconsider what things in life are important? Can the humanities help us to do that?

There is no correct answer to how the arts and humanities might help us be better doctors but if we hope to be holistic, to bring all of life under Christ's lordship, then we would be negligent if we fail to use them in the service of our patients.

***James May** is a SHO from east London*

references

1. Lewis CS. 'Learning in War Time' in *Fern-Seed and Elephants and other Essays on Christianity*. London: Fontana, 1975: 28
2. Brand H, Chaplin A. *Art and Soul: Signposts for Christians in the Arts*. Nottingham: IVP, 2001
3. Walton JH. *The Lost World of Genesis One: Ancient Cosmology and the Origins Debate*. Nottingham: IVP Academic, 2009



Encountering Depression

Frequently asked questions answered for Christians
Andrew and Elizabeth Procter

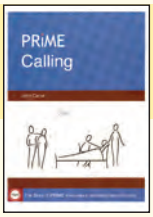
- SPCK, 2012
- £8.99 Pb 110pp
- ISBN 978 0 28106 472 4

Included among the 20 questions covered by the authors are: Does my depression stem from my lack of faith? I must have done something wrong? Am I being judged? Why doesn't God heal me? and Why do I find worship/fellowship difficult and struggle to go to church? A chapter for carers is entitled: What can I do to help? And one for church leaders: How can my church help?

It is written by a husband (a pastor) and wife (psychiatrist). Each question is answered using the same format. The chapter starts with 'Information' about the question being addressed. Then the 'Inspiration' section gives a testimony or quotation for encouragement. The 'Meditation' section gives helpful Bible passages. The 'Perspiration' provides useful, simple exercises.

Occasionally the authors made statements which do not have scientific validity such as 'Depression particularly strikes those who have high expectations of themselves and depression is the "curse of the strong". It hits generous, good hearted people who care about others.' Overall it gives valuable insights for those suffering with depression.

***Dominic Beer** is a retired psychiatrist in London*



PRIME Calling

John Caroe

- PRIME, 2012
- £5.00 Pb 60pp
- ISBN 978 0 95595 271 5

Written to convey the early years of PRIME (Partnerships in International Medical Education), *PRIME Calling* recounts briefly the early coming together of a group of Christian doctors in Sussex who wanted to 'reconcile [their] professional responsibilities with [their] Christian faith'.

Out of that grew the 'Doctor's Dilemmas' course at Burrswood Christian hospital in rural Kent, bringing together Christian GPs for professional postgraduate teaching and spiritual (and indeed, physical!) refreshment. Into this environment of clinical teaching, prayer, long woodland walks and warm fellowship, they invited some Romanian doctors they knew. The Romanians were so encouraged they asked the team to run a similar course in Romania, and the rest, you might say, is history.

In a few brief vignettes, the story is told of those early trips in Romania, then Albania, Russia, Armenia, and more recently to Kenya, Ethiopia, India, Nepal and beyond. It seems that the natural human compassion that motivates many into medicine is so driven out of us by our training that having permission to put it back into practice is a liberation.

A short, helpful read for anyone interested in the ethos, origins and work of PRIME.

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

Ka Sefofane

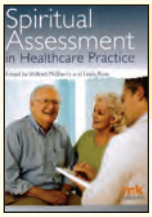
The Story of Flying Mission
Malcolm J McArthur

- Milton Contact Ltd, 2011
- £19.00 Pb 321pp
- ISBN 978 0 95626 496 1

What is the fastest way to get from one town in Botswana to another across miles and miles of uncharted desert? By plane (*ka sefofane* in the local language), of course. As a young missionary doctor, the author spent many uncomfortable and often anxious hours bumping along desert tracks in a 7-ton Bedford truck, to reach small clinics in remote areas of the country. On one such occasion, noticing the effortless, elegant flight of some vultures overhead, the idea of equipping the medical service with wings was born.

This is the story of how the Flying Mission was started and progressed to become a respected professional service to the people of Botswana, linking the provision of medical services with the spread of the gospel to every corner of the country. I was as challenged as I remember as a young teenager reading the stories of the great 19th century missionaries, going to unknown lands and peoples with the gospel, leaving behind the comforts of a professional life at home for the uncertainties and hard work of those remote and poor regions. Buy this book and see why those old missionary stories are still relevant.

***Pablo Fernandez** is CMF Head of Graduate Ministries*



Spiritual Assessment in Healthcare Practice

Wilfred McSherry and Linda Ross (eds)

- M&K Publishing, 2010
- £27 Pb 190pp
- ISBN 978 1 90553 927 7

The editors have brought together contributors from nursing, medicine, theology, and chaplaincy from the US and Europe to offer a broad perspective on spiritual care and assessment. I found the excellent and practical spiritual history chapter by Christina Puchalski especially relevant. She suggests that the first step in communicating about spiritual issues is to show a genuine interest and compassion. The second step is to listen carefully to identify and respond to spiritual or religious themes. These include meaninglessness and feeling worthless as well as religious distress. She helpfully lays out a simple set of targeted questions which can be used in medical student teaching.

The book is up to date with British and US healthcare developments and controversies such as praying with patients. John Swinton's helpful chapter explains various secular approaches to spiritual care. The limitations of such approaches are stated with clinicians encouraged to also identify and help patients meet their religious needs. This allowed me as a Christian to understand how this broader construct of spiritual distress can be at times a stepping stone to Christian witness.

***Scott A Murray** leads the Primary Palliative Care Research Group, University of Edinburgh*

Keeping Faith in Faith-Based Organizations

A Practical Theology of Salvation Army Health Ministry

Dean Pallant

- Wipf & Stock Publishers, 2012
- £16.00 Pb 222pp
- ISBN-10: 1610979230

Dean Pallant, Head of International Health Services for the Salvation Army, looks at the place of faith-based organisations in providing health services in the developing world and asks the fundamental question 'Whose faith are we serving?'

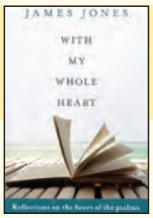
The temptation for Christian hospitals and faith-based health organisations is to go where the money is – towards commercial, international donor or state sponsored health priorities. And in a climate where Faith-Based Organisations (FBOs) are currently being fêted as the 'next big thing' it is easy to get sucked into all of this. Alternatively, we get driven by the profit motive, seeing health services as a cash cow to fund mission, rather than as mission in its own right.

Pallant is arguing that we need to take another view – one that puts our faith at the centre of all we do in health and seeks to work with the poor to find health solutions that spring from our deepest theological and spiritual convictions.

Instead it means understanding and rediscovering a theology of health that focusses on becoming 'healthy people' – not just free of illness, but freed to become the people God created us to be.

This does not mean ignoring the global community or global goals and strategies. But it does mean not being hidebound by their external agendas.

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



With My Whole Heart

Reflections on the heart of the Psalms

James Jones

- SPCK Publishing 2012
- £8.99 Pb 176pp
- ISBN 978 0 21068 050

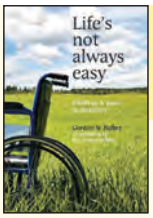
Bishop James Jones turned to the *Book of Common Prayer* when, within one week after making a heartfelt speech in the House of Lords, he underwent an angiogram followed by cardiac surgery. It all came as a shock and this collection of 78 meditations is the result.

Initially for his own counsel and consolation he selected psalms that mention the heart, but the result is a commentary that will hearten all who read it. As do the psalms themselves; the book finds words to cheer the sad and frightened, to rebuke the wayward, to revive the hearts of those hemmed in for whatever reason and to proclaim the wonderful works of the Lord.

Whilst James Jones was away from the front line his reflections brought fresh clarity about the risks and roots of personal pride and public immorality when hearts are deflected from the grandeur and purity of God, for 'the heart is the seat of the will'.

Neglect of the psalms is to deprive ourselves of a rich source of inspiration and encouragement. This little book will help us to find passages that speak most clearly to the heart's present need and promote our grateful meditation – before we send for another copy to give to someone else.

***Janet Goodall** is a retired paediatrician from Stoke-on-Trent*



Life's Not Always Easy

Children & pain or disability

Gordon W. Kuhrt

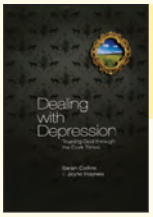
- Morse-Brown, 2011
- £7.00 Pb 60pp
- ISBN 978 1 90761 505 4
- Available from bookshops and email: omkuhrt@tiscali.co.uk

Gordon Kuhrt writes for children on the problem of suffering. In Part 1 the author tells his own story of long periods in hospital and repeated operations, while being separated from his parents, who were missionaries in India. In Part 2, he reflects on the big questions his story has raised. For instance, the problems for a child being 'different', ugly, pitied, bullied, misunderstood and of missing school. He writes helpfully on: Why do people suffer? And does God heal people?

Feeling unable to evaluate its style and content for children, I had no hesitation giving it to my ten-year-old grandson, whose mother is now in a nursing home with advanced MS. He wrote, 'Good. I think it is suitable for ten-year-olds. I liked this book and enjoyed it. It is broken up well and I liked the pictures. It makes me think about these things, and had helpful answers.' After the six point chapter Where is God in all this? he wrote enthusiastically, 'Good ideas!'

And I agree. A pastoral book giving children a good introduction to theological and apologetic issues, and giving you plenty to talk about afterwards.

***Peter May** is a retired GP based in Southampton*



Dealing with Depression

Trusting God through the Dark Times

Sarah Collins & Jayne Haynes

- Christian Focus Publications, 2011
- £4.99 Pb 128pp
- ISBN 978 1 845 506 339

Here is a primer for the families, friends and pastors of those suffering from depressive illness, as much as for those currently walking with the 'black dog' themselves. The authors (one a doctor) describe the condition in ways that will help sufferers to make sense of their experience, and both to cope and to hope.

It will help carers to give effective support. It's interspersed with the personal stories of those afflicted and affected, in short testimonies and three *appendices*. Further printed and online resources are listed, with useful organisations for contact.

There is a healthy emphasis throughout on inter-dependence and community and on realistic boundaries for all involved. The value of depression is described in terms of its potential pastoral and creative fruitfulness, free of any suggestion that suffering is intrinsically good. The depressed person's relationship with God, and the value and power of Scripture, are central to the discourse, with the highlight for me being 'in the Psalms people's words to God become God's words to us'.

I've a few minor gripes about terminology, distracting repetition and typos, but it should prove a very helpful read for believing patients and carers encountered in general practice, out-patient psychiatry and pastoral work.

***Julian Churcher** is CMF graduate staffworker for London and the South East*

eutychus

Fight against TB is still 'fragile' says WHO

Some 51 million people are alive today having been successfully treated for tuberculosis over the last 17 years, but the WHO warns the fight against TB remains fragile. 'The momentum to break this disease is in real danger. We are now at a crossroads between TB elimination within our lifetime, and millions more TB deaths,' says Dr Mario Raviglione, director of the WHO Stop TB department. TB remains a major killer. Fewer people are contracting TB but there are still 8.7 million new cases annually. (*WHO Global Tuberculosis Report* 2012. *http://bit.ly/RDfOCz*)

Euthanasia 'out of control' in the Netherlands

Euthanasia in the Netherlands is growing steeply according to September media reports. In 2011 they were up 8% to 3,695, with increases of 13% in 2009 and 19% in 2010. From 2006 to 2011 there was a steady increase: 1923, 2120, 2331, 2636, 3136 and 3695. Euthanasia accounts for 2.8% of all Dutch deaths. Euthanasia for people with early dementia doubled to 49 last year and 13 psychiatric patients were euthanised. Numbers could be much higher since not all cases are reported. (*Lancet* 2012; 380 (9845): 869-870, 8 September)

New debate about circumcision

The National Secular Society (NSS) plumbed new depths with a campaign against male circumcision. 'Why MGM and FGM are not considered equally reprehensible defies compassionate reason', NSS opined. Really? FGM (female genital mutilation) is barbaric. It's illegal in Britain, but still happens. This NSS campaign seems to have more to do with anti-religious prejudice than science and insults the legion of women who have suffered FGM. The American Academy of Pediatrics (AAP) said in August 'health benefits of newborn male circumcision outweigh the risks': decisions about it should be left to parents. (*AAP* 2012, 28 September)

Visit the murky world of body snatchers

In a major exhibition the Museum of London (19 October 2012 to 14 April 2013) depicts the murky world of 'resurrection men'. Early nineteenth century surgeons had a stark choice: hone skills with live patients or on bodies some of which were provided by gangs who robbed graves and even murdered. The exhibition relates to excavations of a burial ground at the Royal London Hospital, uncovering a 'confusing mix of bones with extensive evidence of dissection, autopsy, amputation, bones wired for teaching, and animals dissected for comparative anatomy'. (*Museum of London* 2012, 26 October. *http /bit.ly/MGfEWI*)

Lunar end of life rite

For the price of a plot with headstone in a London graveyard it may soon be possible to have your ashes scattered in space. The scheme is the brainchild of a university graduate who thinks the service will appeal not only to space enthusiasts but also 'Orphans of Apollo'–people whose wish to go on a space mission was never fulfilled. The entrepreneur is reported to be looking for commercial partners among funeral directors and crematoriums. (*BMJ* 2012; 345: 6358, 26 September. *http://bit.ly/TPQmZP*)

High cost of alcohol-related illness in 'boomers'

A study by Alcohol Concern claims the NHS is spending more money treating alcohol-related illness in baby boomers than young people. The report found the cost of drink-related hospital admissions among 55 to 74-year-olds in 2010-11 was more than £825m. This is 10 times the figure for young people aged 16-24. Alcohol related in-patient admissions cost nearly £2bn in England, the report found. It says more than 10 million people are drinking more than recommended levels. Some 454,317 baby-boomer generation patients were treated compared with 54,682 persons under 24. (*BBC News* 2012, 12 October. *http://bbc.in/RkWRo8*)

Big rise in diabetes projected

The number of people with diabetes is set to rise by 700,000 by the end of the decade, according to new research. The analysis is based on data from the Yorkshire and Humber Public Observatory. 4.4 million people in England and Wales will have the condition by 2020, an increase of one fifth. Barbara Young, CEO of Diabetes UK, says the healthcare system is nearing breaking point in terms of its ability to care for people with diabetes, but it 'is still not too late to take the action needed to avert it.' (*http://bit.ly/QFNIhT*)

Health Secretary favours reducing abortion limit

Britain's new health secretary announced himself and sparked media debate saying he favours reducing the limit for women to have abortions from 24 weeks of pregnancy to 12. Jeremy Hunt said that after studying evidence (which he did not enumerate) he believed that 12 weeks was 'the right point.' He told the *The Times* newspaper (6 October): 'It is just my view about that incredibly difficult question about the moment that we should deem life to start.' (*Times* 2012, 2 October)

There's got to be a better way

UK researchers show few qualms about using and destroying embryos. One day Shinya Yamanaka looked into his microscope and founding himself wondering: 'When I saw the embryo, I suddenly realised there was such a small difference between it and my daughters,' Yamanaka, told the *New York Times* a few years ago. 'I thought, "We can't keep destroying embryos for our research." There must be another way.' Now Yamanaka and team have successfully turned adult skin cells into the equivalent of human embryonic stem cells without using an actual embryo, research earning him a Nobel Prize. (*Slate* 2012, 9 October. *http://slate.me/PRdGWC*)

Forgiveness: good for your health

As well as soothing the soul, forgiveness can bring cardiovascular benefits, says a recent study. It measured the blood pressure and heart rate of 202 people. They were given the option of either brooding angrily over some past wrong or taking a forgiving perspective. Compared to angry ruminations, forgiveness made a significant difference to fluctuations in blood pressure. Want to protect your heart? Don't get angry, try forgiveness. (*Psychosomatic Medicine* 2012; 74:745-750)

Lois Fergusson and **Catherine Butcher** reflect on the Olympic opening ceremony

SET APART TO SERVE

In those days when the number of disciples was increasing… the Twelve gathered all the disciples together and said, 'It would not be right for us to neglect the ministry of the word of God in order to wait on tables. Brothers and sisters, choose seven men from among you who are known to be full of the Spirit and wisdom. We will turn this responsibility over to them and will give our attention to prayer and the ministry of the word.' (Acts 6:1-4)

The opening ceremony of the Olympics celebrated the NHS and children's literature in a sequence featuring staff and patients from Great Ormond Street Hospital. GP in training, Lois Fergusson was among the 7,500 volunteers who spent on average 150 hours practising during the build-up to the three-and-a-half-hour show under the direction of artistic director Danny Boyle. There were 800 health professionals in the NHS sequence: nurses, physiotherapists, speech therapists, public health workers and doctors.

Reflecting on the event Lois said: 'I learnt so much from my experience. I saw a leader in action, who envisioned his followers, was present for all the hard work and who was trusted to stand up for us to those in power.' (There had been calls to axe one of the volunteer performer sequences to shorten the ceremony.)

Lois added: 'I was part of a team so huge that you were individually anonymous but together produced something unique and unforgettable. The show is now over, the hospital beds have gone on to have real patients in them in Tunisian hospitals and my nurse's costume is hanging in my wardrobe. But the lessons and experience will be with me forever.'

The Olympic focus on the NHS was a reminder that it is a service of which we can be proud. For the many Christians employed by the NHS, it is a service which reflects the servant heart of Christ. As Christians we are not only envisioned by a great leader, we are also empowered by his Spirit.

When the early church was growing, the first disciples recognised the need to care for widows. Acts 6 describes how seven men were chosen for this practical service. Their qualification? They were 'known to be full of the Spirit and wisdom'. Stephen, who became the first martyr, was one of those chosen. He is described as 'a man full of faith and of the Holy Spirit'… 'a man full of God's grace and power, [who] performed great wonders and signs among the people'.

These godly, practical servants were presented to the apostles, who prayed and laid their hands on them. The result: 'The word of God spread. The number of disciples in Jerusalem increased rapidly, and a large number of priests became obedient to the faith.'

Working as one of 1,186,790 NHS staff[1] it might be easy to say 'What difference can I make?' Instead, let's be envisioned by our servant king,[2] following his example in service and empowered by his Holy Spirit to play our part in seeing the word of God spread and Christ's kingdom established.

Lois Fergusson *is finishing GP training in east London.*
Catherine Butcher *is CMF Head of Communications.*

references

1. http://bit.ly/TNAmrq
2. Philippians 2:7

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