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The care and cure of modern man and society

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CONTRIBUTORS

Introduction 5

1 A medical perspective on society and our relationship with the Third World

Lewis Mackay, General Practitioner, London, England 6

Dirk van Tetterode, General Practitioner, Holland 8

John Lester, Clinical Assistant, Crewe, England 9

2 Motivation — how to get people to take on the work that needs to be done

Sturla Johnson, Lecturer in Neurology, University of Tromsö, Norway 11

Christiane Garin, Surgeon, Switzerland 15

Elisabeth Hamrin, Research Fellow, Department of Clinical Physiology, Uppsala University Hospital, Sweden 15

Violette Rosset, Nursing Superintendent, Switzerland 17

Berkeley Vaughan, General Practitioner, Australia and India 17

3 Teamwork and how to achieve it

Stephen Lester, Consultant Obstetrician and Gynaecologist, Birmingham, England 19

Elisabeth Hamrin, Research Fellow, Sweden 22

Anne-Marie Gabrielsson, Planning Secretary, Sweden 23

Harry Ferngren, Paediatrician, Stockholm, Sweden 24

Daphne Horder, Dietician, London, England 26

Mary Joan Holme, Senior Physiotherapist, London, England 27

4 Ethical questions at the beginning and end of life

Frances McAll, General Practitioner, Southampton, England 28

Berkeley Vaughan, General Practitioner, Australia and India 28

Karel Gunning, General Practitioner, Holland, President of the World Federation of Doctors who Respect Human Life 29

5 The meaning of life and death

Ulla Qvarnström, Doctor of Philosophy, Lecturer in Pedagogics, University of Stockholm, Sweden 33

Jean Twiss, Edmonton, Canada 37

Marlies von Orelli, Switzerland 38

Conclusion 40

Introduction

Health is of interest to all of us. Many of the issues which doctors and nurses have to face should be the concern of everyone. The medical profession spends a great deal of time dealing with the casualties of a society which needs change. This gives insight and understanding of people's needs which are important to the community.

Basic questions about the meaning and purpose of life often lie hidden behind the conflicting views on many social issues, medical or otherwise. Most people look at life through materialistic spectacles of one tint or another. Whilst this is true of many in the health professions, the daily touch with the deepest and most personal problems of individuals often calls forth different values.

In August 1978 at the Moral Re-Armament conference centre, Caux, Switzerland, during an international assembly, one hundred from all branches of the health professions of several countries gathered. They considered aspects of health care which are all too often glossed over.

This report, compiled from some of the statements made, is offered because the views expressed on some vital concerns of society are rarely articulated and run counter to many of the prevailing trends of society. Above all, it is an attempt to record experiences rather than theory, and to throw the spotlight on to possible solutions to our problems.

Each contribution is a personal view and stands as an essay or comment in its own right, but has been edited under one of five headings:

1. A medical perspective on society and our relationship with the Third World.
2. Motivation — how to get people to take on the work that needs to be done.
3. Teamwork and how to achieve it.
4. Ethical questions at the beginning and end of life.
5. The meaning of life and death.

1 A medical perspective on society and our relationship with the Third World

HOW A GENERAL PRACTITIONER SEES SOCIETY

Lewis Mackay
General Practitioner central London

At the Geneva Assembly of the World Health Organisation in 1968 were doctors from countries where civil war was going on. One of them was proud that the number of cases of smallpox in his land was below 100 that year. His main concern, however, was the thousands of lives lost through hate and what to do with men who only knew how to kill. He himself died a short time later, attacked by thugs at his home.

My medical problems are not mainly to do with hate but with rootlessness and poor relationships.

Thousands pour into London seeking their fortunes or because there is something wrong at home. Some see the notice outside my consulting rooms and come to the door. It is not at all what I was led to expect at medical school — pneumonias, heart attacks, surgical emergencies. These do occur at times but often it is a matter of stress or homesickness. For example, one young man who has been coming frequently was on heroin. He wanted my help to get off it. He has been on a substitute which is less harmful but still undesirable. When I read the report from the psychiatrist who had seen him, it was clear that this man had started taking all kinds of drugs out of dissatisfaction and insecurity. He has a neurotic mother, an absent father and an unhelpful wife from whom he is separated. The problem is not a drug so much as poor relationships.

Another attender is a woman who has been in jail. She steals from shops. She does not want to return to her husband, who is rough with her. She is in a state of fear and hysteria. Another woman has had two husbands and eight children. One died. Six have been taken out of her care because she could not look after them properly. The youngest has been running away from school. She feels her neighbours are unhelpful or hostile. In twenty-three years she has had innumerable social workers looking after her.

Along the street is a hostel for unmarried mothers, supported

by the state. The children are always falling sick. Other patients who need a lot of attention are the old living alone. Sometimes what they need or depend on is a person to care for them selflessly in a way that will not be resented.

These kinds of patients have led me to wonder whether a major danger to society is a slide not just into violence or dictatorship but into disintegration.

A new department has been opened near me to deal with disturbed children. I asked the psychiatrist in charge what the main cause of the trouble was — home, television or what. He described going to the local school — a modern structure of glass and concrete — and asking the headmaster about a particular teacher. The head fished in his pocket and found the name of the teacher on a list. He did not remember who and where the teacher was. Then the doctor went to the teacher to ask what he knew about a particular boy, a problem. The teacher had to refer to a list to recognise who the boy was. When the boy was asked who he was, he said, "I am one of the so-and-so gang". He did not know where else he belonged. Another doctor said one third of the children she saw in her clinic came from broken homes.

Every year two local hospitals admit 3,000 people, mostly young, who have attempted suicide. It seems that some of the girls have taken an overdose at the time that their children might have been born if they had not been aborted.

I don't want to paint only a picture of gloom, but we need to be clear about the direction society will take unless it is run by men motivated by God.

With individual patients, I try to see them as persons who happen to have illnesses, rather than illnesses which happen to be in persons.

The most important point is that they should be in touch with God, sick or well, and find His plan. One cannot change them all at once, but I can ask God for the love and thought to give to them, however successful or otherwise my efforts seem at first. As well as pursuing orthodox, up-to-date medicine, there is the extra dimension of helping patients find what is right for their lives.

One fact is that the more time and care one gives in the right way, the less tension there is or need for pills.

HEALTH AND THE RICH POOR GAP

Dirk van Tetterode
General Practitioner Holland, who recently returned from working in Indonesia

Indonesia is the sixth biggest oil producing country outside the Arab world. Seventy per cent of its exports come from oil and in terms of national resources it is one of the richest countries in the world.

The population of its main island, Java, is eighty-four million. If the USA had as dense a population per square kilometre, then the entire population of the world would live within its borders. I saw a woman in Java carrying wood on her back. It was fuel with which to cook her food, for she was too poor to buy the readily available kerosene. So many villagers do the same that there is a danger that the nation will be de-forested, causing soil erosion and loss of fertile land. Loss of such fertile land coupled with the increasing population is a recipe for increased poverty. Poverty thus creates more poverty. It leads to malnourishment with its accompanying intellectual and physical impairment. Millions of people still live within this vicious circle of poverty, malnutrition, lack of health, leading to inability to work, which causes still more poverty.

Poverty and disease affect 1.5 billion people, or one third of the world's population. Yet the poor are also often without medical help. Switzerland, with a population of six million people, has 11,500 doctors. Upper Volta, with the same number of people, has 150 doctors. Most West European countries have one doctor to 650 people. Upper Volta has one to 55,000, and Ethiopia one to 70,000.

The question is how to motivate people to go where they are needed. Most Indonesian doctors do not readily go to the villages. In India eighty per cent of the doctors work in the cities, whereas eighty per cent of the people live in the villages.

In Sweden and Norway it is difficult to find doctors who are willing to work in the remote areas. In the University of Leiden in the Netherlands, it is quite likely that a modern department for premature babies will have to close for lack of trained nursing staff.

There is a great need for new motivation, for people who want to care for their fellow men. Many overseas students are in Europe. West Germany, for example, has 5,000 Indonesian students. Will they return to their country with a God-inspired motivation to serve, or will they be taken over by the self-centred, materialistic way of life so prevalent in our countries at this time?

John Lester
Clinical Assistant
England
formerly in
western India

An African called Philip Vundla had a dramatic effect on me for I recognised that his love of country was far bigger than my love of career. As a result I, too, decided to live not to do what I wanted but what was needed, and quite early on in our marriage my wife and I found ourselves in India, far from where we had expected to be, for years which were extremely rewarding.

We met a very fine medical couple named Arole who are doing excellent work in the villages in a certain area of India. They asked the villagers what their five greatest needs were. Health was not one of them. They were, in order of priority, water, food, shelter, work and education.

The Aroles realised that health was bound up with all these. A safe water supply, for example, for drinking would greatly improve the quality of life in India and cut down by about fifty per cent the incidence of disease. Malnutrition, too, occurs often in the presence of food because of lack of simple knowledge on the right way to feed it to children. The Aroles have brought down the infant mortality rate in their area to levels usually associated with Europe.

Some months ago I sat in front of a temple in a village in India giving thanks with the villagers for the building of the first toilet, made out of simple, readily available materials for a very few rupees, and built by a dedicated Gandhian who charged nothing. There are 600,000 villages like it, many still needing such simple health resources.

It is curious to reflect that such toilets, if built across India, would cure more ill-health, and even save more lives, than the most sophisticated new equipment being requested by Western hospitals.

We need to ask ourselves whether we are increasing our expectations at the expense of the expectations of others. For example, as health care becomes more expensive, and it does, we seek new ways to pay for it, very often by encouraging a growth in our economies. Such growth demands an increasing use of the world's non-renewable resources. By using them we deny their use to other countries. The oil price rise reflected Western demand for oil. It hurt Europe but it was even harder for the economies of the developing world, where it was needed to produce essential fertilisers for the crops.

Is it possible that our health services are meant to improve from increased care and a change in our way of life rather than through increased material benefits?

For example, there are two answers to the problem of old age.

One lies in an increasing care by families. The other lies in building new hospitals which cost a great deal of money. Or take our way of life — we all hope that there are enough coronary care units available in case we suffer a heart attack, which any of us could do. Yet a smoker under the age of forty-five is fifteen times more likely to die of a heart attack than a non-smoker of the same age. Therefore the cost of that indulgence is not only the money needed to buy the cigarettes but the money needed to build the extra coronary care units to deal with the heart attacks it causes, and the loss of productive work to the community. Other factors, such as obesity, lack of exercise and stress have made it the West's biggest killer.

But it is quite a point for us to consider that our way of life produces diseases which are expensive to treat and may be paid for at the expense of the health facilities of the rest of the world.

If, meanwhile, we train doctors in the West from many countries to use and enjoy using complex equipment, then we encourage them to return to the cities and not to the villages where health care is really needed and could make a great difference.

For all these things we need a reassessment of our values.

2 Motivation — how to get people to take on the work that needs to be done

MOTIVATION FOR MEDICAL WORK

Sturla Johnson
Lecturer in Neurology University of Tromsö

When you live up in the north of Norway you become intensely interested in the word motivation. To get a better health service for the quarter of a million people who live along this wide-stretched coast is something that concerns everybody. It is a vast area. Most of it is north of the Arctic Circle. For a month or two in winter we don't see the sun at all. The weather is unpredictable. The winter is long and cold.

People are scattered. The cost of living is higher than in the south and many amenities and comforts that you find elsewhere in the country are not present. People remain because they love the area. The population in the three northern provinces has been fairly stable for the last twenty years. But the health service is inadequate, in spite of efforts to attract doctors and other health personnel.

For example, someone living in the north east on the Russian border may have to fly 800km to see a skin specialist or an orthopaedic surgeon. In the psychiatric hospital in Tromsö where I have been working, two doctors have to do the work of five in our department. There is a shortage of nurses and all types of skilled health personnel. One nursing school could not admit new students this year for lack of teachers.

The biggest need is in the primary health service. You have islands with several hundred people who only see a doctor when there is an emergency. A working week of up to ninety hours is not unusual for a district doctor. The result is that these doctors stay on the job for only one year on average. They do not have the strength to continue and of course this constant change of doctor is a problem for the population.

How to get people in our society to take on the work that needs to be done, that is a question we must find the answer to, not only in the medical profession but in many areas of life in our democracy.

I want to look at my own medical training for a moment.

I studied medicine in Oslo. To get into medical school you had to have excellent results in your high school examination. One hundred of us were accepted, but five or six times as many applied. There is a danger in this method of selection. A boy with ambition and a brain for mathematics and physics will not necessarily become a doctor with compassion for people.

During our first year at medical school, while we were studying chemistry and anatomy, we often asked each other the question: "Why do you want to become a doctor?" Usually the reply was: "Because I want to do something for other people."

But then after a few years of studies, our thoughts more and more came to centre on other considerations. In what should I specialise? What type of work or research would suit me and my interests and talents? How could I make a lot of money? Where would be a good place to live? Our motives for medical work seemed to have undergone a shift. The needs of the country or of any particular field of medicine seemed to fade into the background.

One reason for this change is the way our medical course was constructed. We saw no patients for the first two and a half years. We were looking into microscopes and studying mice and rats and looking at test-tubes. We also had a tight schedule. Lectures and courses were compulsory and your name was called. We worked hard and had little time to spare. Soon we became competitive, looking over our shoulders to see how the others were doing. Something died in many of us along the way.

Perhaps the main reason for this was the fact that our teachers were exactly like us. There were few who could inspire and lift us and give us something more than just medical science. There were hardly any enthusiasts. Few were able or willing to give us ideas for living and help us see our work as doctors in a bigger context.

I think we need to take a hard look at the type of person, and the type of doctor, such a six-year course is producing. In some places this has been done, among them the medical school in Tromsö. There an attempt has been made to create a different type of medical course. I shall come back to this later.

After three years of medical studies I was fortunate enough to come to Caux. A friend of mine and I were hitch-hiking in Europe and decided to have a look at Caux, which I had heard about. I was at that time looking for something more for my life than just a profession. I only spent a week here, but during that time I began to think through my whole life. I began to examine

my motives, my relationships with other people, the plans I had made for my life. The man who helped me most in this was a young British factory worker. We shared a room together. His honesty about himself helped me to become absolutely honest. We walked in the hills above Caux. I had difficulty understanding his English, but I got the point.

What intrigued me most was the idea that God might have a plan for my life. What a relief if this was true, I remember thinking. In the end I decided to try it. I began with the simple discipline of getting up every morning and taking time to listen in quiet. With this decision I went back to university. During the following months my faith and conviction grew. To my surprise I found that even my studies improved. I was able to concentrate better and needed less time to learn things. Life was much more fun.

Then suddenly a few months later I was faced with a bigger challenge. A handful of people in Norway had decided to set everything else aside and produce a play by Peter Howard. It was to be shown right around the country. It showed the effect on a newspaper of the change in one young journalist who decided to be honest. I was asked to take part in the play.

By some strange coincidence that same afternoon a large paper in Oslo came out with a vicious attack on Moral Re-Armament. It was a half-page of lies and suspicions about an ideology which I had become convinced we needed in my country. Suddenly I felt the country was in danger.

I remember going to my room in the boarding house where I was living. I knelt down by my bed and said: "God, if you can use me I am willing." As I got up, I knew with absolute certainty that the thing to do was to leave my medical studies and go into battle with that play. I remembered the war years when young people like myself left their universities to join the resistance movement and fight for freedom.

To me this decision meant giving away my dearest possession, the security of having an education. I believed then that it was for life. But I was able to do it with certainty and freedom. This set me on a road that took me through Scandinavia with the play, then to Africa, where I worked with the force of Moral Re-Armament for five years. After six and a half years away from home, God began to speak to me again about medicine. Gradually the decision matured to go back and complete my course. I was accepted back at medical school and graduated in 1965.

To leave medicine for ideology was at that time, twenty years

ago, something unheard of in Norway. Today people are more accustomed to it. I discovered last year in Tromsö that two fully qualified young doctors had quit medicine and were working one as a lorry driver and the other in the fish processing industry. They did so out of a conviction to spread class war. They only went back to medicine after considerable pressure from the labour unions who said it was a waste of resources.

The northern part of Norway has always interested me: its closeness to the Soviet Union, with which we have 200km of common border; the strategic importance of this area for the whole of Europe; its natural resources — fish, untouched nature and now oil which the geologists are certain is there in large quantities under the sea; then you have the Sami (Lapp) people with their several thousand years of history and their unique culture and way of life. They are now a frustrated people, who feel they are being pushed around and not listened to.

There is a need to seek the mind of God on these and other problems in the north. There is a need to find solutions and to bring out the resources in people. My wife is also a medical doctor and we both have a sense of calling to this area. That is why we worked there in 1967 and returned again last year with our children. We are now buying a house and intend to stay.

Finally a few words about the university in Tromsö. It was established eight years ago in order to meet the needs of the north and provide a stimulus for that region. It is being built up gradually and has today 1,300 students, 200 of them studying to become doctors. The six-year medical course has been put together with the aim of motivating doctors for primary health work.

You can no longer get in only on the basis of excellent high school results. Emphasis is placed on other qualifications as well. An attempt is made to pick the candidates who are most motivated for medical work. Students from the north are preferred because it is assumed they will stay after graduation. You have a better chance of being admitted if you speak the language of the Sami people, or if you have worked for a year or two in a hospital or been a social worker.

Very early in the course the student meets the patient. Right from the start he is introduced to sick people in the hospital and some basic knowledge of diseases is given to him. After four years the students are sent out to work for four months under supervision in a local hospital and then for two months with a district doctor as his assistant.

Soon I shall begin teaching the first group of final year students

in Tromsö. I am keenly interested in finding out how much this type of medical course has affected their motivation.

Christiane Garin
Surgeon
Switzerland

I am a qualified surgeon. As I was growing up I often sat in the audience in similar conferences here in Caux. This contributed to motivating me first to study medicine, then to go on to surgery.

Now I have always been rather suspicious of big speeches and I prefer doing things. I have also become more and more concerned about the big difference existing between the good, at times extremely good, medical care in our European-Western countries, and the great needs in other parts of the world.

That is why I have accepted to take on the job of surgeon in a hospital of Bophuthatswana, a newly independent Homeland within South Africa where they desperately need trained people.

MOTIVATION OF HEALTH PERSONNEL — IN EDUCATION AND IN THE DAILY WORKING SITUATION

Elisabeth Hamrin
Research Fellow
at the Department
of Clinical
Physiology
Uppsala University
Hospital, Sweden

All university and college education in Sweden today is vocationally directed. It is a response to the need to develop society and strengthen democracy rather than to the purely intellectual approach of seeking new knowledge for the sake of knowledge. The reform has met certain resistance. But we in the nursing profession are extremely happy that our training moves in step with doctors, dentists, physiotherapists, occupational therapists and others in the same educational system. We feel it gives us broader dimensions and more possibilities to work together as a team from the beginning.

The number of applicants for medical and nursing training is increasing every year. For autumn 1978 there were seven applicants for each place in a medical school and about ten applicants for each place in basic nursing education.

The question my colleagues and I in nursing education often ask ourselves is what happens to these very fine and highly motivated young people during and after the training. We have seen many of them become disillusioned. Many students feel they cannot apply in the working situations what they have been taught in school. These are problems the schools, the hospital and the

students themselves are trying to deal with. One other thing, which is good, is that both medical students and nursing students today are much more interested in total patient care including meeting the patient's psychological needs than was the case when some of us took our training. They are also more engaged in international and political questions. Because of this they respect teachers who stand for something, even if they sometimes oppose it.

I am myself for the moment engaged in nursing research. I am leading a project in the Medical Clinic of the University Hospital in Uppsala with the title: "Activation of stroke patients in the acute nursing care situation". Seventy-five per cent of our patients are over sixty-five years old.

In our study we are looking into several questions:

1 What is the effect for the stroke patient of a more systematic individually adapted nursing/activity programme during the first four weeks? How does it affect the patient's own motivation and possibilities for further rehabilitation?

2 What is the staff's motivation to nursing and rehabilitation of stroke patients? Will it change through more education about the patient group and a better nursing/activity programme?

So far we do not have any statistically tested results of the study. But since we started there is:

1 Growing motivation among the registered nurses and others of the staff to meet the stroke patients' individual needs. As one nurse puts it, "Before, stroke patients for me have been just one big grey body. Now I start to see them as individuals."

2 A better co-operation inside the team around the stroke patient — better communication between the rehabilitation team (physiotherapists and occupational therapists) and the nursing staff.

3 A growing interest and motivation among the doctors to improve the diagnostic and therapeutic side for the patients with strokes (which in itself is not part of the study).

In our project group we see it as a great privilege to work with stroke patients — even if it sometimes has been rather tough. Every patient is a human resource. I want to live and act in such a way that people around me, students, staff and patients find a quality of life according to each one's resources.

AN ALTERNATIVE APPROACH TO ABORTION ON DEMAND

Violette Rosset
Switzerland

In 1958 I took over as Nursing Superintendent of the Department of Obstetrics and Gynaecology in a University Cantonal Hospital. I was shocked by the atmosphere prevailing in it, the cynicism of the doctors, slackness everywhere and a lack of care for the patients.

Abortions were performed on a huge scale, being allowed by our local liberal laws.

I was bitter and critical. I wanted either to change everything or leave and take another job.

But then I took a pledge to fight with God, in the place He had put me; and to obey daily any hint He would give me.

One of the first things I did was to write to the Director of the Unversity Hospital and to the Professor of Obstetrics giving them a vision of what their establishment could bring.

We created a committee to take care of every woman coming to ask for an abortion. This committee was composed of a medical doctor, a religious minister, a psychologist, a social worker and a nurse. We studied every case, and the requests for abortion, to find an alternative to performing it which could help the mother-to-be to carry on, and not come back a few months later with the same problem. The abortion rate dropped by seventy per cent.

I worked in this hospital twelve years longer and many of my bitter enemies became good friends.

Care and respect for every royal soul, born or unborn, is the only answer to today's pressures throughout the world.

THE RESOURCES OF OLDER PEOPLE

Berkeley Vaughan
General Practitioner
Australia and India

Perhaps one of the forgotten resources we have lies in our older people.

In 1973 I was invited to a conference in India. It was a long time since I had had a break from my busy general practice in Australia, so I went.

One morning I had a thought — the word "aeroplane". A day or so later I had another thought, "You are to retire from practice in Australia and give the rest of your life to India. This must be with the full support of your wife, who is not to be pressured in any way."

I thought of many difficulties. How could I ask my wife to leave our home and family of three children and ten grandchildren at her age — we were approaching seventy years of age? I had two grandsons whose education I was financing, both had gone through school with distinction and both had been allotted places at university. I had not enough assets to support them and us in an unpaid job. Then I thought of my two secretaries. Both had been with me for years and served me loyally. I knew that they would find it very hard or impossible to get other jobs. Finally I realised that I would have to give up flying. I had been an air pilot for some years but had only recently bought my own aeroplane. I hated the thought of giving this up. Then I realised why God had said "aeroplane" to me. It was to tell me that He understood, and this was His will.

I returned home and told my wife and we together decided to go ahead. We made arrangements to sell our home and move to India. Then an unexpected thing happened. A new government came into power in Australia, and it made university education free and provided a living allowance for students. This took care of my grandsons. The sale of our home provided more than we expected, enough to support us in India.

I talked to my two secretaries. The older one said, "Don't worry about me, I have been thinking about retiring for a long time." The other one suddenly got engaged to be married and I had the privilege of giving her away at her wedding. Finally, I sold my aeroplane for a good price, and the money paid our fares to India.

We have now been in India for nearly five years, and are very grateful to God for giving us a most interesting and rewarding job.

3 Teamwork and how to achieve it

TEAMWORK WITH THE UNIONS

Stephen Lester
Consultant Obstetrician and Gynaecologist Birmingham England

The British National Health Service is a vast organisation on which the Government spends more than on anything else except defence. Hospitals are no longer institutions staffed only by dedicated people, but huge complexes costing many millions of pounds, and run by many groups of staff.

If teamwork is to be found in such a set-up then many human problems have to be answered. But there is one other factor. There have come into the Health Service men and women who seek to exploit the differences and destroy the service. If teamwork is destroyed, democracy is destroyed, as the only two alternatives to teamwork are anarchy or some form of coercion and punishment.

One day I wanted to start my operating list promptly. I was ready, the theatre was ready, the anaesthetist was ready; but where was the patient? In the end I went to the ward to find out what was happening. The patient was on a trolley, but in the path of the trolley were some laundry baskets. The porter and the laundryman were having an argument. The porter would not bring the patient because "it is not part of my job to move laundry."

At a hospital in London a nurse lifted a patient on to the operating table and the theatre porter called all his men out to prevent any further operating that day.

I invited a group of general practitioners, consultants and trade unionists in the National Health Service to meet informally at my home on a number of occasions. We were able to speak freely of our deep concern at the way in which attitudes of ill will, mistrust and class prejudice have disrupted the service, and of our belief that the trend can be reversed.

The NUPE* Branch Secretary from one of the big hospitals in the Midlands said, "I have never been in a doctor's home before. I have never met a group of doctors in this way and I had not realised that you ever thought of anyone but yourselves. This gives me hope."

* National Union of Public Employees

"Some think," said one of the consultants present, "that we in the NHS all share the same aim, but it is not really true. Our trade union friend here told me over lunch that he had come today to see what the enemy was doing. That is a valuable cold douche of truth. If you face the fact and accept it as true then you can plan to change it. The truth is that the trade union representatives and the hospital medical staff are in confrontation. Could he and I heal this division? I am ready to get together with him to tackle the problems at the local level."

Another surgeon who has worked in the same hospital as the NUPE Secretary for many years said, "I had no idea until today that we were part of such a hated group." To which the trade union man replied, "There is more than a division between us, there is real bitterness. My members give a massive vote for any issue that is against the consultants.

"Take the trivial issue of the white coats. The porters were given white coats. Then a notice went out from the Hospital Secretary stating that it had been brought to his attention that porters were not buttoning up their coats and it must stop. I went to the Secretary on behalf of the porters and said that on the day the doctors button their coats, we will too. 'Well,' said the Secretary, 'the doctors are a law unto themselves.' 'From today,' I said, 'we are too.' You see, we feel that you consultants think that you are in some way special."

"But that is just the point," said one of the consultants, "I do think of myself as something special. I have worked for it and feel I have earned respect. If I do not get it, I am as bitter as you; and we don't get it. The other day your union stopped our coffee for a meeting at the weekend even though it was in our own time because they said it was a meeting for our own interest and not for the patients. It was probably healthier for us to go without it but this is the sort of thing that drains our morale."

An even clearer picture of the divisions of our society emerged as two of the men talked together. The first was an orthopaedic surgeon who wearily spoke of his frustrations. "In all my years of training," he began, "I respected my chief. I opened the door when he came in. I fitted in with what he wanted because I respected him for his skills and his experience. And as I worked I climbed the ladder of honour.

"I assumed, not that I was worthier than another, but that through my hard work, training and diligence, others would look up to me and respect me.

"For years in the National Health Service I have worked

harder and longer than I ever needed to under my contract. Pay has never been a factor. My responsibilities have put strains upon me that few have had to carry. All the time I have done it willingly because I enjoy the work, because it is fulfilling and because it has been a genuine contribution to the community.

"If the Government had paid me less I would still have done it. If they had paid me more I would not have had the energy to have done more.

"All I expected was the loyalty and respect of my staff. But suddenly it has gone. Nobody opens the doors now for me because who am I to expect it?

"I am asked to remove my car from my privileged parking spot because I have no right to be privileged.

"The cup of coffee that was handed out to me as a favour has now been withdrawn. It is served in the canteen with everyone else. The operation which was done before whenever I wanted it has to fit in now with the hours and wishes of the theatre staff. In addition, the Government is deciding what is right for us all without any genuine consultation with us.

"In short," he said, "my status has gone and with it my morale. I had no right to it, but as it has been taken away, so has left me my desire to do the very large load of work which I am used to."

The second man is a lifelong trade unionist who has also worked very long hours. In the beginning he not only did his routine job, but took an extra job to earn more. "I understand," he said, "all you say, but you are not the only ones to suffer. I turned to the trade unions thirty-two years ago because of my sufferings and that of so many people in Britain.

"You say that work is losing its satisfaction. For millions of us it has never had and cannot have any satisfaction. We do a routine job which is only a means to an end — survival.

"You say that money does not matter. We say how lucky you are. You must earn a great deal of money to feel that it does not matter. We have never had enough to be able to say money does not matter.

"The hatred you now have of interference in all you do has been with us always. People told us first that we must clock in and out for we were not trusted. They locked things out of our way for the same reason, and put supervision over us to check on all we did.

"The bitterness you feel may now help you to understand the bitterness which so many of us have felt for years — the exploitation, and the lack of respect and trust for us as individuals." At

this point the surgeon was silent. He then suggested that he might bring many of his medical friends to meet the trade unionists.

These two men had discovered that in sharing their real feelings, they had a great deal in common. They were both committed men: the one to medicine, to his patients and to his own career; the other to his class, his union and to justice. Yet both have had commitments which have brought the Health Service close to disaster because they were so limited that they left the other out.

Such encounters should be common but they are not. This particular surgeon had never talked like this with a trade union man in twenty-six years of practice. One might expect such honesty would increase hard feelings. On the contrary, it brought resolution. The NUPE man said, "I see that we have got to get away from this attitude of 'Them and Us'." While the surgeon from the same hospital said, "I am grateful for frank speaking today. A mountain of ill-will has grown up and we doctors have been unaware of its extent."

It was obvious that the feelings which were present were due to wrong attitudes over a long period and we doctors recognise that we are as responsible as anyone for this.

TEAMWORK BETWEEN DOCTORS AND NURSES

Elisabeth Hamrin
Research Fellow at the Department of Clinical Physiology Uppsala University Hospital, Sweden

The Scandinavian working group preparing for this health conference in Caux has learned important things together. Our preparation work went on for more than a year. At one point I told the doctors in our group how I felt about them — that they never listened to me and that they had a complete lack of understanding of the important work I was doing, especially through nursing research. I assumed that after this type of honesty everything would change between us, but nothing happened and I became more and more angry.

One morning as I prepared a speech for the doctors in the medical clinic in our University Hospital about my project on stroke patients, I had the clear thought that bitterness was never right. I needed to ask for a miracle in my feelings towards doctors in general and the doctors in our preparation group in particular.

I asked God there and then to take my bitterness away. Then I rode my bicycle fast to the hospital because time was short.

That time with the doctors in the medical clinic was the best

time I had ever had with them. I found myself talking to them quite differently from the way I had intended. Instead of the usual tough "here I am, you have to listen to me" attitude, I said, "I need your help and co-operation for this is a difficult project." The doctors declared they would like to co-operate and gave some very constructive advice on the design of the study.

Later on I apologised to the doctors in our preparation group for the health conference for my resentment. I realised it had delayed what we were meant to do together. One of them said, "I now believe there is a real point in our arranging such a conference." I have gained new hope and perspective for teamwork inside and outside the hospital. The root of class war is bitterness and we in the health service can only play our part in curing it through saying no to bitterness in our own lives.

Anne-Marie Gabrielsson
Planning Secretary
Sweden

I am employed by the University Teaching Hospital in Linköping, Sweden. I am a nurse with a Bachelor of Science degree and today I have an administrative job.

One of the big problems in our wards is that the sisters in charge are very young and have little experience. We have to develop the sisters in charge as team leaders so that they are able to develop staff team work. We want the doctors to be members of the team not only as medical consultants but also participating in the team-caring for the patients.

It's been a great joy to me to participate in and develop training courses in teamwork for the staff in hospital wards. Administrators, the senior physicians, sisters in charge, and one or more representatives from the ward staff have been invited to a seminar for three days in an hotel. All are from the same ward and thus are part of the same working team. One of the aims of this seminar has been to have enough time to get to know each other, discuss problems, especially the problems of the ward and relationships between members of the team. Our task is to assist in giving the help needed to find new ways of teamwork. Another aim is to try to strengthen and develop the co-operation between the sister in charge and the medical attendant so that they can, together, manage more efficiently and develop the staff into a well-functioning unit.

In the beginning it was difficult to get the doctors interested in this, but they have altered their views and no longer need to be talked into participation but come along voluntarily. Of course,

the most important part is what happens when the group are back in their daily work.

No team has been to a course without some changes taking place, smaller or bigger, and as a result of the better teamwork the patients will receive better care.

TEAMWORK WITH THE ADMINISTRATORS

Harry Ferngren
Paediatrician
Stockholm
Sweden

I worked as a paediatrician from 1970 until 1977 in the Karolinska Hospital in Stockholm. Although it is an old hospital, it is a very good one, enjoying the status of a teaching hospital with 1,500 beds, and 6,000 employees of whom 500 are doctors.

Early in the 1970's, this hospital was asked to find new ways of encouraging participation in the administrative decision-making processes. A small committee was formed with one representative for each of the three major trade unions,* and three management representatives under the chairmanship of the Vice-Director of the hospital.

They soon discovered that the so-called "co-operation committees" which had existed for some time handled only details, while the policy decisions were taken by the heads of department. To replace this system they proposed three central committees covering personnel, training and planning and three clinical committees formed by a majority of representatives of the personnel involved with only the professor representing the employer. The representatives were nominated by the unions, and I served from the beginning in the one concerned with the Children's Centre.

I would like to give an example of the way in which these committees worked. We had a number of problems centering around the emergency cases which came to us in the evenings and at weekends when we only had one doctor on duty.

One morning, after I had been up all night dealing with such emergencies, I felt that I needed to fight for a solution to this problem, since the conditions of work for the doctors were inhuman. I indicated to my professor that we should take up this question on our new committee, and that we should invite some-

* Three main organisations, representing many different unions, organise all employees. There is one for the aides and porters, one for the nursing staff and secretaries, and one for doctors and physiotherapists.

one from central administration. He was not for it, but I persisted.

The meeting was thrilling because of the support we had from the nurses and ancillary personnel. One of my colleagues presented a study of the emergency cases showing that one quarter of the patients came during hours when only one doctor was on duty.

The administrator suggested flippantly that we erect a sign at the entrance which showed the way to the exit. But he was quickly taken to task. Quite soon after the meeting, the Director of Personnel gave us an extra doctor for peak hours.

Some of the personal lessons that I have learnt from Moral Re-Armament have been of great help in the problems we have had to solve, especially when they were concerned with personal relationships. The conviction and motivation to fight for this change in the department came from a simple yet compelling thought in the quiet of the morning before a busy day. We in the health services must learn more about this art of listening, and then learn to fight out the application of it in hectic daily life.

By 1974 we were asked to list topics in which we could move from joint discussions to participation in decision-making. About thirty were invited to a conference in which we decided that policies concerning personnel and appointments were among the most important points. We wanted representatives from the unions to be in the majority in any decision-making bodies.

One man from the State Department arrived and became anxious when he heard what we wanted saying clearly that the Government could not agree to something as radical as we had suggested. The item which caused most difficulty was the question of who should decide how resources were spent.

The Central Administration worked out a scheme for the topics which could be decided in the new committees and sent them to the three different hospital unions for comment.

When the Professionals' Union discussed this, I, and another member, were not present. The others decided that the plan was not acceptable as the consequences had not been fully analysed.

The other unions became very angry and the administration had an excuse for not going on with the plans. The co-operation that there had been between our unions stopped. It was a difficult time for me trying to be loyal to my union but not agreeing with them.

Finally I had the chance to come to a conference in Caux. In the stillness of the mountains and in conversation with certain people, certain things became clear.

I realised how important the fight for participation was and

that I had not fully understood it.* I realised that I needed to fight for my convictions and go to the Chairman to be honest about what I felt about the situation. It was wrong that our union had opposed it. Also I invited a union colleague for dinner and analysed with him why our union had gone wrong and how we as younger doctors could sort the situation out.

On the second day after coming home I talked with the Chairman. He took it well and said that he thought that he should resign as Chairman as a senior doctor and that he had been manipulating others. I replied that I felt that we had indeed been manipulated. I also had the thought to invite an official from the Central Organisation to our Annual Meeting to help convince the professionals about the value of participation.

In the meantime the other two unions had gone to the Minister of Civil Affairs and he had promised them that the Government would allow an experiment on the basis that had been suggested at the Karolinska. So when the new proposals came from the Central Administration, we in the Health Professionals' Union were also ready to accept.

* A new law, "participation in working life", was finally introduced in Sweden in 1977. The law states that the employer must negotiate with local representatives of employees in all questions regarding relationships between employer and employees.

TEAMWORK WAS THE THEME OF OTHER SPEAKERS

Daphne Horder
Dietician in a large London teaching hospital

One of the wards was dissatisfied about food. The catering staff also had complaints about the ward, and their management and service of the meals. Both complained — both to me and others — but no one had thought of sitting down together and talking it over, until I suggested it.

To my surprise both sides were glad to do it, and we met and talked frankly over the issues which led to more understanding of both sides of the problem, and effective action was taken together to deal with it.

Mary Joan Holme
Superintendent Physiotherapist
St Giles Hospital
London

I have an example from my own work recently when I realised how easy it is for one person to destroy teamwork and yet how that person can rebuild it if they so decide.

I was on duty one weekend but went to work wanting to get through as quickly as possible. I was not whole-hearted and was certainly not giving my best. An unexpected situation arose and I should have put aside my plans and worked hard on a certain patient. Instead, I hoped that the doctors and nurses could cope and held back. This put a strain on the rest of the team but at the time I felt justified.

Then driving back home, I saw what my attitude and behaviour had done to everyone else and that my selfishness and stubbornness prevented me from working fully with the others. I asked God to forgive and I put it right with the people concerned, and in fact found a deeper friendship with them as they generously forgave.

The zest and enjoyment of work which I had lost suddenly came back and I had the best week working fully as part of the team.

4 Ethical questions at the beginning and end of life

Frances McAll
General Practitioner
Southampton
England

Ethics at the beginning and end of life are not just a matter of personal opinion. Increasing permissive legislation is used by some as a means of establishing a way of life based on the individual's "right" to avoid trouble. Apart from the damage caused to individuals through such acts as abortion, this attitude of mind is very readily exploitable by those who would destroy democracy.

The possibilities of control of life and death are terrifying. Whenever people are controlled by individual rights, whether it be the right to destroy a baby, the right to die when life is difficult, the right to break up a family when happiness is threatened, the right to strike regardless of the needs of others, democracy and civilisation are in danger. Every time I am guided by my own desire for peace or by my rights, I cease to be a democrat and become an anarchist.

Berkeley Vaughan
General Practitioner
Australia and India

One afternoon some years ago a woman patient came into my office in great distress. I knew her well; she had a family of teenaged girls and now found herself unexpectedly pregnant. She wanted an abortion. I told her that I believed that God created life and only He had the right to take it away. She said that if I did not abort her she would commit suicide. I did not know what to do. If I aborted her I felt deeply it would be wrong, but if I did not and she killed herself I would feel that I had caused her death. As I sat at my desk I silently prayed for a higher wisdom, and a thought came into my mind, "Do what you know to be right and leave the result to Me".

I told her I would help her in any way I could to have an easy pregnancy but I would not agree to an abortion. She left in tears.

A month later she came to the office for a check. She was full of bitterness, blaming me, her husband, and everybody else except herself. When she came for her six months' check I realised that she was no longer complaining. At eight months she was quite excited and looked forward to the birth.

The labour was an easy one and a boy was born, the first male

in two generations. She was delighted, her husband and relatives heaped flowers on her, and she was the heroine of the hour.

Two months ago I visited that home. She and her husband proudly introduced their son, a tall young teenaged Apollo, quite a prominent athlete. They showed me his school report. I have never seen one to equal it. Every subject was marked "A" and his teachers could not find higher praise for his work.

I asked him, "Son, what would you like to be?" "A doctor," he replied.

Karel Gunning
Holland, President of the World Federation of Doctors who Respect Human Life

One day I was called by a lady who had just given birth to a baby boy. She already had two girls. But the midwife told her that the boy might be a mongol. When I arrived the mother asked me to look at the baby, and when I confirmed the diagnosis, she asked me to give an injection to kill the baby. I answered that that was not my habit as a doctor, and asked why she wanted me to do it. She said she was afraid of what people might say.

I told the woman that a mongol child could be born to any father or mother. I added that I had more admiration for a mother who took care of a handicapped child than for a mother of a normal child; and that I had more admiration for the achievements of a handicapped person than of a normal person. I said that it is our natural tendency to be afraid of anybody who is not exactly like ourselves, but that real progress means that we accept all people as they are and help them to make the most of what they have got.

Then I told her a story I had witnessed. When I was a doctor in Casablanca, I was invited by a French colleague to have a cup of coffee after church. On the way home he told me they had eight children and one girl of twenty-four was a mongol. But he and his wife had decided from the beginning that the child should be treated and cared for in the same way as all their other children. They would give her the same challenges and the same punishment if necessary. The result had been that the girl had developed more than many other mongol children. When I arrived it was the mongol girl who served the coffee. She said to me, "Do you realise I am mongoloid? And do you see what I can do?" The girl was really proud to be a mongol child !

After that the woman said she would talk things over with her husband, and for a long time I did not hear anything from her. But some three or four years later, a paediatrician called me on

the telephone. She said, "Do you know Mrs so-and-so? Do you know she has a mongol boy?" I said, "Sure enough, I know." Then she said, "You know there is something funny with this woman. I have never seen such a thing before. She is proud of having a mongol baby."

Ethics can be defined as the means of distinguishing between right and wrong for a profession as a whole. It is of the greatest importance that we in the medical profession are clear about ethical questions. But we must also realise that it is not enough to say that abortion and euthanasia are wrong. We need to help people to discover that life is worth living if you take it in the right spirit, that is if you see life as an opportunity to care for other people.

Of course, we doctors and nurses must try to cure people. But to care may even be more important than to cure. I think that this care also shows the way in the ethical dilemma at the beginning and end of life.

If we really care for a woman with an unwanted pregnancy, we will find a way that is good for her and that is good for her unborn baby as well. If we really care for a patient who wants euthanasia, the very fact of this care may be enough to make him want to live again.

Real care is not easily taught but must be learnt in practice as we open our hearts to our fellow men.

In our country more and more people are beginning to say that the active killing of dying or suffering people ought to be normal medical practice. I am sure most of these men have the best intentions, but have reflected little on the consequences.

The cost of hospitals and health care is growing so high and the number of actively producing people is becoming so small — also as a result of the huge numbers of abortions — that there will be strong pressure on doctors to end the lives of all those who are heading for a long period of non-productivity.

That is exactly what some people propagate already today. It would mean the end of democracy. It would mean that our lives are no longer protected by law. It would mean that we give some doctors the power to decide who must die and who are allowed to to live.

I think we must cut out this way of thinking from the beginning. I think we must stick to the millennial code of ethics that says, "I will never intentionally end the life of any person under my care, whether born or unborn." If we close that door quite deliberately, we will find the way to care for people in such

a way that they will find life worth living, whatever the circumstances.

Last year we had a conference where one of the speakers was the director of one of the biggest homes for the aged in my country. This doctor concluded, "If my patients ever begin to ask for euthanasia, I will feel that I have failed to give them the care they need."

The only patient who had ever asked him for euthanasia was a young man who had had a severe car accident, which had made him an invalid for the rest of his life. When he was helped to find a new meaning for his life under these new conditions, he was quite happy and thanked my colleague that he had not granted his wish to be killed.

One of the greatest challenges to all those involved in care of patients may be to help them discover that they are still very much needed; that there are certain things to do which no one else in the world can do.

If we are going to meet this challenge I think the ethical standards of our profession must be complemented by absolute moral standards in our personal life. We need honesty. We take it for granted that if we ask for a haemoglobin count the laboratory assistant will fill out honestly what she finds. If not, there is no sense in asking for a count at all. But we also need a clear idea of our own weaknesses and our own possibilities. We need honesty about our fears of criticism, about our ambitions and jealousies, about our feeling hurt sometimes.

We need purity as well. It is not enough to scrub our hands before an operation. We must realise that though we possess a perfect excretory system to clear every last cell in our body of poisons and waste products, there is no such system to clear our hearts and minds. It is our own responsibility to discover all the hates and impurities in our hearts, to be honest about them and apologise if necessary. I find that if I ask God to take away these things, He really does.

We need unselfishness too. Happiness cannot be found by doing our best to be happy, but by trying to give happiness to other people. The more we forget ourselves, the more happy we are, the more we are free to care for other people and the more we learn about the kind of life that is worth living.

Absolute love is, of course, the goal we should set ourselves just as health is the goal for the medical profession. As professional men we always try to bring our patients as close to health as possible, though we know we probably never reach it. It is the

same with absolute love. The most perfect example of love has been the life of Jesus Christ. We can try to come as close as possible to this example.

If this could become the normal practice in all our medical services, we would be able to find an answer to all the problems we have discussed so far.

PATIENTS' REACTIONS TO IMPENDING DEATH

Ulla Qvarnström
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University of Stockholm
Sweden
Doctor of Philosophy

Questions associated with death and dying are being discussed in more and more industrialised countries. Most Western societies take an evasive and denying attitude to death.

One of the aspects of this is man's psychological isolation in the hour of dying. The reasons for this isolation are clear. From a historical point of view, death and dying were dramatic events that used to take place in the family arena, and death became a natural experience for both children and adults. The family that worked and lived together spanned several generations. Everybody was born and died as a member of such an extended family. Child birth and the death bed formed a natural part of life.

However, modern Western societies have lost the extended family. Today, the elderly are separated from younger people and looked after by the state.

In a study of the metropolitan area of Stockholm (1971), it was found that eighty-five per cent of the population died in some kind of institution. Because these social changes have taken place in our society, young people stand little chance of having a natural touch with people who are dying and for the first time in our history men and women may live the greater part of their lives without coming into contact with death.

Since people in our society tend to deny death's existence, it has as a phenomenon no place in the prevailing pattern of child upbringing or within the framework of our compulsory school system. The nursing personnel who are going to care for the dying patient have therefore been given very few opportunities of confronting death before they join the medical services. In addition, the various programmes of training for the medical profession and other groups of staff allow little scope for imparting theoretical knowledge about the psychology of dying so that such personnel are ill-equipped to meet the psychological needs of the dying patient.

When the patient finally dies in spite of all medical efforts, the

personnel often interpret this as a failure on their part. This attitude to the dying patient has evolved in parallel with medicine's increased resources for saving and prolonging life, and the big difficulty in medicine in these circumstances may be summed up in the question: At what stage should the patient be deemed "lost" to medical cure? Confronted with this uncertainty, care of the dying tends solely to take the form of medical treatment and basic physical care. Hospital care and organisation in general has so far not considered the dying patient's needs, which may sharply diverge from those of the sick but recovering patient.

But dying is not only a stage in a morbid process. It is also part of life itself. The phenomenon of death has universally human, deep-seated psychological aspects for those whom it strikes — the patient and his family — which has little to do with the disease itself.

In 1973 the Swedish Government established a committee which was given the task of investigating medical and other problems connected with the care of terminally ill patients. Within the terms of reference laid down for this committee, I have carried out a study of patients' reactions to impending death.

As a nurse on a general ward, I nursed and talked with fifteen terminally ill patients during their terminal phase up to the day of death. The study was undertaken to describe the experiences of dying patients during the period preceding death and at the moment of death. With my investigation I have tried to shed light on the psychological problems a dying patient confronts and, through this, to create an understanding of the dying person's reactions, experiences and behaviour.

In the course of planning my work, I realised that my experiences as a nurse with traditional education were not enough. In order to have meaningful talks with the dying it was necessary for me to move beyond the traditional role of a nurse and broaden my ability to establish a deep relationship with the patient. With this in mind, I studied and practised terminal care in Great Britain, the United States and Canada. These countries are building special institutions or special institutional wards for terminal care. In Britain they are called "hospices" and the best known is St Christopher's Hospice in London.

Care at St Christopher's stems from the fundamental idea that it takes time to live, so it must take time to die. The stay at the hospice is described as a journey during which the patient prepares to meet the inevitable end with minimum discomfort and pain, and with human dignity preserved until the moment of death. The

objectives of the care are two-fold. First, efforts are made to give the patient the best possible medical and nursing treatment by alleviation of all those symptoms of physical suffering which may befall him. Second, efforts are made to help the patient cope with those psychological and social problems which may arise in the course of dying. Those patients who are admitted to St Christopher's Hospice differ from other ill persons in so far as they suffer from a disease that is beyond medical cure and recovery. Today, St Christopher's Hospice is a model for the organisation of terminal care the world over.

Armed with knowledge and experience from this excellent centre, I began nursing dying patients on a medical ward at the Serafimer Hospital in Stockholm. For almost two years I spent all my time with dying patients.

The very deep, and in some cases, prolonged contact I had with them, put me on the receiving end of a flood of reactions.

It is apparent that the dying patient oscillates from complete understanding of his situation to a state of denial depending on the social situation that is at hand. This oscillation illustrates the difficulties the personnel face when they evaluate the patient's awareness of the seriousness of his illness. The oscillation between insight and denial also brings problems in conveying information to the patient.

The knowledge that their illness was incurable brought some patients to a state of submission, which was often mirrored by aggressiveness and despair. These feelings were in certain cases directed towards the ward personnel, who represented health and life. Normally the personnel find it difficult to deal with such reactions, but understanding the necessity for the patients to express such feelings and realising that feelings of this kind are not directed personally should make it easier for the personnel to help the dying accept their situation.

Acceptance as well as protest were reactions that were expressed by the patients. Deeply religious patients seemed to accept the inevitable with self-confidence. Their faith seemed to give them great consolation and they faced death without expressing anxiety.

The majority of the patients had no hope that a medical miracle would occur. Some, however, unrealistically imagined that a miracle would take place and that they would be cured.

A dying person can express his wish to die while at the same time his will to live is very strong. Patients' requests for euthanasia must therefore be interpreted in a broader context, for the fear of suffering and of being abandoned are feelings that may be con-

cealed behind the death wish.

The realisation of this study, which was entirely dependent on the terminally ill's willingness to participate, is in itself a sign of the fact that the very ill and dying person has a need to speak to someone about his situation and is also anxious to share his experiences with someone who is willing to listen. It is important for him to be recognised as a human being. The constant recurrence of anxious questions, as well as the expression of fear and anxiety, does not necessarily mean that the patient is in need of or wishes the help of a psychiatrist. What the patient often seeks instead is compassion.

The nature of my study confronted me with problems that patients do not normally disclose to nursing personnel. Being together with a dying patient conferred a wealth of experience, not least psychological. With psychological support from different people, I continuously analysed every kind of thought and emotion that came forth while I was together with patients.

One feeling that often came to me was a nagging sense that I was somehow intruding into an area that was strictly the patient's private concern. But like others who have talked to dying persons about death, I found that my apprehension was unjustified. The patients welcomed the opportunity to talk about their situation.

My nursing care to the dying afforded great scope for empathy, and by trying as far as possible to live into and understand the patients' situations, I became a virtually indispensable bedside companion in certain cases. My resolve to share in all the worries that could arise during the difficult period that most patients had to go through before they died no doubt instilled in them a measure of security. They showed this feeling openly whenever they preferred to receive help and support from me instead of from someone close to them.

In such situations striking the right balance between emotional nearness to and distance from the patient was like trying to walk a tightrope. My ambition in these cases was to use my nearness to the patient to bring them and their relatives closer to one another.

My experiences of intensive contact with the dying argue for the need to mobilise psychological support from the human environment. In this way, the dying patient and the personnel can experience growth in character.

THE VIEWS OF TWO PATIENTS

Jean Twiss
Edmonton, Canada

In 1957 I had an operation for breast cancer. In 1976 it was discovered I had lung cancer which only recently my doctors have agreed is a recurrence of the breast cancer. For over two years I have had various treatments including chemotherapy.

I was fortunate to have met Moral Re-Armament before my illness, when suddenly everything was taken from me — teaching, which I loved, the ability to walk, to lie down at night, to breathe easily. For a time I was physically helpless.

I still had a spirit and a mind intact and I knew how to turn to God, minute by minute during these difficult days.

Last January (1978) my cancer specialist told me all indications were that life on this planet was very short for me. Cancer was spreading rapidly and there was nothing more that medical science could do for me.

I am an only child. I have no family. I did not want to depart this world leaving burdens for other people to attend to. There were various things — jewellery, silver, pictures, furniture, etc I wanted friends to have, so I gave these away. I arranged for cremation. My friends requested and insisted that there must be a notice in the paper and a memorial service. So I wrote my obituary, helped plan the memorial service, the soloists were chosen and invited to sing. All was ready. A friend, at my dictation, wrote a farewell form letter to be sent to all my friends.

I was in constant pain. I did not want to live. I had glimpsed the other world and longed to be a part of it. My doctor had given his verdict. Was I a case for euthanasia?

If euthanasia ever becomes legal, I think, human nature being what it is, it will be legalised murder.

In my country, Canada, changing laws and rules in order for everyone to follow his own selfish desires is fast becoming a major aim in life. We "opt out" of eveything distasteful to us, be it a relationship, a job or something else. Euthanasia would be "opting out" of life when it becomes distasteful to us.

"Opting out" is a selfish, soft and permissive aim and a destroyer of democracy.

When I faced why I wanted to "opt out" of life, I discovered my motives were totally selfish — I did not want a slow and painful death — to die by degrees, I did not want to be dependent on others, I did not relish facing the future in our troubled world, years which will be difficult even for healthy people.

God told me that I had given my life to Him, so it was no longer mine. I could not choose whether or not I would be dependent on others, I could not choose how or when I would die. God told me He had a plan for each day He gives me to live, that is dependent only on the state of my spirit and the guidance it receives and that I must learn to live outside my body which cannot be trusted, that is to live outside oneself; for instance, feelings that never can be trusted to guide me, things not going my way, pain and physical weakness to mention a few. It is very difficult to want to come back to living in this world because all that one has known before, the way one has lived before will never again be the same. One must find a new role. I do not find this easy. But with God, this is possible, and I have decided. Once more life is worth living, purposeful, joyous and victorious.

I am grateful for suffering because without it we can never know the love of God. With God piloting us through suffering it gives depth to living and the most worthwhile thing in life — the "Pearl of Great Price".

Marlies von Orelli
Switzerland

When we speak about healing, we need to know what sickness is and what a sound society should look like. It is not always the sick in hospital beds who make a sick society.

I was and still am self-willed, quick-tempered and ambitious and therefore part of the sickness in society. For such a headstrong case, strong medicine was needed. The first that was applied was contact with Moral Re-Armament through my then fiancé. Through that I was torn out of the circle centred on myself and my own interests and began to get to know God.

The second strong medicine was my accident more than seven years ago. (For the professional people: major fractures, extensive burns, shock, unconsciousness for many days, intensive care, morphia for a long time and countless other drugs).

Through all this, and being in hospital for more than a year altogether, I experienced in myself many healing forces.

1 The passionate, superlative, devoted art of the doctors who gave much encouragement but also a great challenge.

2 The care of the Sisters. I owe them a lot. All of them gave their best. I remember an elderly nursing assistant who did so much in an unbelievably selfless way, to make life in the sickroom bearable with her cheerfulness and her un-

conquerable readiness to help. In the course of time, I discovered how much self-renunciation, sacrifice and faith stand behind these nursing talents. It was just the same with two Sisters of the Order, who were working as nursing Sisters. They helped me a lot to understand and accept the meaning of sickness and suffering. They thereby contributed to an inner healing. I am especially grateful that they were not sentimental and were not afraid to scold me. It came out of their deep longing to help.

3 The family. In today's world one asks whether the family is still a healing force. Without doubt mine was and is. I speak for all the members of our family: each one has his task, but we all work together, we have the same conviction and the same goal.

So many of the nursing Sisters told us that they had had to watch the break-up of families at the sickbeds of many who were critically ill. At the most difficult moments my family helped me infinitely greatly through their care, their readiness to sacrifice, and their input of joy and humour. We grew much closer to each other. The times we spent together singing, praying and reading aloud were times which gave rest and peace, which deepened faith and through that strengthened the healing power.

4 Countless friends helped so much through their thoughts, letters and prayers. I was a case about which one of the Sisters said, "We must pray it through," and that they did.

From these personal experiences I would like to say that illness can very well be a healing factor in a person's life and thus in society. We tend today to shut off sickness and suffering if at all possible and to push it into the background. But I am deeply convinced that they are means of strengthening soundness, faith and healing in the world.

When at a specific moment I was able to switch from "**why** has has God allowed this accident" to "**what for**", a decisive point was reached. The meaning of life gives the necessary impulse; the aim is important. The security that everyone has a part in God's plan, whether he has many or few powers at his disposal, is a spur. The fact that God is completely available helps.

Because my character is still not fully changed even after seven years, although the fractures and burns are cured, I continue to need the help and friendship of my family and fellow men, and I need the help of God.

Conclusion

The ancillary workers, nurses, doctors and administrators who met informally at this conference did so on an equal footing, which is at present unusual.

It showed the value of honest, adequate communication between such people and a need for the willingness to forego rights of status and prestige if full teamwork is to be achieved.

We share a common conviction that the role of the health services is significant not only in the care of patients, but with and through them, in the care and cure of modern society.

That society requires an explosion of care.

Those of us who participate in the healing professions should do so because of what we can give and not because of what we can get.

Let it never be said that there are limits to our care: that because of our desire for more money, or because of difficulties in our relationships with others, we will give less than our best. Nor let us become so engrossed in the problems of our own people and our own jobs that we fail to comprehend and respond to the magnitude of the burden carried by millions who are currently denied the basic necessities of life.

For this explosion of care to be achieved, new attitudes must be born. Among those that were apparent at this conference were:

- a new respect for other workers who have roles and backgrounds different from ourselves
- a deeper understanding of the personal needs and aspirations of individual people and their families
- a heightened appreciation of the value and meaning of life
- a developing responsibility towards the whole community.

The needs of the health professions are therefore seen to be just one manifestation of the needs which face all society.

The task of helping ordinary men and women to live healthy, satisfied lives and to play an effective part in building a better society for the next generation is indeed the role of the health professions, but it is also the role of all of us.