Winter 2014

for today's Christian doctor

triple helix

Ebola

Christian doctors on the front line

Plus: medical innovation: to fast track or not, saying yes to broadcasting, personality disorders, medical war heroes, junior doctors and the local church, a secular funeral

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contents

Cheap Grace

a deadly enemy of the church

Dietrich Bonhoeffer: grace is costly.

Many Christians are suspicious of ethics. They think it undermines grace and distracts from the preaching of the gospel. They also fear that it leads to legalism. They want to emphasise, quite rightly, the fact that salvation is a gift that we cannot earn.[1,2]

Salvation is indeed through God's grace alone and is received by faith alone. This is one of the great biblical truths rediscovered by the Reformers.

The idea of 'substitutionary atonement', that Christ died *in our place for our sins* and for our justification, is absolutely central to both Old and New Testaments. It underlies the Passover, the Jewish sacrificial system, temple worship and the Day of Atonement and is clearly taught throughout the Prophets,[3] the Gospels[4] and the Epistles.[5]

But I wonder if by misunderstanding 'grace alone' we are in danger of embracing what the German war-time Christian martyr Dietrich Bonhoeffer termed 'cheap grace', 'the deadly enemy of the church'.[6]

'Cheap grace is the grace we bestow on ourselves. Cheap grace is the preaching of forgiveness without requiring repentance, baptism without church discipline, communion without confession... Cheap grace is grace without discipleship, grace without the cross, grace without Jesus Christ, living and incarnate.'

'Cheap grace' results from a lack of understanding of the true nature of repentance and faith, which in turn stems from a failure to appreciate the holiness of God and the seriousness of sin.

Both repentance[7] and faith[8] are themselves gifts of God's grace – he enables us to repent and have faith because we are incapable of doing it on our own.

But repentance is more than saying sorry. It involves an active turning from sin to obedience. We leave our former life behind and follow in Jesus' footsteps. He becomes our Lord and master.

John the Baptist tells his would-be baptism candidates to 'produce fruit in keeping with repentance'.[9] Jesus takes the same approach: to the rich young ruler, 'sell your possessions and give to the poor';[10] to the healed cripple by the pool of Bethesda, 'stop sinning or something worse will happen to you';[11] to the woman caught in the act of adultery, 'leave your life of sin'.[12]

To say sorry, and to then continue in sin, is not repentance. It is presumption.

In the same way faith is more than mere belief, mere intellectual assent to a doctrinal checklist. It is trusting obedience. James tells us that even demons believe – and shudder.[13] Demons however, do not possess saving faith. They do not trust and obey.[14]

Of course this does not mean in any sense that we contribute something to our salvation. We are powerless to do anything to save ourselves, but nonetheless *the evidence* of genuine saving faith is a changed life – actions. James gives us the examples of Abraham and Rahab who demonstrated the genuineness of their faith by what they did.[15]

They were, we are told, 'considered righteous for what they did'. If we were in any doubt, James summarises it for us, 'Faith without deeds is dead'.[16]

The apostle Paul's letters are full of the same principle. His letters are full of ethical instruction.

He commends the Thessalonians for their 'work produced by faith' and their 'labour prompted by love'.[17] He prays that the Colossians will 'bear fruit in every good work'.[18] He tells Titus that Jesus gave himself for us 'to redeem us from all wickedness and to purify for himself a people that are his very own, eager to do what is good'.[19] He tells the Romans that they are called 'to the obedience that comes from faith'.[20]

Galatians speaks of faith 'expressing itself through love'[21] and Ephesians adds that we are 'created in Christ Jesus to do good works, which God prepared in advance for us to do'.[22]

Nowhere is this principle of obedient trust more evident than in the Gospels themselves. Jesus says that to those who call him Lord but *do not do* his Father's will, he will say 'I never knew you'.[23] The difference between the man who built his house on the sand and the other who built it on the rock, is this: Both heard Jesus' words but only one '*put them into practice*'.[24]

Obedience to Christ is of course only possible by God's grace, through the indwelling work of his Holy Spirit,[25] but as Christians we are nonetheless called to obey him. In fact the heart of the great commission, sadly so often distorted into an exhortation merely to evangelise, is to 'make disciples of all nations… *teaching them to obey everything* I have commanded you'.[26]

As a clear corollary of this teaching we are told that a life without obedience is evidence of non-regeneration.[27]

Christian ethics lie right at the heart of the gospel. And following Jesus – having real faith – means having his attitude,[28] walking in his footsteps[29] and obeying his commands.[30]

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

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news reviews

Assisted suicide

Making laboured parliamentary progress

Review by **Peter Saunders**
CMF Chief Executive

Lord Falconer's Assisted Dying Bill[1,2] reached Committee Stage in the House of Lords on Friday 7 November. It seeks to legalise assisted suicide (but not euthanasia) for mentally competent adults (aged over 18) with less than six months to live, subject to 'safeguards' under a two doctors' signature model similar to the Abortion Act 1967.

Opponents to the bill opted to strangle it slowly in committee rather than voting it out at second reading and so the whole House of Lords is now debating the bill line by line and considering 175 proposed amendments.[3] Only four of 40 groups of amendments were formally considered on the first day of committee (7 November)[4] so there is still a long way to go and the bill is fast running out of parliamentary time.

It may not even reach the third reading stage necessary for it to clear the House of Lords and, even if it does, those on both sides agree that there is no time for it to go through the House of Commons as well before the general election on 7 May 2015. This means almost inevitably that the bill will fall and that Lord Falconer will have to start all over again next summer.

The debate now however is still very important as it will form part of the parliamentary record and will influence future discussions. So it is still essential that those opposed to the bill still write to peers urging them to reject it fully at third reading, if it should come to a vote.[5]

One development on 7 November was the 'acceptance' of an amendment by Lord Pannick that judges, not doctors, should take final decisions about whether someone should be given the go-ahead to take their own life. This amendment puts a fearsome onus on judges but also demonstrates one of the weaknesses of the bill, that its so-called 'safeguards' are not safe.

A fuller analysis of the bill and a paper giving warnings from Oregon where similar legislation was passed are both available on the Care Not Killing website.[6]

A similar bill to Falconer's, originally introduced into the Scottish Parliament by the late Margo MacDonald MSP but now sponsored by Patrick Harvie MSP, will be debated in Holyrood in March 2015 after oral evidence has been taken in February.

Harvie's bill is proposing to legalise assisted suicide using trained 'licensed facilitators' for mentally competent adults (aged over 16) with a 'terminal or life-shortening illness' or a 'progressive and terminal or life-shortening condition' who have concluded that the 'quality of their life is unacceptable'.

The bill has more holes than Falconer's including relativistic definitions, poor reporting provisions, minimal penalties, a 'saving' clause protecting doctors acting in 'good faith', no specification of 'means' of suicide and the absence of a conscience clause.

Unlike Falconer's bill, its progress will not be halted by the general election. But it is even more dangerous, if that was possible, and needs to be defeated at the time of the first debate.

A new ComRes poll[7] has shown that a clear majority of the public say there is no safe system of assisted suicide. More than four in ten believe assisted suicide will be extended beyond the terminally ill if the current law is changed.

The voice of the medical profession, and especially that of Christian doctors, will be crucial at 'such a time as this'.[8] We must not be silent.

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End of life care

Time to go beyond good guidelines

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

A survey published by the Royal College of Nursing in early November[1] suggested that the large majority of nurses felt unable to give the right level of care consistently to dying patients. This frustration was laid at the door of poor staffing levels, inadequate resources and lack of training.[2]

Over a year after the Neuberger Review[3] scrapped the Liverpool Care Pathway (LCP), it seems that we are still not addressing end of life care in hospital or community. Shortly after the LCP was scrapped, a leading palliative care nurse expressed concerns that this would set back care of the dying in this country by years.[4] Since then, a new set of inter-professional guidelines has been developed (*The Priorities of Care for the Dying Person*),[5] emphasising the involvement of the dying person and their family in individualised care planning, sensitive ongoing communication with the patient and within the care team.[6] This is all very positive, but it is still early days for these guidelines, and this RCN survey suggests that nurses at least are still struggling – not for a lack of guidelines per se, but lack of resources or real training.

A 2010 review by *The Economist* ranked the UK as the global leader in end of life care.[7] If we want to continue in that position, and enable and encourage other countries to improve their end of life care, it is vital that we go beyond guidelines on good practice to training and resourcing good quality end of life care throughout the NHS. Half a million people die every year in the UK; end of life care is not a minority concern!

The RCN survey also highlighted that nurses felt giving good quality end of life care was a huge privilege and responsibility, and one that they wanted to discharge to the best of their ability. As a society, we should be doing all we can to enable them to do this.

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Expensive 'mistakes'

Government pays out millions for 'wrongful births'

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

A recent reply by the Government to a Parliamentary question on the number and cost of so-called 'wrongful birth' cases elicited some startling findings.[1] Government figures show that since 2003, the NHS has paid out more than £95 million on 164 successful claims for damages from parents wanting compensation for the birth of a child. Defence costs for a further 83 claims that were unsuccessful are not included in this figure.

It has been commonly assumed that these kinds of 'wrongful birth' claims are mostly for damages based on the extra cost to parents for raising an unexpectedly disabled child. And in just over half of the successful cases, this has been true.

Claims based on the disability of a child included eight pay-outs to parents for babies born with Down's syndrome. These claims are controversial enough as they reinforce the view that the birth of a child with a disability is a harm for which one may be compensated. Although for some parents there will also be a genuine need for practical support and financial help. However, nearly half of the claims granted were for *healthy* babies (45 out of 104 closed claims).

'Legal claims in such cases can be brought by the mother of the child who is born with the abnormality on the basis that, *had it been detected*, she would have been offered counselling and the option of termination *and would have chosen to terminate the pregnancy*' (emphasis added).[2]

The Government answer reveals that the pay-outs were made for healthy babies born after an 'unwanted pregnancy' (two), 'failed contraception' (eight), 'failed sterilisation' (24), 'inaccurate fertility advice' (one), 'failure to diagnose pregnancy' (one) and for 'failed terminations' (six).

Should the NHS (or anyone) be paying out millions for the birth of healthy babies? Where can a line ever be drawn in this expansion of the right to sue? If claims are successful for 'failed sterilisation and contraception', why not for all other failed contraceptives? If claims are successful for 'inaccurate fertility advice' why not for failure to provide teenagers with contraceptives?

And what effect will these claims have, psychologically, on the children themselves, as they grow up, knowing full well that their birth was agreed to be an expensive 'mistake' and they should never have been born?

The financial cost of 'wrongful birth claims' is in the millions of pounds to the taxpayer, and this is likely to increase. But an even greater price being paid is the reinforcement of a culture that sees the birth of disabled *and* unplanned children as not just an inconvenient mistake and a financial burden, but to be avoided at all cost. It could hardly be more different to the psalmist's view of children as a blessing, a reward and a gift from the Lord (Psalm 127).

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One small step...

Groundbreaking treatment offers hope for paralysis

Review by **Rick Thomas**
CMF Public Policy Researcher

It is 45 years since Neil Armstrong uttered his now famous words. Within the last few weeks other noteworthy steps were taken that have been hailed as 'more impressive than man walking on the moon'. This is no tabloid hype, but the opinion of Prof Geoff Raisan, Chair of Neural Regeneration at UCL's Institute of Neurology. The 'steps' were those taken by Darek Fidyka, a forty year old Polish man, previously paralysed from the chest downwards as the result of stab wounds four years ago that almost completely severed his spine.

For 40 years, Prof Raisan has been studying how to repair the spinal cord. In animal studies he showed that olfactory ensheathing cells (OECs) injected into the rat spinal cord could reverse paralysis. OECs form part of our sense of smell; they act as pathway cells that enable nerve fibres in the olfactory system to be continually renewed. The breakthrough occurred using multiple micro-injections of cells cultured from OECs taken from Mr Fidyka's olfactory bulb into the neural tissue either side of his cord transection. The 'gap' was bridged by tiny strands of nerve tissue, taken from the patient's ankle, acting as a scaffold. The OECs appear to have stimulated the spinal cord cells to regenerate, bridging the severed cord. MRI scans show the previous gap has filled in.

Three months after surgery Mr Fidyka noted new muscle growth in his thigh and after a further three months he was able to take faltering steps between parallel bars, using knee braces. Two years after the surgery, he can now walk outside, with only the aid of a frame. Bladder and bowel sensations are beginning to return.

The pioneering neurosurgery was undertaken by Pawel Tabakow at Wroclaw University Hospital who said: 'what we thought for many years was impossible [regeneration of the spinal cord] is becoming a reality'. Any hype over the years has been about the promise of *embryonic* stem cells. This has led to millions of pounds of public money being ploughed into questionable research projects, destroying more than three million human embryos in the process. What is so wonderful about this case is that (once again) it demonstrates the potential of adult stem cells. Commenting on the news, Lord Alton declared: 'When good science and good ethics march hand in hand, it is an unbeatable combination and serves the highest interests of humanity.'

The final word goes to Prof Raisan: 'Our goal now is to develop this first procedure to a point where it can be rolled out as a worldwide general approach. We stand on the threshold of a historic advance.' Now that really would be 'one giant leap for mankind'.

Pablo Fernandez and **Philippa Taylor** assess the risks with early medicines ahead of full clinical trials

TO FAST TRACK OR NOT TO FAST TRACK?

key points

- There have been mixed reactions to the 'easy access to medicines' scheme. Fast-tracking ZMapp to treat Ebola appears to be a success story.
- Clinical research is highly regulated for good reasons. While costly and time consuming, it ensures protection against drug disasters.
- It's possible to over-estimate the likelihood of benefit based on early trials. Fast-tracking could lead to reduction of people willing to take part in double blind and placebo-controlled trials.
- Doctors can be pressurised by patients and families and may feel they are forced to act against their better judgement.

'Towards the end [Dad] was about ready to try anything. …There must be nothing more maddening than dying of a disease when there is a great clinical trial going on that suggests had you developed the disease a year later, you'd be saved.'

'There's a reason for pharmaceutical regulation: drugs can be unexpectedly dangerous. I'm concerned that desperate patients will be harmed as much as helped.'

These were two reactions to news about the 'early access to medicines scheme'[1] which gives patients with life-threatening or seriously debilitating conditions access to medicines that do not yet have a marketing authorisation. Since its introduction in April, Lord Saatchi has submitted a draft bill to the House of Lords, aiming to allow the use of innovative new treatments for cancer and other diseases.[2] It has Government support but is opposed by the BMA, Medical Defence Union and Academy of Medical Royal Colleges, among others.[3]

This debate reflects an increasing struggle between those who support the identification and use of effective and safe therapies through the standard, thorough but lengthy regulatory processes, and others who advocate greater access to promising therapies that are still undergoing efficacy and safety testing.

The recent Ebola outbreak has put a spotlight on the research efforts needed to combat global health threats and emergencies. The novel treatment, ZMapp, has been fast-tracked and appears – so far – to have been relatively successful in the few cases where it has been used.

A report on initiatives to try untested treatments on Ebola patients suggests legal changes are unnecessary.[4] 'Everyone has gone beyond their comfort zone', noted the chief investigator, showing the unease of administering untested drugs in a non-controlled, non-randomised way. However, results are reviewed carefully for risk-benefit, and strict stopping rules apply if the treatments do not drastically reduce mortality. This is a far cry from the very open criteria in the proposed legislation.

UK clinical research is highly regulated; patients' rights and interests are well protected. The increased oversight of drug development is designed to protect the public and ensure all human research is carried out in the best interests of the subjects.

However, whilst being rigorous, drug development is costly and time consuming. Current procedures decrease the risk of drug-related disasters but correspondingly increase costs and delays, thus delaying public benefits from potentially effective drugs.[5]

This is the drive behind the Saatchi Bill. However, its premise – to allow access to medicines before they have passed all standard regulatory processes and trials – raises practical and ethical questions.

Efforts to fulfil desperate hopes of extending life are understandable, particularly if the patient takes full responsibility for the consequences and no one else is harmed. However, using investigational drugs outside of clinical trials is not straightforward.

1. Drugs in the early phase of development may not only lack efficacy but may be more risky than preliminary data shows

It is estimated that only 5% of cancer drugs undergoing human testing are eventually approved for human use. Safety problems, lack of efficacy or economic unviability mean many studies fail before phase III testing (after promising earlier tests).[6] The Motor Neurone Disease Association (MNDA) claims only one drug for MND has ever been found to be efficacious in a phase III trial, although dozens more have appeared promising at phase II.[7]

2. Overestimate of benefit from phase I trials

Positive results from early tests can cause patients and investigators to overestimate the likelihood of benefit, and to forget these are experimental, tests, not

therapies. Media coverage claiming greater efficacy of investigational drugs, unsupported by research, can incite premature expectations and raise false hopes.

3. Clinical trials may take longer if patients who could participate are also given the option to have an untested or partially tested drug outside of a study context

If patients with an incurable disorder are offered a new (potential) treatment, they may not want to volunteer to take part in a double-blind, placebo-controlled trial where they might be given the placebo. For a low prevalence disease it could possibly even remove entirely the population of patients available to take part in phase II / III trials.[8]

4. Unbiased and meaningful data outside clinical trials can be difficult to gather, particularly information on efficacy

The rigorous process of protocol-driven data collection, verification and analysis required for clinical trials allows patient and treatment data to be interpreted with a high degree of confidence. This degree of standardisation and control is extremely unlikely in normal day-to-day clinical practice. Allowing access to a drug that has not passed all regulatory controls would likely adversely affect clinical data collection and thus ultimately delay approval and broad availability.

5. Balancing benefit and risk to commercial interests

Reduced trial recruitment and possible adverse reactions before safety trials are completed are a risk to companies. Conversely, advanced exposure to, and use of, new treatments can boost their marketing. Media and public exposure can provide a competitive and economic advantage for companies not just from the publicity generated but also from public pressure on regulatory bodies. This happened after NICE's 2006 decision to refuse funding of Herceptin in some forms of breast cancer, on the basis of low cost-effectiveness. The ensuing public outcry eventually resulted funding being granted.[9][10]

6. Dilemmas for doctors

Doctors can, under pressure from patients or families, be persuaded to provide a new treatment against their better judgment. They may feel they cannot refuse to offer investigational treatments as they could be seen to be removing hope from the patient or lacking compassion.

7. The rights of terminally ill patients to be treated with investigational drugs

The question of personal autonomy and individual rights is at issue here. Demand for access to investigational drugs centres on the right to forgo participation in clinical studies and regulatory protection and to take personal responsibility for the risks entailed.

Ethicist Edmund Pellegrino comments that the principle of autonomy has become absolutised in medicine and in the controversy over access to investigational drugs as well. He believes limits must be put on personal autonomy if it impacts others, for example, if a patient asks for a treatment that the doctor feels is not safe or effective and thus not in the patient's best interests.[11]

9. Will pressure to approve drugs prematurely progressively weaken the authority of regulators?

Granting rights based on personal autonomy may, in the long-term, lead to other 'rights' claims for access to other medicines, substances, artificial devices, or for self-administration, without a doctor's supervision or help. The drafting of the Saatchi Bill would prevent this for now.[12]

10. Informed consent

Informed consent, which can be difficult enough when a body of evidence has accumulated following clinical trials, becomes much more difficult when there is little evidence to support the effectiveness, safety and risk-benefit profile of the innovation.[13]

11. Providing hope

Understandably, seriously ill patients may reach out in desperation for anything that might help, without fully considering the consequences. However, while there is a danger that patients will turn to unproven remedies to restore hope, there is also a benefit to maintaining hope, which may serve partly to justify early investigational drug treatment, regardless of the chances that it will or will not work. Maintaining hope may improve the quality of life for the patient. And of course the drugs may work.

Clearly there are challenging questions here for regulation. Do concerns about the time and costs of the current system of regulation justify exposing patients to the risks of experimental interventions? How would evidence about the safety and efficacy of experimental, innovative, interventions be generated and collected? Under what conditions should evidence generated outside of a clinical trial be considered persuasive?

At the moment, using innovative treatments is a bureaucratic process and there probably should be a cultural shift towards more openness towards, and flexibility with, innovative treatments. The rapid use of the putative Ebola treatment is a good illustration of the fact that, given the political will combined with obvious public need, current legislation already has mechanisms that allow the development and use of innovative treatments. But it remains a rare example.

Research subjects, especially the seriously or terminally ill, are vulnerable and open to manipulation and abuse by the strong, including powerful academic, commercial and government agencies. There are no easy answers, but it is essential to try to achieve a balance between encouraging innovation and drug development while protecting patients.

Pablo Fernandez *is CMF Head of Graduate Ministries and* ***Philippa Taylor*** *is CMF Head of Public Policy.*

The recent Ebola outbreak has put a spotlight on the research efforts needed to combat global health threats and emergencies

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Vicky Lavy in conversation with Professor Sir Eldryd Parry, pioneer in global health

NEW APPROACHES

key points

- Disciplined prayer and Bible study must be the basis of our faith.
- Listening to national colleagues is always better than thinking 'we know best'.
- Creating partnerships yields huge benefits.
- There is a place for mission hospitals but there are many other possibilities for Christians.

'Keep the Lord always before you.' That was Eldryd Parry's answer when I asked his advice for today's junior doctors. I had expected him to talk about a global perspective, or serving the poor, or the importance of teaching. All of these came up in our conversation, but his first words to today's doctors were about priorities in our Christian lives.

'My worry about the church today is that Christians seem to be less distinct – their habits seem no different from everybody else. Take Bible reading. A survey done in a popular local church not long ago found that only a small percentage of the members read their Bibles regularly. I don't know how that's possible – how can faith grow unless it's built on daily prayer and Bible reading? I remember a story about Charles Simeon, a minister in Cambridge in the late eighteenth and early nineteenth century. He often found it hard to get up in the mornings, so he decided to give a guinea to his bed-maker every time he overslept. He soon found he was making the bed-maker rich! So he decided to throw the coin into the river instead. He soon stopped wasting his money and started to be disciplined in his Bible reading. He was greatly used by God.'

Professor Sir Eldryd Parry, KCMG, OBE – to give him his full title – has made a unique contribution in the world of global health. Between 1965 and 1985 he worked in five medical schools in Africa. On return he founded the Tropical Health Education Trust (THET), pioneering new approaches to medical education in developing countries. He planned and edited the seminal textbook, *Principles of Medicine in Africa*, now in its fourth edition.

However, he is a humble, approachable and encouraging man. I first met him while I was doing a course at the London School of Hygiene and Tropical Medicine. I was getting married a week after the course finished and setting off to work in a rural mission hospital in Zambia three weeks later. I told him that friends were concerned about us going away to such a remote place so soon after getting married. 'People can be so boring!' he said, 'I think that's a splendid idea.'

Medical schools in Africa – a new approach to teaching

His life has certainly not been boring. As a junior doctor, he was offered a one-year secondment to Ibadan, Nigeria, and stayed for two and a half. After finishing an MD thesis in London, he was invited to return to Africa to teach Ethiopia's first ever medical students at the University in Addis Ababa. This was the start of 20 years of uninterrupted service in Africa, which later took him to Zaria, then Ilorin in Nigeria and finally Kumasi in Ghana. 'At the beginning, I was just part of a team doing conventional medical teaching. Then in Ethiopia, I had the chance to shape the medical school, and we started doing new and innovative things – getting students into the community, introducing problem-based learning, and trying to relate everything to the needs of the local population. Education should be about stimulating students and bringing out their gifts – getting them to want to learn, rather than teaching them.'

'We didn't realise it at the time, but the experience we had in one place would equip us for the next. At the beginning of each year we would read, as we still do, Deuteronomy 8: "You shall remember all the ways the Lord your God has led you these 40 years. Your feet did not swell and your garment did not wear out." What a beautiful medical metaphor – it's talking about "famine oedema", how God led and provided for his people, just as he has done for us.'

On return to England in 1985 he worked for the Wellcome Trust, creating learning programmes for rural medical officers in Africa. 'I would ask them what they wanted – what they needed in their situation – and they told me. As I travelled around, I realised that Britain's historic responsibility for medical schools was being neglected. After the Second World War, the Inter-University Council for Higher Education Overseas was set up to help new countries build universities. But in the eighties the focus was on primary care – the ink was still drying on the Alma-Ata Declaration – and nobody wanted to know about medical schools. It was a time of great difficulty in Africa – the main streets of Kampala were full of potholes – and when I visited medical schools, I saw no books and no teachers, I saw no interest from Britain, and this was wrong.'

THET – a new approach to aid

Out of this concern for medical education came THET, which became a registered charity in 1989. Initially focusing on facilitating postgraduate training for key individuals, THET has supported over 200 partnerships around the world, linking health institutions in the UK with counterparts in developing countries. Eldryd explained: 'The pattern of aid has so often been "we know what is best, this is what we'll do for you, take it or leave it." THET's philosophy is about responding to what a country identifies as its need. We ask the question "where are you wanting to go and how can we help you to get there?" People were amazed: "We've never been asked what we want before. We've always been told what we need!" At THET we talk less about needs and more about opportunities. Rather than seeing pictures of starving children, we see a vision of people waiting to be trained so they can do a job.'

THET – Tropical Health Education Trust

Pioneering a unique partnership approach that harnesses the skills and knowledge of volunteer health professionals in high-income countries to meet the training and education needs identified by their counterparts in low-resource settings.

Health Partnership Scheme, established three years ago:

- Investing £30 million over six years
- Supporting 85 partnership projects in 26 countries
- 1,000 NHS workers have volunteered with projects
- 25,000 health workers overseas have received training
- Developing capacity of over 100 government and civil society institutions

THET also runs large health workforce capacity building programmes in Zambia and Somaliland.

Find out more at *www.thet.org*

A new approach to mission

I asked Eldryd about the contribution Christians can make overseas. 'I thought I'd be a missionary doctor – everyone did – and my closest friends went overseas as missionaries. But when I wrote to a mission society they weren't interested in me as they didn't feel I had a strong enough "call". The opportunity for Christian health professionals is as great today as it ever has been, but it may be in a variety of different models, often expressing faith in a secular context. Mission hospitals make a great contribution, but they need to operate in conjunction with governments. There are huge opportunities with people at the margins. For example, there's an enormous slum on the edge of Nairobi. Urbanisation wasn't an issue when mission hospitals began, but it is a big problem now – will the church respond? Again, we must consult with the government to find out if they have a plan, and see how we might fit in. Wherever we work, our motto must be "I am among you as one who serves".'

I returned to the subject of Eldryd's advice for today's junior doctors interested in global health. 'Professionally, they've got to be excellent. They should do what they enjoy and what they're good at. These days a postgraduate qualification is almost essential, in order to be able to train others. Take a long-term view; get some early experience by all means, but don't be like confetti, all over the place – get to know a country and stick with it. There's no denying it is difficult with today's rigid training programme. But I still meet wonderful people who say "Never mind what the postgraduate dean says, I'm going to have a go". Those are the people who will do much more with their lives than those who play safe.' Eldryd's own life has been a testimony to that.

Vicky Lavy *is CMF Head of International Ministries.*

Take a long-term view; get some early experience by all means, but don't be like confetti, all over the place – get to know a country and stick with it

Andrew Fergusson shares experience of working with the media

SAYING 'YES' TO BROADCASTING

key points

- An ever-growing agenda of medical issues presents huge opportunities for Christians to work with the media.
- Winning over your audience can be almost as important as winning the argument.
- The status of being a doctor is an enormous benefit.
- Always focus on the main message and keep repeating it.

My phone rang. On the line was a BBC local radio station. 'Would you take part in an upcoming live debate with a pro-euthanasia spokesperson?' This was back in the early 1990s. I had recently taken over from Keith Sanders as CMF General Secretary and was flying solo.

I had joined the anti-euthanasia coalition that became HOPE (Healthcare Opposed to Euthanasia – a forerunner of Care Not Killing). The first question was: did CMF do that sort of thing? The prevailing culture, from our 1949 foundation under Douglas Johnson onwards, said 'No'. Keith Sanders had never been encouraged to broadcast.

I contacted the then Chairman, the late Alan Johnson, Douglas' son, to ask advice. He did not hesitate to say 'Yes'. I panicked, prayed, over-prepared with masses of facts, figures and arguments, and turned up to put on headphones and sit in front of a radio mike for the first time. To my surprise, I enjoyed it enormously; the half hour flew by, and I'd like to think our side was ahead on points by the end.

With that first broadcast CMF began electronically communicating our unique Christian perspective on the ever-growing medical issues that brought Britain's changing culture into the media spotlight. Since then, I have done approaching a thousand radio and TV broadcasts, and I have been asked by CMF's Head of Communications to share some reflections, hopefully encouraging some of you to 'just say Yes' to broadcasting.

What is our message?

This is the critical issue. Sometimes this is obvious and without controversy – on euthanasia, for example, CMF was and is about 99% solid in opposition. For abortion, particularly back in the 1990s, that was much less so, and being a spokesman for an organisation's viewpoint sometimes meant accepting limitations on what I would have preferred to say.

So, a CMF position has to be agreed informally, and here the regular Medical Study Group discussions with more formal endorsement are vital. Then comes the equal challenge of focusing on getting that message across.

How do we get it across?

There is what is called the 7-38-55% rule. Professor Mehrabian's much quoted (and much criticised) research[1] suggests that when two people are communicating face-to-face, only 7% of the message eventually communicated is in the content of the words used. 38% is in the tone of voice, and a massive 55% comes across non-verbally in body language. It is not enough to have an argument, a stunning statistic, a killer soundbite – we have to get that content across and win the audience.

Some general points:

- If possible, listen to or watch the programme in question to get a feel of it, of what works and what doesn't.
- You will probably be the bad guy! The broadcast media are generally liberal, coming from a worldview that does not welcome Christian perspectives, and by definition they are interested in change – 'BMA rejects change in law on euthanasia' is not news.
- Because of this, have as much discussion as you can before (and after) the programme. Try and get that first researcher who phones you at least to see that your arguments have merit, and she will amend the brief she's writing for the producer and presenter. Put yourself in her place; she's probably much closer to the average listener or viewer than you are.
- The media know what they are doing: they are very professional and virtually all have ethical integrity. In almost 1,000 broadcasts I have only been deliberately misrepresented twice, and a drug treatment with only 0.2% harmful side-effects would be a pretty safe treatment... So, try to get them to help you tell your story.
- Which brings us to – use stories. It has been said that 'a single death is a tragedy, a million deaths is a statistic'.[3] Statistics may not work well on radio, and television can if necessary show them visually. But a relevant story to illustrate a broader ethical point always works. Prepare one to use if you get the chance – obviously, don't forget patient confidentiality and be concise. If you are being recorded it may be selected as the perfect illustrative soundbite.
- Keep getting that main message point in – for pre-recordings, the interviewer may well come at you from several different perspectives and choose their favourite, so don't give them ammunition, keep saying it. For live transmission, they can't cut it out so you don't need to keep repeating, but make sure you say it early, first even, because you'll be surprised how quickly the interview goes by!

Here our status as doctors helps enormously. Although public respect is declining, we are still the profession most trusted to tell the truth.[2] Further, on television there will be a caption at the bottom of the screen giving our title, name, and affiliation and the viewer will assume the station has searched far and wide to bring them the leading authority. In fact, it's probably another example of the cliché: 'It's not ability that counts, but availability'! (NB: that expression of affiliation may need very careful negotiation with your employer to avoid unintended consequences of anything deemed controversial.)

Radio

Radio is a great medium, and not only for those of us who are increasingly developing 'the face for radio'! Because of the 7-38-55% rule, 55% of the communication (for me the troublesome part) has already been eliminated. It doesn't matter what you are wearing, you can have notes to hand or if at home have a CMF briefing up on the computer screen, you can sip coffee or water ad lib, and it's much easier to sit back, relax, and enjoy.

Radio is a conversation between two people – you and the presenter, or you and a member of the public on a phone-in. Forget the thousands, the tens or hundreds of thousands who are listening in. This is you in a one-to-one, and most doctors become pretty good at that sort of conversation…

TV

There is usually time for significant preparation for radio – time to search CMF's amazing website, or to phone the office for advice. I say 'usually' – I recently was woken just after seven by a BBC local radio station and without notice was on air three minutes later! But then I sometimes feel I do very familiar subjects on auto-pilot…

However, there is always significant preparation time for television, because they have to get you to a camera or get a camera to you. So, a guaranteed getting ready, but appearance (the 55%) becomes so much more significant. Media staff should give you advice about clothing. If they are filming you in a professional medical context they will know what they want; if in doubt, ask. Look like the sort of doctor you are. Sit or stand comfortably, and don't look at the camera(s) but maintain eye contact with the interviewer. The crew will take care of all the technicalities – stick with your role. As always, get that main message in, again and again if they are pre-recording soundbites, or very early if it's live.

Audit

Get family, friends and colleagues to listen/watch if possible, and get their feedback. Make sure you watch or listen to a recording yourself. Although you'll probably cringe at times, it's an important part of doing it better next time, and you are certain to see at least some of your prayers answered.

Media training

This short article can only touch on some aspects of the benefits and blessings of broadcasting. After I had media training long ago, I found that most of the fear went, and now I almost always enjoy what I do.

CMF has regularly run training sessions for members; I've had the privilege in the past of working with Christian media professionals to train some of you. With developments in digital technology, there are more and more requests for interviews, and CMF's own media department is able to do more and more, more and more easily.

As Christian doctors we have that uniquely privileged opportunity to get our message across. If you're asked, just say 'Yes'.

In retirement, ***Andrew Fergusson*** *is a regular spokesman for the Care Not Killing Alliance.*

As Christian doctors we have a uniquely privileged opportunity to get our message across. If you're asked, just say 'Yes'

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Vicky Lavy talks to three CMF members playing key roles at home and away

David* (7) and Mamie* (4) sit on a bench outside their grandparent's house. Their parents died after contracting Ebola (EVD virus). Save the Children is supporting children and families affected by the Ebola crisis in West Africa. (*names changed to protect identity)

Photo: courtesy of Save the Children/Aubrey Wade

CHRISTIAN DOCTORS ON THE FRONT LINE

key points

- Ebola has triggered a unique crisis: an escalating epidemic of a disease with no known treatment or vaccine.
- It has already taken a toll among health workers. At the time of writing, WHO estimates that 546 health workers have been infected and 310 have died.
- The epidemic is an enormous opportunity for Christian service and Christian ministry and to create links with humanitarian workers of other faiths and none.

Ebola is unique. We have seen some terrible disasters in the past ten years; the Tsunami in 2004, Myanmar's Cyclone Nargis in 2008 and the Haiti earthquake in 2010. Each saw hundreds of thousands of lives lost to extreme weather conditions and the devastation that followed. This current emergency is a different beast – a rapidly escalating epidemic of a disease with no known treatment or vaccine. In March 2014 the WHO reported a rash of 86 cases of Ebola in Guinea, the first ever seen in West Africa. From then until the start of November, the number has risen to 10,000 cases. But the epidemic's exponential growth means we may be seeing 10,000 new cases every week by the end of the year.[1] The Disasters Emergency Committee (DEC) launched an appeal on 30 October 2014 – the first time in its 50-year history that it has done so for a disease outbreak. It seems we are in unchartered territory.

Healthcare workers in the front line

WHO has declared the crisis a Public Health Emergency of International Concern and health workers are in the front line. They are paying a high price – some are unable to go home because their communities are afraid they may bring the disease with them. Many have paid with their lives. At the time of writing, WHO estimates that 546 health workers have been infected and 310 have died. Liberia's President Ellen Johnson Sirleaf paid tribute to them, saying 'they were trained to preserve life, and they gave life.'[2] The three countries affected are some of the poorest in the world that can ill afford to lose health workers. Liberia has only one doctor for every 100,000 people. Sierra Leone's population of six million is served by about 100 doctors, but a number of them have died of Ebola, including the only haemorrhagic fever specialist.

The international community has been slow to respond, but health professionals are now going in greater numbers to help. I interviewed three CMF members who are playing key roles.

Sam: Setting out to serve

I spoke to Sam Dunnet just before she set out for Sierra Leone in early November to work as Staff Health Manager for Save the Children. 'I'll be responsible for the healthcare of all those sent out by the British Government and all the national staff working with Save the Children, and their families. It's probably the biggest job I've ever had in terms of responsibility.'

Sam is no stranger to Africa, having worked in six African countries over the past ten years. She was not planning to return for a while and has been doing a course in cross-cultural mission at Redcliffe

College. 'I saw the advert for the Save the Children job on the CMF International Facebook group and made enquiries. I decided not to go, but the thought kept coming back to me. I was reading through the life of David and was struck by the phrase "At the time when kings go off to war…David remained in Jerusalem." [3] Was I staying at home when I should be going to the battlefield? I was challenged by the story of Abigail, whose brave and timely action averted a disaster. [4] Was God trying to tell me something?'

I asked Sam how she felt about stepping into an epidemic of a deadly disease. 'I'm a bit daunted by the work and responsibility, but I'm not fearful. It says in Psalm 139 "all the days ordained for me were written in your book before one of them came to be." God knows when I will die. Whether it's there or here, my life is in his hands. His purpose for our lives is not to be safe, but to glorify him and share his love with a hurting world.'

Ibrat: Behind the scenes

Ibrat Djabbarov works for Save the Children as a Humanitarian Health Advisor. He has been responsible for recruitment of medical staff for the Ebola crisis. Save the Children received over 750 direct applications in less than two months in response to adverts to work in the Ebola Treatment Centre. 'It's a good response, though it's a huge job to process all the applications! CMF has been very supportive – several members are helping with reading CVs and doing interviews. The calibre of applicants has been very high. Nearly 100 doctors and nurses were already approved by early November and are ready to go some time in the next few months. Our treatment centre has just opened, so we are just getting started with clinical care.'

'It's not been easy as this is a new situation that no one was prepared for; we've had to think creatively and adapt. Even seasoned humanitarian workers say this crisis is unique, with its rapid growth, late response and the risk to personnel. Health systems on the ground have collapsed and we are doing everything we can to ensure our staff's safety while being deployed. Getting good information is difficult – we're learning as we go.'

Simon: Serving those who serve

Simon Clift is the Director of Health Services at InterHealth, a Christian charity providing specialist travel and occupational health services to mission and humanitarian aid agencies. 'We have previously provided services on request to people going out to earthquakes, floods and typhoons. But the health risks of Ebola mean that agencies are coming to us for guidance and training; "What must we do for our staff? What do we need?" We also have a role working with Public Health England to ensure public safety when aid workers return to UK.'

'Little did I know when I took up this post at Easter that Ebola would soon fill my waking (and some of my sleeping) moments. But this is such an opportunity for us to serve not only those in Christian ministry, but also humanitarian workers of other faiths and none. I am passionate about safeguarding InterHealth's Christian identity. As we pray "Your kingdom come on earth as it is in heaven," we seek to make God and his values visible in the world.'

What can we do?

What about the rest of us? What can we do? It's likely that only a few of us will go, but the rest of us can support others, give and pray.

There will be a need for doctors on the ground for months and years to come. While the countries' health systems are collapsing under the strain of the epidemic, babies are still being born, children are still dying of malaria and people are still suffering with TB and other infections. The UK International Emergency Medical Register (UKIEMR) is coordinating volunteers from the NHS and agencies such as Save the Children will be sending staff over the coming months. Those remaining here can support by covering duties and arranging rotas to release others to go. Interhealth needs doctors with overseas experience to support those going, both in their London clinic and working remotely by phone and email.

We can all give – a number of organisations are running appeals. And we can all pray for these nations living in grief and fear, for the health workers battling against the odds, for the thousands of orphans left behind and for our brothers and sisters in the church.

The hope of the gospel

What can the church do? Do Christians have a unique contribution to make? We certainly don't have a monopoly on compassion or courage. Medecins San Frontiers (MSF), a secular relief agency, has been at the forefront of the battle since it began. National churches are playing a vital role in community mobilisation, being present even in remote places, and having leaders who are trusted and respected. More than this, Christians have the hope of the gospel. We know that this life is not all there is, that death is not the end and that our lives are in God's hands. We look forward to the new heaven and earth of Revelation 21, [5] but we also know that God is even now at work restoring our fallen world. We can be co-workers with him as we strive both to fight disease and to hold out the word of life. One day there will be no more death or mourning or crying or pain. [6] There will be no more Ebola. But until then, we must play our part in the fight.

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

Photo: courtesy of Save the Children/Louis Leeson

Sensitisation teams go out into villages and towns to warn people of the threat of Ebola, how to spot someone with the virus, and how to prevent its spread.

I'm a bit daunted by the work and responsibility, but I'm not fearful…God knows when I will die. Whether it's there or here, my life is in his hands.

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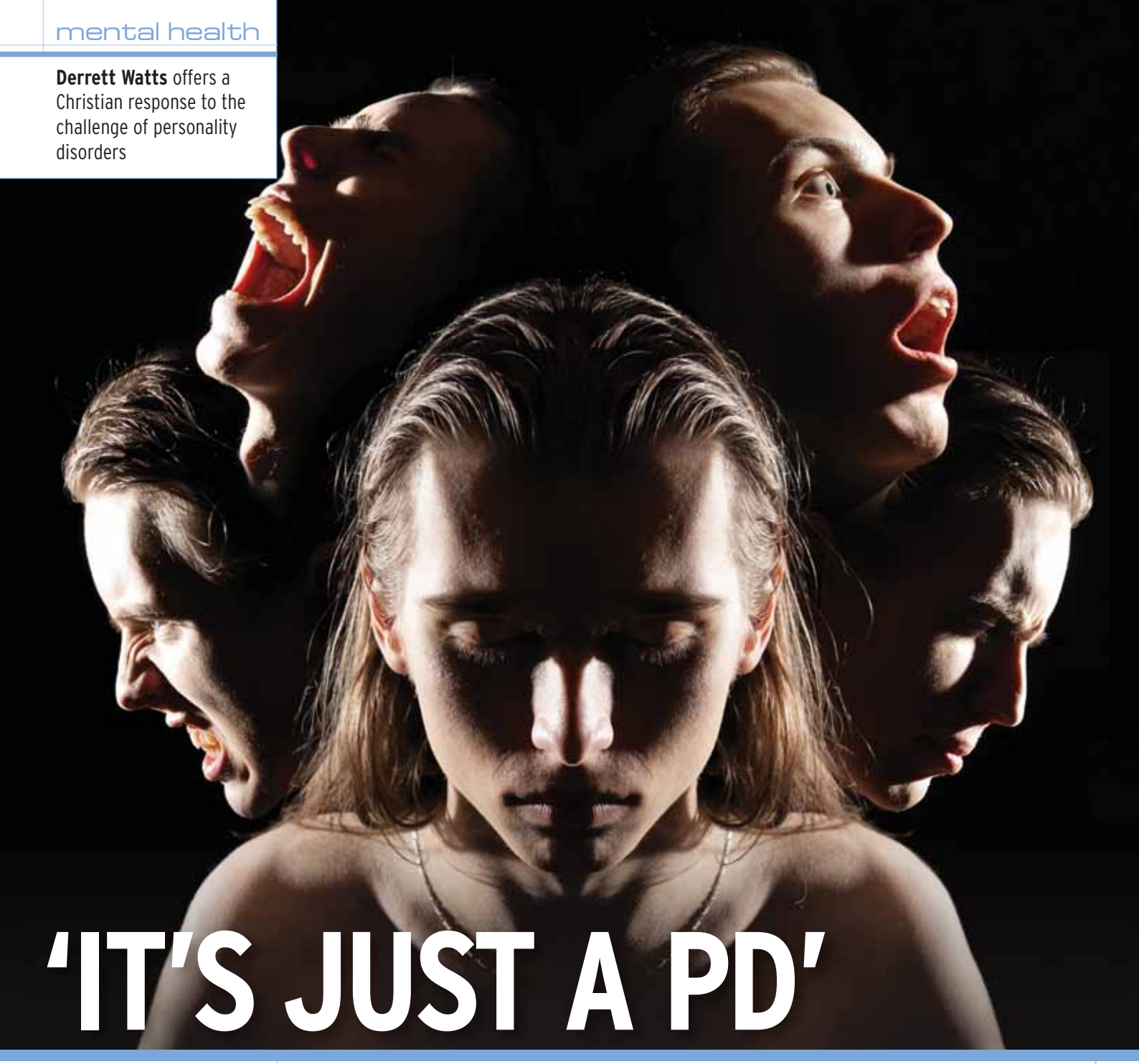
Derrett Watts offers a Christian response to the challenge of personality disorders



'IT'S JUST A PD'

key points

- The concept of PD was known by the ancient Greeks and most recently referred to as 'antisocial personality' (DSM III, IV).
- Depersonalising language is unhelpful and can reveal underlying prejudices.
- The view that PDs were untreatable has altered over recent decades and a range of treatments have shown efficacy.
- Christians believe no one is irredeemable, not least since the work of the Holy Spirit can make people new.

How many doctors say, 'It's just a PD'? This often-used phrase may be heard before or following an assessment when someone presents with psychological distress. Acronyms throughout medicine are legendary, used by all practitioners at some point as shorthand in communication. Rarely would these terms flatter. Worse, they may reveal underlying prejudices which could affect treatment delivery.

Let's stop for a moment and think about the language being used here. 'It's.' This is depersonalising language. 'Just.' This is minimising language. 'A PD.' Here we have a single term being used to amalgamate a range of diverse conditions. Part of the particular challenge personality disorders pose is that this is 'the crux of the mad/bad debate',[1] raising the question of responsibility for actions (madness or badness).

This article explores the recognition and management of people presenting with personality disorders and asks why it may be viewed differently from other conditions. Finally it seeks to examine how Christians might respond.

Definitions

We begin by asking 'What are personality disorders?' The English word 'Personality' comes from the Latin word persona, meaning a mask. Assessing personality involves understanding the mask people portray and the internal processes which influence it. Allport's classic definition puts it thus: 'Personality is the dynamic organisation within the individual of those psychophysical systems that determine his characteristic behaviour and thought.'[2] Various theories describe different aspects of personality development. Freud developed his Psychosexual and Structural Model;

Table 1 (Adapted from Hermann et al, 2013)[3]

Cluster	Type	Description
Cluster A (Odd, Eccentric)	Paranoid Personality Disorder	Pervasive distrust and suspiciousness of other people
	Schizoid Personality Disorder	Pervasive pattern of social detachment and restricted range of emotional expression
	Schizotypal Personality Disorder	Pervasive pattern of social and interpersonal limitations
Cluster B (Dramatic, Emotional, Erratic)	Antisocial Personality Disorder	Pervasive pattern of disregard for the rights of other people that often manifests as hostility and/or aggression. Deceit and manipulation are also central features
	Borderline Personality Disorder	Experience intense and unstable emotions and moods that can shift fairly quickly
	Histrionic Personality Disorder	Pattern of excessive emotionality and attention seeking
	Narcissistic Personality Disorder	Significant problems with sense of self-worth stemming from a powerful sense of entitlement
Cluster C (Anxious, Fearful)	Avoidant Personality Disorder	Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
	Dependent Personality Disorder	Strong need to be taken care of by other people
	Obsessive-Compulsive Personality Disorder	Preoccupied with rules, regulations, and orderliness

Untreatability has gained a sickening hold on academic psychiatry...but the Christian view is that no-one is irredeemable

Piaget: Cognition; Erikson: Psychosocial; and Kohlberg: Moral.

The concept of personality disorder was known to the Greeks. Theophrastus, Aristotle's pupil, identified 30 'characters' (eg dissimulator, distrustful man, unpleasant man). These ideas persisted until around the end of the eighteenth century, when Pinel described '*manie sans delire*' (insanity without delusion). Prichard (1837) spoke of 'moral insanity' – no apparent illness but gross disturbance of behaviour. This led to personality disorder being differentiated from other mental illnesses.

The term 'moral insanity' fell out of use with the work of Koch (1888) and it was replaced by the term 'psychopathic inferiority'. Koch's thought was influenced by Darwinian thinking, suggesting this was due to degeneration of the nervous system. Then in 1935 William White in the USA described 'psychopathy', whilst the UK 1959 Mental Health Act included psychopathic disorders amongst those patients who could be detained. The 1952 version of the *Diagnostic and Statistical Manual* (DSM) included the term 'sociopathic personality disturbance' whilst the 1968 revision used 'antisocial personality,' and this was retained in *DSM-III* and *-IV*.

Core Features

From *ICD-10* and *DSM-IV*, five characteristics can be identified to assist identification of personality disorder: An enduring pattern of *inner experience deviating markedly* from expectations of one's culture. This pattern is *inflexible* and *pervasive*. It leads to clinically significant *distress* and/or functional *impairment*. The pattern is stable, *long-standing*, beginning in adolescence or early childhood. This pattern is *not attributed to another mental disorder or substance misuse*.

Types of disorder

Some ten distinct types are found which may be placed into three clusters as shown above.

Some people may have traits rather than a disorder; they demonstrate some of the behaviours but without interference in daily functioning as for those with a disorder.

Prevalence

The overall prevalence rate for personality disorders is estimated to be 4.4%,[4] rising to 10–12% in primary care, 33% in general psychiatric outpatients and 70% in prisoners.[5] Rates are highest amongst men, separated, unemployed and those living in urban areas. Cluster B, including antisocial and borderline types which cause the most concern, has a prevalence of 1.2%.[6]

Associations

Across the clusters there are increased rates of social and health related difficulties. Cluster A disorder patients are three times more likely to have been in local authority care before the age of 16 years, Cluster B patients are more likely to have had a criminal conviction, been in prison and/or been in local authority or institutional care, and Cluster C patients are more likely to have received psychotropic medication and counselling.[7]

Both borderline and antisocial personality disorders can cause serious impairment and are commonly

Table 2 – Principles of treatment approach (Derived from Kendell et al, 2009)[13]

	Antisocial Personality Disorder (NICE CG 77)	Borderline Personality Disorder (NICE CG 78)
Attitude to Treatment	■ Treatment resisting	■ Treatment seeking
Treatment Agencies	■ Specialist personality teams or forensic service ■ Need effective interagency working with clear pathways	■ Community mental health services responsible for routine assessment, treatment, and management ■ Should not exclude from any health or social care service because of the diagnosis
The role of psychological treatment	■ People in community or institutional care, consider group-based cognitive and behavioural interventions focused on reducing offending and other antisocial behaviour	■ Structured care along with supervision for the therapist ■ Generally avoid brief psychological interventions (less than three months) specifically for borderline personality disorder
The role of drug treatment	■ Offer treatment for any comorbid disorders in line with other NICE clinical guidelines ■ Do not exclude people from treatment	■ Do not use drug treatment specifically for borderline personality disorder or for associated individual symptoms or behaviour ■ Use for short term in crisis periods ■ Avoid polpharmacy
Treatment Approach (to both)	■ Open, engaging, and non-judgmental manner ■ Be consistent and reliable	

associated with depression and anxiety.[8] Conditions such as opiate and alcohol dependence, and PTSD are strongly associated with Cluster B disorders, whilst Obessisve Compulsive Disorder and Social Phobia is likewise linked to Cluster C disorders.

Some 8% of all people committing suicides in England were found to have a primary diagnosis of personality disorder, rising to 18% for under 25 year olds. Some 73% were found to have a co-morbid psychiatric disorder, most commonly alcohol dependence/misuse (43%) or drug dependence/misuse (32%).[9] Aetiologically, the association with events in childhood is strong. Borderline personality disorder is 'all too often the late result of significant harm to personality development from neglect, abuse or trauma in childhood'.[10]

What treatments work

The view that personality disorders were untreatable has altered over the last 20 years, with increasing evidence for interventions.[11] A range of psychological treatments treatments have shown efficacy including: Psychodynamic Therapy; Cognitive Behavioural Therapy; Dialectical Behaviour Therapy; Therapeutic Community; Cognitive Analytic Therapy; Behaviour therapy and Nidotherapy.[12]

Respecting the particular concern for Cluster B, NICE guidelines have been issued for antisocial and borderline personality disorders, and are summarised in Table 2 above.

A subsequent Cochrane review has suggested a more expanded role for medication, particularly, mood stabilisers for symptoms such as affective dysregulation and impulsive-behavioural dyscontrol.[14]

The Christian Response

Rick Warren, pastor of Saddleback Church, California, whose son suffered from Borderline Personality Disorder and depression and committed suicide in 2013, stated in his first sermon following this event that 'God is calling us as a church to remove the stigma of mental illness.'[15]

Borderline Personality Disorder has 'a stigma associated with it that goes beyond those associated with other mental illnesses', and this may cause practitioners to minimise symptoms[16] ('It's Just a PD') and distance themselves, reducing the likelihood of therapeutic success. The previous views of therapeutic nihilism as discussed above have added to this.

Dr Bob Johnson, speaking from experience of working in prisons, stated that 'untreatability has gained a sickening hold on academic psychiatry ...but the Christian view is that no-one is irredeemable...'. He felt that the attributes required for successful therapists are patience, firmness, discernment and empathy.[17]

Clearly these attributes are not restricted to Christians, but the difference is that for Christians, they will be present because of God working within us – the fruit of the Holy Spirit[18] – rather than our own ability. We can say with Paul, 'I can do all things through Christ who strengthens me.[19] The hope is that 'a Christ-like approach invoking the compassion of the Servant King and the power of the Holy Spirit may help to engage the damage person who is barricaded behind his mental defences.'

The gospel speaks relevantly to the situation of persons struggling with their sense of self: be it lost altogether, disordered or overtly strong (manifesting in antisocial traits). Christians witness to the liberation that comes through discovering personal identity in Christ, and thus being made new. Herein is an opportunity for the church in mission.

Derrett Watts *is a consultant addiction psychiatrist at the Edward Myers Unit, Stoke-on-Trent.*

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Peter Pattisson reports on the 15th ICMDA World Congress in Rotterdam

KALEIDOSCOPE OF CULTURES

In 1963, the first International Congress of Christian Physicians (the forerunner of ICMDA) was held in Amsterdam with 80 delegates from a dozen countries. In July 2014 the jubilee congress was held in the Netherlands again – this time in Rotterdam – a year late for the jubilee for logistical reasons.

In 1963 the participants were predominantly senior, male and white. In 2014, the young (students and junior doctors) outnumbered the seniors, and there were probably more ladies than men, coming from every ethnic group under the sun. There were more than 800 delegates from 80 different countries around the world.

One Spanish doctor, who had been in Amsterdam as a young man, was able to attend the congress at Rotterdam. 200 delegates from financially difficult backgrounds received bursary help towards conference costs and/or travel. CMF members contributed almost £25,000 to this fund; the impact of this investment will be felt for many years to come.

Dutch organisation and hospitality were superb and the organising committee arranged for those who wished to be accommodated in Dutch homes. As well as reducing costs this was an excellent way of integrating delegates from around the world into Dutch life.

The first half of the week, as usual, was for students and junior doctors. They were joined by the seniors for the main congress in the second half of the week. I attended only the main congress, so my reflections are limited to that time. Here are a few highlights.

Morning Bible readings in Titus were taken by Andrzej Turkanik. Andrzej, originating in Poland but now living in Austria, has wide international experience and his straightforward exposition of the text unfolded its relevance for Christian doctors in the contemporary world. A recurring theme was summed up in the apostle Paul's closing words, 'Let our people learn to devote themselves to good works, so as to help cases of urgent need, and not be unfruitful' (Titus 3:14). It was apparent that there were many in the conference coming from situations of 'urgent need', instability and intense pressures. The word of God was nourishment and strength to many such.

Each of the three plenary lectures carried its own poignant message. Wednesday was a day of national mourning in Holland for those lost on flight MH17. Gisela Schneider, a specialist in HIV/AIDS care, spoke of the colleagues she had lost on the flight – colleagues en route to an HIV/AIDS conference in Melbourne. We stood for a silent minute of remembrance and respect.

On Thursday John Wyatt, speaking in part on the current attempts to change UK law over assisted suicide, showed pictures of two archbishops who had decided to support a change in the UK law – George Carey on the basis of a misplaced compassion and Desmond Tutu on the grounds of unbalanced autonomy. Compassion and autonomy, said John, are the two key areas of debate.

On Friday Issam Raad spoke movingly from his own Lebanese background and current involvement across the Middle East of the plight of Christians throughout that region, notably in Syria and Mosul, Iraq. I attended a seminar led by an Egyptian doctor. She spoke of the huge impact that Christians had made in the turmoil of Egypt through their loving care of the injured and through peacemaking – something that we hear very little of in our Western media.

The other seminar that I attended was given by a doctor from a large country represented for the first time at an ICMDA World Congress. It was moving to hear his account of 200 years of Protestant Christianity and missions in his country and of their determination to disciple the young generation of Christian doctors and to take the gospel to the as-yet-unreached parts of the world.

Friday night saw the traditional three hour marathon of an international night; such a kaleidoscope of cultures, each with something to contribute, each with something to be proud of; yet, realistically, each still tainted with sin. One day they will stand before the throne 'from every tribe and people and language and nation' (Revelation 5:9) without sin. Until then 'Let our people learn to devote themselves to good works … and not be unfruitful'.

***Peter Pattisson** is a retired GP and former ICMDA Eurasia Regional Secretary.*

Michael Bryant has advice for juniors who struggle to connect with church life

JUNIOR DOCTORS AND THE LOCAL CHURCH

Why is it that junior doctors find it hard to become part of local church life? It should not be like this. Paul tells us that the church is God's way of showing his wisdom.[1] Church is the only place where an eclectic mix of people from all walks of life comes together with one big focus, Jesus Christ.[2]

Yet so often, young doctors struggle to become actively involved in church. The pressures of long hours, often including weekends and nights, can lead to doctors missing out on vital fellowship. Add to that the constant stresses of relocation between cities and it is easy to see how junior doctors may lose touch with church.

Ironically, this is the stage of life where doctors need most support. The obvious temptations of medical school increase on graduation, with many young doctors finding themselves with less accountability, increased spending power, as well as the chance to reinvent themselves in new surroundings. We are sitting ducks for the tsunami of jaded frustration so prevalent in the NHS, which runs contrary to the joy found in Christ. It saps not only enthusiasm for work but passion for the church.

Take the initiative

So what can be done? It is vital to take the initiative from the start. When I first moved to Swansea, I met with the pastor of our church. I explained my emergency department rota before coming into membership. This led to my being hugely blessed by an assistant pastor. He realised that I was working on most of the evenings when the church discipleship course was running and he was able to take time out to meet with me individually. It enabled me to catch up on teaching often at unusual times between shifts. One bonus was that I went into tiring shifts spiritually encouraged.

Offering to serve when you can, perhaps in ways which don't necessarily involve strict weekly commitments, can be a huge step towards making your church feel like it's a home. The more time you invest, the easier it is to become a 'living stone'[3] within the body of Christ and as such other Christians will take time to invest in you. This will help you to see your medical career in its proper context, rather than all-consuming.

The culture of mobility in operation throughout training has special problems, like friendships falling apart before they are fully formed. There is, however, another perspective. All Christians are aliens and strangers in this world.[4] Many first-century believers were people on the move. For example it is estimated that Paul travelled over 10,000 miles on the missionary journeys recorded in Acts, spurred on by his calling to proclaim the gospel.[5]

> We are sitting ducks for the tsunami of jaded frustration so prevalent in the NHS

As junior doctors on the move, it can be helpful to see each new stage as God sending us out to share the gospel and be a blessing to other Christians. Timothy was sent by Paul to be an encouragement to believers in Thessalonica.[6] When looking to move to a new city, it may be helpful to pray with the leaders of your current church. Ask if there is a church they would recommend where your gifts can be used. As an example, I have been able to use the experience of being part of a church plant in my current church which has a similar vision.

Opportunities

Many junior doctors will have a natural maturity from working with patients at the end of their lives. That can be a blessing to a church. My wife and I have been able to apply this into a hospitality ministry where we have been able to comfort and encourage younger believers, simply by using the listening skills practised every day in work.

Many young doctors often begin to ask questions about God as they start work, coming face to face with mortality for the first time. Answering these questions with the truth found in Christ is far easier when there is a church that non-Christians can feel welcomed into. So for the sake of reaching our colleagues with the gospel, as well as our own growth, commitment to a local church is vital.

***Michael Bryant** is a junior doctor in Swansea.*

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Catherine Butcher recounts the stories of self-sacrifice of two Christians in the Great War

NO GREATER LOVE

Greater love has no one than this: to lay down one's life for one's friends.'[1] These words are quoted often at events commemorating those lost in war. Here are stories of two Christians in the Great War who knew the greater love of Jesus; love that extends to their neighbours and even to their enemies.

Captain Noel Godfrey Chavasse (9 November 1884 – 4 August 1917) was a medical doctor and British Army officer in the Great War, one of only three people to be awarded a Victoria Cross twice. He graduated from Trinity College, Oxford, in 1907 with first class honours, and went on to study medicine under the eminent orthopaedic surgeon Sir Robert Jones. He passed the Fellowship of the Royal College of Surgeons examination in May 1910 and registered as a doctor with the General Medical Council in July 1912. In early 1913, Chavasse was accepted by the Royal Army Medical Corps (RAMC) and joined the Territorial battalion of the King's (Liverpool Regiment), the Liverpool Scottish.

On 1 November, 1914 when Chavasse left with his battalion for France, he wrote to his father, the Bishop of Liverpool: 'Goodbye my dear father. I am going to do my best to be a faithful soldier of Jesus Christ and King George.' He quickly gained a reputation for special commitment to his men. It was unusual for medical officers to do the dangerous work rescuing the wounded. But often Chavasse would work in surgery all day then to go with the stretcher bearers into No Man's Land at night, leading the way while exploding shells and bullets whistled around their ears.

Towards the end of July 1916, Chavasse's battalion was sent to the trenches of the Somme. On 8 August, under a hail of machine gun fire, the battalion of 600 soldiers was devastated. Twice wounded by shell blasts, Noel kept working. He went to within 20 metres of the German front line to rescue three wounded soldiers resulting in his first Victoria Cross. The citation reads: 'His courage and self-sacrifice were beyond praise'.

After he recovered, similar sacrificial action in the offensive at Passchendaele gained him a second VC. The second citation reads: 'Though severely wounded early in the action whilst carrying a wounded soldier to the Dressing Station, Capt. Chavasse refused to leave his post, and for two days not only continued to perform his duties, but in addition went out repeatedly under heavy fire to search for and attend to the wounded… By his extraordinary energy and inspiring example, he was instrumental in rescuing many wounded... This devoted and gallant officer subsequently died of his wounds.'

Commenting on his death, Noel's father said: 'He followed his Saviour so closely in his death, and literally laid down his life for his men.'

Self-sacrifice was the hallmark of Nurse Edith Cavell's life. Edith was executed on 12 October 1915 for enabling around 200 Allied soldiers to escape to neutral territory, but her care had extended to German and Allied soldiers alike. Edith understood that Jesus' greater love commands us to love our enemies as well as our neighbours and friends. As she took communion for the last time, the minister with her said, 'We shall remember you as a heroine and a martyr.' She replied, 'Don't think of me like that. Think of me as a nurse who tried to do her duty.'

Edith Cavell was born near Norwich in 1865. The daughter of a Norfolk vicar, and a devout Christian, she was accepted for training at the London Hospital under Eva Lückes in April 1896. In the summer of 1897, an epidemic of typhoid fever broke out in Maidstone. Six of Miss Lückes' nurses were seconded to help, including Edith. Several other nursing posts followed as Edith gained experience as a Night Superintendent, Assistant Matron and Matron. She was often seen praying at patients' bedsides.

As a fluent French-speaker, her skills came to the attention of Dr Antoine Depage, one of the founders of the International Surgical Society (1902–1912). In 1903 he founded a surgical institute and Edith became its head nurse, pioneering the training of nurses in Belgium along the lines of Florence Nightingale. The pioneer training school on the outskirts of Brussels was formed out of four adjoining houses and opened in October 1907. By 1912, Edith was providing nurses for three hospitals, 24 communal schools and 13 kindergartens. When Germany invaded Belgium in August 1914, Edith was visiting her mother in Norfolk, but decided to return to her work: 'At a time like this,' she said, 'I am more needed than ever.'

Her clinic became a Red Cross hospital with German and Belgian soldiers receiving the same attention. When Brussels fell, 60 English nurses were sent home but Edith remained. In the autumn of 1914, two stranded British soldiers found their way to the training school and she sheltered them for two weeks. Others followed and Edith helped them to escape to neutral territory in Holland. She was trained to protect life: 'Had I not helped,' she said, 'they would have been shot.'

By August 1915 a Belgian 'collaborator' had passed through Edith's hands and the school was searched. Two members of the escape team were arrested on 31 July 1915. Five days later, Nurse Cavell was interned, and was tried and sentenced to death for treason ten weeks later.

A German Lutheran prison chaplain gained permission for an English Chaplain to visit her on the night before she died. They repeated the words of 'Abide with me' and Edith received Communion. She said, 'I am thankful to have had these ten weeks of quiet to get ready. Now I have had them and have been kindly treated here. I expected my sentence and I believe it was just. Standing as I do in view of God and eternity, I realise that patriotism is not enough, I must have no hatred or bitterness towards anyone.'

She was executed by firing squad the next morning.

***Catherine Butcher** is a freelance writer based in Sussex. Her biography of Edith Cavell will be published by Lion in 2015.*

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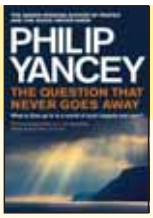


The question that never goes away

What is God up to in a world of such tragedy and pain?
Philip Yancey

- Hodder, 2014, £9.99, Pb 160pp, ISBN 9781444788556
- Reviewed by **Eve Thangaraj**, intercalating medical student and CMF student volunteer

Shoving sweeping statements and apologetic commiseration aside, Philip Yancey follows up his bestselling book *Where is God when it hurts?* with a very different approach to pain than we routinely encounter. In this book, he chooses to travel through the 'land of suffering' and tell us what he's learnt. It is an approach that is inviting from the outset as the reader pictures him not as someone wise speaking from a podium at a seminar about grief, but as a fellow traveller on the road of suffering that has in some way marked and scarred us all. His candour and his unwillingness to simply 'solve' pain would likely strike a chord deep in the heart of someone coming to terms with incomprehensible pain.

The title itself makes it very apparent that he knows this question doesn't just 'goes away' with an easy answer. He relates his encounters with people who have experienced unmitigated misery – from natural disasters to terminal cancer – and remarkably distils their experiences to show us God at work in their lives. He reminds us that as short-sighted and fallible humans, 'we're concerned with how things turn out; God seems more concerned with how we turn out' and that 'pain redeemed impresses more than pain removed'. It is challenging read, whether you're in the midst of suffering, helping someone through it or exploring big questions.

Inspiring hope: *Helping churches to care for the sick*

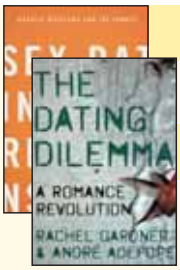
Dr Jane Bates

- EMMS International, 2014, Pb 76pp, Free PDF from emms.org or hard copy £5, ISBN 9780992661908
- Review by **Mhoira Leng**, palliative care consultant, Makerere University, Uganda

This helpful, practical and innovative book encourages churches to engage more fully and effectively in palliative care. The introduction reminds us 'We are called to build God's kingdom, spreading Jesus Christ's good news of love, forgiveness, salvation and hope, through the power of God's Spirit at work among us'.

The book has an African focus where up to 40% of healthcare is provided by faith-based organisations. While most relevant to a sub-Saharan African setting, it also has important messages and resources for churches everywhere. The author, Dr Jane Bates (a CMF member), demonstrates her experience of working in Malawi as a palliative care physician and also draws on many examples of church engagement.

The book was commissioned by EMMS, which, along with others, is promoting and supporting palliative care based on Christian values. Inspiring Hope covers the background to palliative care, outlines the source of our inspiration as Christian communities to engage and provides relevant stories, practical resources and helpful references. I recommend this as a tool to empower the Christian community to address the twin imperatives of seeking justice for the vulnerable and reaching out with compassion and a message of hope; being the love of Christ in this world.



Sex, dating and relationships: *A fresh approach*

- By Gerald Hiestand & Jay S Thomas
- Crossway, 2012 £7.55

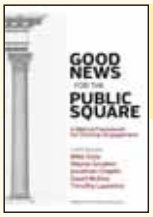
The dating dilemma: *A romance revolution*

- By Rachel Gardner & Andre Adefope
- IVP, 2013 £8.99
- Reviewed by **Laurence Crutchlow**, CMF Associate Head of Student Ministries

Both these books are helpful. Though reaching similar conclusions, the approach taken differs markedly.

Sex, Dating and Relationships could be recommended for its opening chapter alone. A challenging and refreshing exposition of sex as an expression of the gospel sets the book's tone. Arguing that the Bible defines three 'categories' of relationship – family, marriage, and neighbours – dating relationships are placed firmly in the 'neighbour' category, leading to advocacy of 'dating friendships'. However, there is a risk of assuming a biblical example always constitutes a biblical command (which I was not fully convinced these categories do).

The Dating Dilemma is, on the surface, more supportive of modern society's view of dating and relationships; current practice is to be redeemed and improved, rather than torn up entirely. It is intensely practical, and also strong on putting God at the centre of all the things we do, encouraging us to date differently. The theological approach is quite different to *Sex, Dating and Relationships*, but the underlying 'answer' is not so different beneath the very different terminology.



Good news for the public square

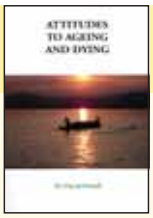
A biblical framework for Christian engagement
Edited by Timothy Laurence

- Lawyers' Christian Fellowship, 2014, £8.99, Pb 126pp, ISBN 9780950645438
- Reviewed by **Steven Fouch**, CMF Head of Nursing

Christian political and social involvement has a long and rich history, but leaves many believers today confused. Some churches' teaching and some secularists' campaigning have left many Christians asking if we should engage with the public square at all, let alone why and how we should.

This theologically and philosophically dense but concise book seeks to give a broad framework to address these questions. Distilled from lectures organised by the Lawyers' Christian Fellowship, it sets out the four sides of the public square as 'public authority', 'public truth', 'public good' and 'public hope'. In these four dimensions the divine mandate to governments and authorities are biblically explored, and the limitations of these mandates and the deeper reality of the gospel's implications for conduct of the church and individual Christians are made clear. The focus is Christ as King, the supreme authority under which all human and spiritual authority is delegated, and what this means for our own engagement with the public square.

This could come across as quite abstract, so there is an attempt to illustrate these concepts with historical examples. The book comes alive at these points, and could have done not only with more examples, but with more contemporary ones. Overall, this is a good starter for anyone wanting to think biblically and critically about public debate around contemporary issues.



Attitudes to ageing and dying

Dr David Powell

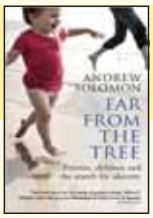
- Powell Charity Trust, 2013, £7 (from cmf.org.uk), 216pp, ISBN 9780956233622
- Review by **Mark Cheesman**

A thoughtful and perceptive book on the subject of our later years and our deaths. Movingly discussed by David Powell, a godly man remembered by many old Cardiff CMF students with much affection. He says he was 82 on starting this book: would that more older Christians wrote out their wisdom for us! I am now 60 and on some points I think differently; no doubt 40 year olds will disagree with me on some things. It was ever thus, and maybe should be.

Christians remain remarkably uncomfortable when talking about death. It should not be so. David displays a formidable grasp of the uncertainties and difficulties found in the real world, which often does not turn out as it 'should'. This is so much better than the slogans one sometimes hears from campaigners. Humans are precious, souls are immortal, relationships are paramount, God is good. Heaven is real, we're going there, and being with Christ, in life or death, is what matters. Excellent.

David goes through many of the cases which have hit the headlines, with a godly scrutiny and a kind heart. Sometimes there is a clear direction, other times it is honestly really difficult to know what's best. He covers a wide and demanding subject with gentleness and skill.

This is a good read, particularly for Christian doctors and campaigners. In particular, I found the last chapters on the Christian's future really uplifting.



Far from the tree

Parents, children and the search for identity
Andrew Solomon

- Scribner Book Company 2012, Pb £8.50 962pp, ISBN 9780743236720
- Review by **Anne Parfitt-Rogers**, a foundation year 1 doctor in Tayside

What defines disability? In this wide-ranging book, the prolific author and psychology lecturer Andrew Solomon – himself the father of a disabled child – explores the lives of hundreds of children who don't fit the mould. It shows how having an apple that falls 'far from the tree' can be a life-changing experience, from gifted offspring to dwarfism and deafness to multiple physical disability.

From beginning to end it is a long read, but as each chapter includes many different anecdotes and life stories, busy readers can dip into the work without losing its meaning. Award-winning author Solomon is bold in exploring the heart-break and struggles that occur, speaking to families from around the world and not shying away from describing their views and feelings.

At times the stories become very challenging, but the tenacity and honesty of people interviewed makes this a very human work, giving a voice to people not often heard as well as more well-known contributors. Although not specifically a Christian book, it delves deeply into spiritual themes, such as finding a path through suffering and how we value individuals in society today. This book casts a fresh view on disability and is an eye-opening read.

Just the two of us?

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

- IVP, 2010, £7.99, Pb 160pp, ISBN 9781844747481
- Review by **Rev Dr Jason Roach**, Co-author of Facing Infertility, CMF

Perhaps the most helpful people on the hard road of suffering are those who both know God deeply and can understand our struggle deeply. *Just the two of us* amply supplies both. Eleanor Margesson and Sue McGowan have blessed the church with this beautiful word to those struggling with childlessness.

Their message reads like a modern day Psalm 13. The psalm begins by honestly crying out 'How long O Lord?' and yet also declares a deep trust in God's steadfast love. Margesson and McGowan begin similarly, by connecting with the pain of infertility. Section one asks questions like 'why me?'. Section two deals with how to cope with: stresses about identity, others' expectations and grief. Section three considers fertility treatment and adoption. The final section addresses how we can adjust to the changed expectations of married life.

Three things make this book particularly helpful. First, real people's stories constantly remind the reader we really are not alone in this struggle. Second, the authors build reflection into the book by suggesting things to read, do and chat about. Thirdly, all this is coupled with a wonderfully accessible weaving of the deep truths of the Christ's suffering, control and love into every chapter. Anyone who reads this book will not fail to feel understood, loved, helped to persevere and equipped to comfort others.

At the end of the day

Church of England perspectives on end of life issues
Brendan McCarthy, Mia Hilborn, Mike Hill, James Newcome

- Church House Publishing, 2014, £12.99, Pb 116pp. ISBN 9780715144534
- Reviewed by **Andrew Fergusson**, Care Not Killing Alliance

This is an excellent review of the approach Christians should take when considering ethical and pastoral issues at the end of life.

Brendan McCarthy's introduction starts with core beliefs, from which guiding principles are derived, and these lead to particular policies and practices. Those who don't necessarily hold our core beliefs should nevertheless support most of these guiding principles and their consequences. Core Christian beliefs are: God as life-giver, Trinity, incarnate, redeemer; and concern for justice and community. These lead, in order of priority, to affirming life, caring for the vulnerable, building a cohesive and compassionate community, and respecting individual freedom. Note that autonomy comes last!

Bishop Mike Hill applies this framework to opposing physician-assisted suicide. James Newcome, current lead bishop in the Lords for health issues, follows with a comprehensive review of organ donation, emphasising the importance of gift; and Mia Hilborn, who chairs the Chaplaincy Leadership Forum, describes the end of life roles and responsibilities of the church in NHS healthcare.

What a pity George Carey and Desmond Tutu hadn't taken these truths on board before their recent misjudged pronouncements supporting assisted suicide.

eutychus

General practice crisis deepening

We recently drew attention to the deepening crisis for general practice (see 'Primary Care in Crisis' *Triple Helix* Summer 2014). According to the Royal College of General Practitioners, while nine out of ten patient contacts within the NHS are managed by general practices, just 8.39% of the overall budget for 2012–13 NHS was targeted to general practice. That is down from 10.95% in 2005-06. No surprise, then, fewer doctors want to be GPs. It's all part of two bigger questions: what is the NHS for and is the current funding model fit for purpose?

RCGP media release, 27 September 2007 *bit.ly/1rSFFIk*

Locked in police cells

Too many people with acute mental issues end up in police cells. Full wards, staff shortages, or drunkenness are some of the reasons why, says the Care Quality Commission (CQC). In some areas there are good emergency facilities for mentally ill people but standards are not universal. Between 2012 and 2013, 21,814 people were detained by police under Section 136 of the Mental Health Act. Police cells are not appropriate and people feel they are being 'punished for being unwell', said the charity Mind.

BBC Health, 22 October 2014 *bbc.in/1yXogWu*

Binge drinking and pregnancy

Women who binge drink and later find themselves pregnant are increasingly seeking abortions, scared their babies will suffer foetal alcohol syndrome (FAS). For the British Pregnancy Advisory Service (BPAS) this is a misapprehension: isolated incidence of binge drinking, it insists, causes 'minimal' damage to babies. There are no UK statistics to back up this claim, but in the USA 0.2 to 1.5 cases occur for every 1,000 live births. Eutychus would want to say the moral of the story is this: eliminate the worry altogether, never binge drink.

BPAS media release, 3 October 2014 *bit.ly/1tDhwd2*

Pill to help drinkers quit

Still on the subject of alcohol misuse, health officials have approved a once-a-day pill that is claimed will help alcoholics stop drinking. Nalmefene is already used in Scotland and reduces the 'buzz' drinkers get. That 600,000 people stand to benefit from the drug says a lot about the scale of alcohol misuse in England. Treating that number of people would cost about £600m a year, according to the National Institute for Health and Care Excellence (NICE). That's probably a fraction of the real cost of alcohol abuse in England, but is this good medicine? A pill will not address underlying issues that shape alcoholism.

Guardian, 3 October 2014 *bit.ly/1vCyt7T*

Children and suicide

ChildLine, the telephone counselling service, reports a frightening increase in consultations with children talking about killing themselves, up by 116% in 2013–14 compared to the previous year. Most of the children involved were aged between 12 and 15. Sue Minto, head of ChildLine, blamed social media. Youngsters, she said, were finding it hard to escape from cyber bullying. Today's children 'live in a highly pressurised world where the internet never sleeps and even if they turn off their phone, it's still there waiting for them.'

BBC News, 31 October 2014 *bbc.in/1nV5viG*

Forgotten souls

Complex emotions come into play when people are faced with taking possession of the ashes of a loved one. The National Association of Funeral Directors (NAFD) has published new guidelines about care of unclaimed ashes. Cremation is increasingly an option in the UK, but surprising numbers urns containing ashes go uncollected – seemingly forgotten. One funeral director in Southampton reports he has 405 sets left unclaimed. Another has ashes dating from 1910. The NAFD says the profession feels 'a deep sense of duty', hence a reluctance to throw away human ashes.

National Association of Funeral Directors *bit.ly/1wFVzLr*

Dementia deaths among women

New figures from the Office for National Statistics say dementia is the leading cause of death among elderly women in England and Wales. This disease is now associated with three times as many deaths as breast cancer, and many more than either heart attacks or stroke. These figures do not necessarily point to an upsurge in dementia: doctors, clearly, are becoming more aware of dementia and are recording it more frequently on death certificates, although it is an underlying cause of death, not a primary one. In many cases pneumonia carries off a big proportion of dementia sufferers.

Office for National Statistics *bit.ly/1tinPBr*

Ebola and duty to care

Are health workers obliged to put themselves on the line to help Ebola patients? Yes, says the president of the World Bank: they have taken an oath to help patients. No, says Canadian medical ethicist Dr Daniel Sokol, who opines it's not unrealistic to expect some healthcare staff to refuse to go to work in places where Ebola patients are being treated. 'If several cases of Ebola emerged in the UK, it would be naive to assume that no healthcare worker would refuse to work,' he says.

BBC News, 29 October 2014 *bbc.in/1wDpz9V*

Many hepatitis C carriers unaware they have it

Public Health England says one in five people with Hepatitis C don't know they have it. The same report says 90% of the 13,570 diagnosed with the disease injected drugs like heroin, cocaine and amphetamines. Two in five drug takers using needles had Hepatitis C, but half were unaware of it. Over 200,000 people in Britain have the infection, with sharing needles a prevalent cause of its spread. Dry blood spot testing which does not puncture veins (difficult in regular needle users) is proving a useful new alternate method for detection.

Public Health England, 5 November 2014 *bit.ly/1E5KaVE*

Tall tales

An Edinburgh study involving 220,000 people released in November, suggests short men are more likely to die from dementia than taller men. Men 5ft 5 inches or shorter were 50% more likely to develop and die from dementia than those 5ft 8 inches and taller. Being tall, particularly in men, seems to be a valuable biological characteristic. Height, says the study, is an important indicator of development difficulties in children, such as stress and malnutrition.

Daily Telegraph, 3 November 2014 *bit.ly/1wZqjad*

Ruth Eardley muses having attended a secular funeral

IT SOUNDED LIKE A PRAYER

'We thank you, Tony, for being a loving husband and father. We thank you for being a great doctor and for your holistic approach to healthcare. We thank you, Tony, for your integrity, your compassion, your warmth. We remember your gifts. We thank you for sharing your life with us, your colleagues, friends and family.'

The celebrant, standing sideways behind his lectern, directed his oration to the flower-decked coffin. And no one seemed to think it in the least bit odd. Tony was my friend, a dedicated professional and a convinced atheist. I wondered what he would make of the church imagery imported into his humanist funeral, especially the speech directed to him when he was beyond hearing or knowing. Part of me felt angry at the hypocrisy of it all: 'You think I'm mad, speaking to an invisible God – at least I believe he can hear me!'

This was my first secular funeral and I was expecting it to be different. The spectator aspect was new – no creed to recite, no hymns to sing, no amen to say – but it was surprisingly recognisable. We stood to pay our respects; we bowed our heads. We sat for the poetry readings; a choir stood at the front for a favourite song. And, when the crematorium drapery hid the casket from view, even the horrid rattle of the plastic curtain tracks was familiar. But it was a secular funeral and it was different: God was studiously and deliberately ignored. It was like being in a parallel universe.

God was not acknowledged but he was present, of course, sustaining and upholding the large and appreciative congregation. He was there in the hearts of his people by his Spirit, bringing his word to their minds: 'The fool says in his heart "There is no God."'[1] '"You fool! This very night your life will be demanded from you"... This is how it will be with anyone who stores up things for himself but is not rich towards God'.[2] God was certainly there, looking for the lost and challenging the careless colleagues (some in their NHS uniforms to signify their association with the deceased). How could anyone be unmoved with such stark reminders of mortality?

'That was great wasn't it? Really uplifting!' said a man on the way out. I managed a weak smile.

Many Christians identify with Saint Augustine's confession that 'You have made us for yourself, O Lord, and our hearts are restless until they find their rest in you.'[3] But I am not sure that all unsaved people have a deep gnawing emptiness that longs, even subconsciously, for a relationship with God. A friend told how, while travelling in a clapped out car in Africa, the fuel tank gauge was stuck on 'FULL'. Mile after mile, the oblivious driver boasted about fuel economy whilst the land became more and more lonely and my friend became more and more anxious. Tony was like that driver. In a busy life crammed with challenging work, exciting sports, fantastic holidays and as many hobbies as an intelligent man can reasonably fit into his spare time, his 'life fulfilment gauge' was stuck on full. 'The god of this age has blinded the minds of unbelievers'.[4]

'What did you think of the funeral?' The death of a colleague affords openings for useful conversation. I found myself having brief but unexpected chats about life, suffering and the meaning of it all with receptionists, nurses, managers and doctors – some were over refreshments following the service but many later at the photocopier or passing on the stairs. Gentleness and wisdom is needed. 'It was fitting because Tony was an atheist but my prayer was for him to know God and to be in heaven. We do miss him don't we?'

Tony's achievements dwarfed my own – he was a great man and a committed clinician. I prayed with all my might when he was dying that God would be merciful to him.

Are we rich towards God? Is our focus on our life, our work and our attainments? May we know the reality of the gospel injunction to 'seek first the kingdom of God and his righteousness'.[5]

***Ruth Eardley** is a GP in Leicester.*

references

1. Psalm 14:1
2. Luke 12:20-21
3. Augustine's Confessions Book 1, Para. 1
4. 2 Corinthians 4:4
5. Matthew 6:33

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