Spring 2013

for today's Christian doctor

triple helix

smart drugs dilemma

the real challenge of care, the Francis report, compassion fatigue, caring with a servant heart, the good life, faith-based organisations and global health, historic milestones in public health

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The real challenge of care

The conclusions of the Francis Inquiry[1] into abuses at Stafford Hospital have shocked the nation. With the growing concern that these failures are more widely spread and the inevitable calls for heads to roll[2] it is clear that we have not heard the last of this issue.

Much has already been written about Stafford's 'insidious negative culture', 'tolerance of poor standards', 'disengagement from managerial and leadership responsibilities' and obsession with 'national access targets' and 'financial balance' at the expense of delivering acceptable standards of care.

Similarly there is widespread agreement about the need to foster a 'culture of service' which 'puts the patient first', develop 'fundamental standards', ensure 'openness, transparency and candour' make all who provide care for patients 'properly accountable' and to recruit and train leaders who will integrate 'shared values of the common culture' into everything they do. These are all good suggestions which resonate with Christian principles of love, justice and integrity.

My concern, however, is that, unless some very fundamental changes take place in British society, things will get worse rather than better.

Around one in three people over the age of 65 will develop dementia in their lifetime and the number of people with dementia is increasing - 800,000 now will become 950,000 by 2021 and is estimated to double in the next 40 years. So will the current costs of care. The £23bn figure being quoted for dementia care today is nearly double the figure spent on cancer and three times the sum for heart disease. And all this is in the face of £20bn 'efficiency savings' needed in NHS spending over the next few years.

In the West we have a growing elderly population supported by a smaller and smaller working population – fuelled by elderly people living longer and an epidemic of abortion, infertility and small families.

These demographic changes, together with economic pressure from growing public and personal debt, and increasing pressure for a change in the law to allow euthanasia, produce a toxic cocktail indeed. Jacques Attali, the former president of the European Bank for Reconstruction and Development, has said:[4]

'As soon as he gets beyond 60-65 years of age, man lives beyond his capacity to produce, and he costs society a lot of money... euthanasia will be one of the essential instruments of our future societies.'

Sunday Times journalist Minette Marin[5] in 2011 was even more apocalyptic in her analysis:

'In 1950 there were 7.2 people of working age (20-64) in the OECD member states for every person more than 64 years old. By 1980 the ratio had fallen to 5.1; now it is about 4.1 and by 2050 it will be 2.1… On top of all the other requirements of the welfare state, old people's needs are huge. Quite apart from the costs of pensions and social security, an enormous part of National Health Service annual expenditure goes on the elderly. Department of Health statistics for 2002-3 show that nearly half the entire NHS budget, 46.7%, was spent on people over 64 and nearly a third of NHS spending, 30.3%, was spent on people of 75 or older.'

Marin's 'final solution' is frightening – euthanasia will become an economic necessity. She sees it as the escape from what she believes is an inevitable living hell for 'many old people' and makes an impassioned plug for the legalisation of euthanasia and assisted suicide, not just for the 'mentally competent terminally ill' but for anyone who has reasons to want it.

Her proposed answers are chilling but she has actually grasped the reality of the demographic time-bomb, which she calls 'an enormous grey elephant in the room'.

It is abundantly clear that unless something is done to reverse demographic trends, 'economic necessity', together with the 'culture of death' ideology which is becoming more openly accepted, may well mean that the generation that killed its children through abortion will in turn be killed by its own children through euthanasia.

But the real answer is not euthanasia and this makes it even more imperative that we fight hard to combat the two British bills and court cases which threaten to legalise it this year.

The real answer to Britain's crisis is in our grasp, but it requires a completely different mind-set to that which has led us as a nation, in our reckless pursuit of affluence and personal peace to mortgage our present, bankrupt our futures, and see those who rely on us as a burden rather than a privileged responsibility.

The demographic time-bomb is a challenge but it does not lead me to despair. Rather it makes me want to live more simply, give more, save more, serve more, love more, value those who are dependent, both old and young, more deeply and work harder to provide good care for all. Over all it makes me want to preach the gospel more. Can we as Christian doctors lead the way?

'For you know the grace of our Lord Jesus Christ, that though he was rich, yet for your sake he became poor, so that you through his poverty might become rich'
(2 Corinthians 8:9)

***Peter Saunders** is CEO of CMF*

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news reviews

Actions with tragic consequences

When altruism is wrongly used as a shield

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

Katherine Bigelow's *Zero Dark Thirty*[1] is riding high in the aftermath of its Oscar nomination, it is interesting to reflect that the film got at least one thing wrong in its telling of the hunt for Osama bin Laden. In 2011, Dr Shakil Afridi entered the alleged compound of bin Laden, ostensibly to take blood samples and administer a hepatitis B vaccination (not a polio vaccination as the film and indeed the Taliban both seem to think). The vaccination was a fake – the operation was a ruse to try to get genetic samples to prove this was bin Laden's household before a CIA strike force was sent in.[2]

The consequence has been all too tragic – murders of polio vaccination workers in Pakistan last year by the Taliban,[3] and in February this year, in Kano Nigeria. up to nine workers (all women) were gunned down, allegedly by the Islamic militant group Boko Haram.[4] In a context of the long-held suspicion of some Nigerian, Pakistani and Afghan mullahs who claimed that global vaccination programmes were cover for a plot by the CIA to sterilise Muslims. This was reinforced with lethal effect by the hunt for bin Laden.

The horror is that these three nations are the only ones in the world where poliomyelitis has not yet been eradicated by vaccination. From over 350,000 cases worldwide a year in 1988 to barely 250 in 2012, the global eradication of polio has been a massive near success. Sadly, the final push may just have been delayed or even reversed by this ignominious episode, as polio rates in all three countries are now going up again.[5]

Zero Dark Thirty may be a Hollywood take on these events but it misses the wider consequences of the operation.

Christians are working in all three countries to tackle the awful health problems afflicting their populations, and have faced harassment, persecution and even death in doing so. Christians are even more readily identified with the foreign policies of Western governments than most, because of the mistaken assumption that the West is Christian.

There are CMF members and their families and colleagues very much in the way of harm as they seek to serve Christ in serving the poor.[6] We need to remember them in our prayers as global events like these affect their lives and ministries.

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Flesh and Blood

giving more than money

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

'What if the Church saw organ donation as part of its giving?' reads the strapline to a new campaign which wants to mobilise UK churches to promote blood and organ donation. The aim of *FleshandBlood* is to build on the Christian culture of giving and make blood and organ donation a part of this.

There were 7,800 people on the UK waiting list for a transplant in 2011. There were 511 deaths of people on the waiting list although this figure may be higher, according to the BMA, perhaps up to 1,000 people.[1]

FleshandBlood encourages church denominations, organisations and individuals to be advocates for donation. They are working in partnership with NHS Blood and Transplant to raise the profile of donation within the Christian community.

'Being willing to give our time, money and gifts is a significant aspect of our stewardship of what we have received. But this applies just as much to the blood that flows in our veins; and the organs that are such an intrinsic part of our bodies.'[2]

A CMF paper[3] by consultant transplant surgeon, Keith Rigg, encourages us all to consider what we would like to happen to our organs and tissues after death. Organ and tissue donation fits within the Christian stewardship responsibility and call for sacrificial giving and love.

Nevertheless, organ donation is not without controversies. There is currently a draft bill in Wales that is likely to introduce presumed consent for organ donation. CMF has submitted several briefings to the Welsh Assembly outlining some ethical and practical concerns with presuming consent to donation when it has not been given.[4] We should also be aware of other agendas, such as conflicts of interest, debates over the definitions of death,[3] use of elective ventilation and 'mandated' consent.[5]

Our support for organ donation is based upon it being a free gift in a context of fully informed consent, not undermined through any hint of financial incentives or felt duty. The altruistic gift aspect of donation, which arises from fully informed consent, fulfills our Christian obligation to love our neighbour as ourself and fits the mandate to heal, motivated by compassion and mercy for others.

This new campaign is based purely on altruistic donation. In addition to advocating blood and organ donation as part of the 'giving' culture of the Church, *FleshandBlood* offers information and resources to equip individuals in local churches to consider donation and to promote it to the wider community. It is a great new initiative that we welcome and support: *www.fleshandblood.org*

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BBC TV sitcom on assisted suicide

Is this the 'Way to Go'?

Review by **Andrew Fergusson**
Chair, Advisory Group, Care Not Killing Alliance

When the BBC announced[1] it was to air a six-episode 'black comedy' about assisted suicide on BBC3, its channel orientated towards young people, there was outcry, Conservative MP Mark Pritchard slamming it for turning suicide into a joke.[2] Care Not Killing, in which CMF remains active, expressed concern but announced it would reserve judgment until the series had concluded.

CNK would assess *Way to Go* under four criteria:[3] does the programme follow World Health Organisation guidance not to 'glorify and sensationalise suicide' and thus risk suicide contagion; does it follow the BBC's track record on this subject and drive an apparent political agenda; is it respectful towards those who face these sensitive matters in real life; and can assisted suicide ever be a suitable topic for TV comedy, even when only used as an innovative context?

How has *Way to Go* done? It is important to realise it is not a serious treatment of euthanasia and assisted suicide, the BBC has done plenty of that – albeit one-sidedly[4] - but a surreal excuse for a storyline about three lads in financial straits. Superficially seeming to accept that assisted suicide is down to individual choice, the four deaths so far actually demonstrate CNK's concerns.

No-one seeking death appears ill, and presumably these unconvincing portrayals are intentional, to maintain the unreal comedy feel. Three are older men, socially isolated – indeed another older man in a care home abandons his plan when soft-hearted Scott arranges sexual services for him and he discovers a reason for living.

A younger woman said to have terminal cancer and less than six months to live has symptoms which appear to be mainly existential. Each moment of dispatch is glossed over so that no viewer could take it seriously, and its illegality is stressed throughout with the potential 14-year sentence mentioned frequently. The series ends with a cliff-hanger: will the lads get caught?

Ethical considerations aside, the series makes depressing viewing for its worldview of casual sex, drug-taking, and trivialised criminality. This reviewer cannot recommend it, but to the extent it treats a hot topic, the case against comes out clearly on top. Neither legalising assisted suicide nor making a comedy about it is the way to go.

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Francis Report shines revealing light on the NHS

Failure of care shakes belief in the health service

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

The horror stories that emerged from the five enquiries into the failure of care at Mid Staffordshire NHS Trust have shaken the national belief in our health service. Patients left in soiled bedclothes, people being triaged by A&E receptionists, appalling hygiene standards, patients left on gurneys in severe distress... The litany of abuse and neglect goes on. Hundreds of patients (maybe over a thousand) are thought to have died unnecessarily as a result, and many more have suffered needlessly.

What is more, those who raised concerns were ignored, threatened or silenced, and the regulatory mechanisms that should have picked up on these failings simply did not work. There was something rotten in the state of the NHS as whole, not just in Mid-Staffs.

The publication of the second Francis Report[1] has sought to address this wider, systemic failure. It has spared no one's blushes in its criticisms of institutional blindness and self-interest trumping the needs of patients across professional and regulatory bodies and the Department of Health.

Francis makes 290 recommendations. Central to them is that transparency becomes a legal duty for NHS trusts and professional bodies, and that there needs to be an overall culture change in the NHS, that puts patients and their needs at the centre of the system. This seems so fundamental that the inquiry's need to state it explicitly suggests how far the NHS has drifted away from its original purpose.

Significantly, while good leadership is vital to this, Francis makes it clear that the culture change is the responsibility of every NHS employee, from 'porters and cleaners to the Secretary of State'. It is a bottom up change, not further top down restructuring that is needed.

A change in culture only arises from a shared set of values and beliefs. This presents a challenge and opportunity for us as Christians to express the God-given value of each and every person made in his image,[2] the centrality of compassion as an expression of God's love and character,[3] and of service and advocacy for those in need as central to an expression of his justice.[4]

Many are calling this a 'watershed moment' for the NHS. It may well be a 'kairos' moment, when 'eternity erupts, transforming the world into a new state of being'.

So let us not just hope that the Francis Report is a spur to action in others, but also a spur for us as Christians to be agents of change and transformation in the NHS.

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Philippa Taylor on the ethical and spiritual questions raised by drugs that increase mental capacity

THE SMART DRUGS DILEMMA

key points

Use of 'smart drugs' or 'brain steriods' is becoming increasingly widespread.

So far most warnings about them focus on their addictive qualities... but these are not the only concerns.

Smart drugs cannot cultivate qualities like self-control, altruism, sacrificial love, relational commitment, faith, discipline.

Consider this scenario. A memory-boosting drug is available off the internet which could significantly increase your daughter's chance of getting into Oxford University. Her grades are borderline. She tells you that many of her class-mates are taking it before exams. She says not having it will jeopardise her chances, not only of getting into Oxford, but even getting into higher education at all. She questions what the moral difference is between buying the drugs, paying for extra tuition, or taking a very strong coffee or ProPlus pills.

Seen by some ambitious students as the winner's edge and maybe their ticket to a top job, so-called 'brain steroids' or 'smart drugs' can be purchased on campuses, or off the internet, for a few pounds. By improving concentration and alertness, students use them to study longer and perform better during exams.

Their use by American students is already widespread,[1] with one student from George Washington University claiming that: '*...among my personal friends, I'd say the use is "only" like 50%-60%.*'[2] The journal *Nature* found large-scale use within academia as a whole, not just among students. Of 1,600 academics from 60 countries, one in five said they had used 'smart drugs' for non-medical reasons, particularly to enhance their focus, concentration or memory.[3]

The UK Government's Foresight Project predicts that: '*pharmacological enhancement of cognition in both the young and old healthy populations seems set to become increasingly popular, extending from dietary*

supplements and caffeine to drugs specifically targeted at improving cognition.' It cites evidence that healthy volunteers can improve performance with the cognition-enhancing drugs such as methylphenidate and modafinil.[4]

It is not only academics interested in these drugs. The healthy, ageing population is increasingly being considered as potential candidates because deficits in both executive functions and memory are among the most prominent problems with normal ageing. Doctors are also seen as possible users. Research at Imperial College reported last year that: '*...fatigued doctors might benefit from pharmacological enhancement in situations that require efficient information processing, flexible thinking, and decision making under time pressure.' It did add that: '...no improvement is likely to be seen in the performance of basic procedural tasks*'.[5] Indeed, all of us are candidates. The Foresight Review claims that some people regularly use cognitive enhancers to compete in their work and study environments, to help them overcome the stress and fatigue of a 24/7 society.[6]

The most popular drugs at the moment, which are aimed at improving attention, reasoning, planning and even social skills, are Ritalin and Modafinil (Provigil). Although Modafinil is licensed for treatments of narcolepsy in adults, 90% of prescriptions are for off-label use, such as jet lag, tiredness and sleep substitute.[7] The stimulant, Adderall, available in the US, has been used by athletes to enhance their reaction time, energy levels and performance, but has recently led to some NFL players being suspended.[8] Although the sizes of the effects of these drugs (to date) range from small to moderate, even small percentage increments in performance could have a significant impact.

So far, warnings have centered on the addictive properties and side effects of these compounds. Of particular concern is the use of smart drugs among people aged 18–25, the most common non-medical users. The brain continues to mature until the late twenties and beyond. No one really understands the consequences of long-term use of stimulants on the developing brain. At present, there is only scant data about off-label use. The physical risks may however be countered by the potential improvements in both safety and performance of the drugs, and people are often willing to accept a trade-off in risk for immediate benefits. The popularity of cosmetic surgery illustrates this trade-off well.

Cheshire is surely right to warn that: '*The astonishing complexity and delicate fragility of the human nervous system require that pharmacological interventions be undertaken with utmost caution and care.*'[9]

It may be that by using new pharmaceutical drugs, some capacities are minimised in order for others to develop. For example, the 'doogie' mouse is a genetically modified mouse with enhanced memory, however this has also enhanced its capacity to experience and remember pain.[10] If pills aim to block painful memories, how would we then learn to deal fully with suffering or sorrow? Will new drugs undermine the opportunity to truly 'flourish' with rich, fulfilled lives? If your daughter takes some 'smart drugs', gaining entrance to Oxford University as a result, has she missed out on essential human experiences – striving for success and learning to live with discipline, perseverance and perhaps failure? Will she feel under pressure to continue taking pills, to maintain her 'achievements'?

Some worry that enhancements will make personal efforts and achievements meaningless because we will not know if achievements are due to our own striving or to technology.[11] Others agree that desiring happiness and success is good, but not without the real disciplines, attachments and achievements that are essential for true human flourishing.[12]

Arguments to legitimise the use of 'smart drugs' often appeal to ideologies of individualism and autonomy: '*To prevent (people) making decisions is to judge that they are unable to make a decision about what is best for their own lives*.'[13] However, ironically, once technologies are widely adopted this can generate an expectation, and peer pressure, to conform to a new standard or norm. A student using pills to help study and concentrate may actually feel he/she has no choice but to take them in order to keep up with others. This is not dissimilar to the pressure for athletes to use steroids - not necessarily to gain a decisive edge, but just to remain in the game.

Regulation of these drugs is desirable, but not straightforward. One-third of the drugs used for non-medical purposes are purchased over the internet. Globalisation strongly influences off-label use of them via internet marketing, which is almost impossible to regulate and control.[14]

These are challenging dilemmas, and we need to work out how to achieve the right balance here. Enhanced cognitive abilities do not automatically mean better, happier lives. Christians will have a different perspective on achievement and performance. '*But you, man of God, flee from all this, and pursue righteousness, godliness, faith, love, endurance and gentleness*.'[15] God loves us as ourselves in our weakness, not strength. '*God chose the foolish things of the world to shame the wise*.'[16] Christians understand that humans are of value not because of what we can do but who we are, made in the image of God.

CS Lewis predicted our present challenges of transformational technologies, warning that technology, which is always said to extend the powers and abilities of the human race, is in fact a means of extending the power of some over others. Thus: '*Each advance leaves him weaker as well as stronger*'.[17] A prescient warning that technology may bring benefits but it will come with costs attached. We need God's wisdom to weigh these up.

Philippa Taylor *is CMF Head of Public Policy*

Arguments to legitimise the use of 'smart drugs' often appeal to ideologies of individualism and autonomy

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Sam Leinster on how Jesus turns prevailing attitudes on their heads

THE GOOD LIFE

key points

Jesus sets out a vision for the good life.

It may require going against the cultural tide.

To experience the good life our focus must be on God's kingdom

In the TV sitcom *The Good Life* (shot between 1975 and 1978), Tom Good (played by the actor Richard Briers who died recently) has a midlife crisis and turns his back on the rat race. With his wife Barbara, Tom turns his manicured suburban garden into a farm. The advent of pigs and chickens and the couple's madcap lifestyle schemes consistently knock the neighbours off balance.

The Good Life is consistently voted one of Britain's favourite sitcoms. One of its enduring qualities is the way it laughs both at conventional values espoused by neighbours Jerry and Margot, and the woolly-jumper pretentiousness of Tom and Barbara. For all the genial banter it makes a serious point: it is hard to be different from people around you. It takes a lot of courage and grit.

Paul urged early Christians not to be conformed to the pattern of this world, or as JB Phillips famously put it, 'Don't let the world around you squeeze you into its own mould.'[1] Jesus sets out his vision of the good life in the Beatitudes at the start of the Sermon on the Mount.[2] He uses the word 'blessed' (maranathos) to capture its essence. Throughout the Beatitudes, Jesus literally turns the conventional wisdom of his day on its head. The characteristics he associates with maranathos are in stark contrast to what people then and now crave for as the good life.

> 'Don't let the world around you squeeze you into its own mould'

Although Jesus sets out a series of discrete definitions, it is important to recognise that these are facets of a single entity. The person living the good life will display all of these characteristics, and the absence of any one characteristic will detract from their experience.

Poverty instead of wealth

Wealth is regarded as one of the major determinants of the good life. Jesus says to be blessed is not to be wealthy but to be poor in spirit.[3] To be poor in spirit

is to recognise that we are entirely dependent on God. Our satisfaction with life is not based on our salary, car, pension plan or wardrobe, but on the knowledge that all of God's resources are available to us to meet our physical, emotional and spiritual needs. The dependence we often see in our patients should be a reminder of the dependence we have in reality with God.

Mourning instead of pleasure

For some the good life is a life of pleasure. Jesus says, however, 'Blessed are those who mourn'.[4] This mourning is more than personal grief at bereavement. It is sorrow at our own sin and the suffering and injustice in the world. We experience this when we feel the vulnerable are neglected at the beginning and end of life, when dignity is denied and when global health inequality is unaddressed.

Meekness instead of status

As doctors we can define ourselves by our standing in the community. In contrast, Jesus says, 'Blessed are the meek'.[5] The meek are those who do not push themselves forward. Contrary to popular opinion, they are not weak. The idea behind the word is that of a well-broken horse. It retains all of its strength but uses it at the direction of its rider. So the meek person is one who acts always under the control of God rather than for his or her own ends. As servants who quietly work for the good of our patients, we have a unique opportunity to model this.

Righteousness instead of achievement

A particular temptation for members of the medical profession is to define the good life in terms of achievement. Jesus sets us different goals – 'blessed are those who hunger and thirst for righteousness.'[6] There are two aspects to this longing. The first is the desire for personal goodness: the wish to live in accordance with God's laws and standards. The second, which in the Bible is closely associated with personal holiness, is a concern for justice in the world. The Old Testament prophets are clear that religious observance that is not associated with a concern for justice is repugnant to God. Whatever we feel about NHS reform or the direction of medical ethics, we need to be concerned for justice for patients and all in the profession.

Mercy instead of power

Doctors are in positions of power in their relationships with patients and with other members of the health team. We can be tempted to use that power to get our own way. Jesus says 'Blessed are the merciful'.[7] True happiness is not achieved by forcing our will onto others but by recognising and meeting their need. This is, of course, most difficult to display when their views and desires do not match with ours. It is there that the battle lies to cooperate with colleagues and patients to create a merciful healthcare plan.

Purity instead of conformity

Most of us would prefer it if we did not stand out as different from those around us. As a result, we are reluctant to challenge accepted ideas and behaviours even when we feel they are wrong or inappropriate. This reluctance can extend into our professional lives leading to failure to challenge poor professional practice when it occurs as was notoriously the case in the Bristol pediatric cardiac unit. The problem is that we have double standards: we know that some views are right from a Christian viewpoint, yet there are others that we tacitly accept and put into practice because they are the norm among our colleagues. In response to our acceptance of double standards Jesus tells us that 'the pure in heart will see God'.[8] We need to be prepared to stand out even if it is uncomfortable for the sake of Christ.

Peace-making instead of avoidance

It is easy to avoid conflict habitually rather than actually dealing with it. So often tensions in teams can rumble below the surface unaddressed or issues between doctors and management can become intractable. However Jesus calls us to be peacemakers. By definition, a peacemaker has to go into situations of conflict rather than avoid them. Archbishop Desmond Tutu brought peace to South Africa by bringing enemies together, not by ignoring the issues.

Righteousness instead of acceptance

Perhaps the most difficult element of Jesus' definition of the good life is the inclusion of persecution for the sake of righteousness.[9] The key is that the persecution occurs because of our commitment to righteous action in the world. In other words the good life consists of working to advance kingdom values even when the personal consequences may be hard. In such cases it should of course be our concern for righteousness and justice that leads to our persecution rather than our own arrogance or stupidity.

Living the good life

With great privilege comes great responsibility. If we are to experience the good life as Jesus described it our focus must not be on ourselves, but on his kingdom and purposes. God willing, as we strive to be the salt and light that Jesus describes, *a watching world will see our good works and glorify our Father in heaven*.[10]

***Sam Leinster** is the President of CMF and Emeritus Professor of Medical Education at the University of East Anglia.*

The good life consists of working to advance kingdom values

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2. Matthew 5:1-7, 28
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7. Matthew 5:7
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9. Matthew 5:10
10. Matthew 5:16

David Cranston on the conflicting demands of home, work and patient care

CARING WITH A SERVANT HEART

key points

Many factors conspire to compromise our care of patients.

For Christians the challenge is to care as Christ cares.

If we put serving God's kingdom first, the rest will fall into place.

We are all asked as children what we want to do when we grow up. At job interviews we may well have given the standard answer – that we wanted to care for people. And yet it is so easy to see that high ideal dropped as our job becomes a means to an end: supporting our families, earning enough to keep up with the neighbours, or buying a certain car. Other factors conspire to decrease the time we have to care for our patients: shorter working hours, meeting targets, cutting costs. It's not that these are necessarily wrong. Indeed some may bring us personal benefits. But our attitude towards these things will reflect on whether or not we care as Christ cares.

How does our attitude to work reflect our attitude to care?

Professor Harold Ellis, former Professor of Surgery at the Westminster Hospital, once wanted to issue an advertisement for his house job which said: '*Scrimshankers, clock watchers, time wasters and layabouts need not apply, there are plenty of other jobs available for those sorts of people.*' Needless to say, even 40 years ago, medical staffing would not allow it. Ellis was an inspirational teacher who used to give his houseman a day or two off in six months if they were lucky. His philosophy was 'knife before wife'.

> 'When I was training we talked about vocation, now the talk seems to be more about vacation'

We need to find a balance. It's like walking a tightrope when balancing conflicting demands between home life, work life and patient care. A senior Irish urologist told me recently, 'When I was training we talked about *vocation*, now the talk seems to be more about *vacation*.' We are all called to ministry. When anyone told John Stott, the eminent Anglican preacher, that they were thinking of entering the ministry he would say, 'I am so glad, but which ministry are you talking about? If you mean the pastoral ministry then please say so.' Shortly after his conversion William Wilberforce told his wise mentor John Newton that he was going to leave politics and enter the ordained ministry.

Newton encouraged him to stay in politics and we know the result.

Paul Brand was for many years a missionary surgeon in Vellore in India where he pioneered the treatment of leprosy. Shortly before he died in 2003 he told his biographer Philip Yancey: '*Because of where I practised medicine I never made much money at it. But I tell you that as I look back over a lifetime of surgery, the host of friends who once were patients bring me more joy than wealth could ever bring. I first met them when they were suffering and afraid. As their doctor I shared their pain. Now that I am old, it is their love and gratitude that illuminates the continuing pathway of my life.*'

Can you climb the ladder with a servant heart?

God did not make us to drift around the sea like plankton. It is good to have ambitions. We all need targets to set our sights on. But what are our primary ambitions? Jesus in Matthew's Gospel tells us, '*But seek first his kingdom and his righteousness, and all these things will be given to you as well.*' If that is our first and primary ambition, others will slot into their right place. Yes, perhaps good jobs, perhaps lots of money, perhaps high office. But perhaps it will be in an isolated practice here or abroad, or working with the poor and disadvantaged, but knowing that you are in the place that God wants you to be. If we do get to the top of any particular tree we need to remember that the methods used to get there will be the methods needed to stay there, be they honest or dishonest, straightforward or underhand.

How do you lead with a servant heart?

Servant leadership is not something we see a lot, but when we see leaders being true servants, it is very impressive. The portrait of George Thomas, (Lord Tonypandy) a former speaker of the House of Commons, hangs in the staterooms of the Speaker's House with his personal coat of arms underneath. It encorporates the crown and portcullis design of the House of Commons, surmounted by a miner's lamp. The lower half includes an open Bible. The motto translated from Welsh says 'He who would be a leader must be a bridge.'

Ambroise Paré was born in 1510. Considered as one of the fathers of modern surgery, he became the great royal surgeon for four French kings in succession: Henry II, Francis II, Charles IX and Henry III. Even today soldiers who are wounded in Afghanistan or Iraq owe him a debt of gratitude for he was a leader in surgical techniques and battlefield medicine.

Paré did two great services for surgery and therefore for suffering mankind. First, he showed that wounds need not be cauterised with boiling oil. When he ran out of oil one day, he treated other patients with a recipe made of egg yolk, oil of roses and turpentine. Paré discovered that the soldiers treated with the boiling oil were in agony, whereas the ones treated with the ointment had recovered because of the antiseptic properties of turpentine. Then, secondly, he replaced the red hot iron for the ligature in controlling the great vessels during amputations. By these two discoveries, both based on close clinical observation, he saved thousands of wounded soldiers from the tortures previously inflicted on them.

Some surgeons have a reputation for arrogance. In an arrogant world we can learn a lot from Ambroise Paré and his partnership with God. His most quoted saying is '*Je le pansai, Dieu le guerit*', 'I dressed him, but God healed him'. I wonder when did you (and I ask myself the same question) wipe a dirty bottom that was not a baby's or help move a patient on or off a trolley, or get a mop and mop the blood off the theatre floor or make a cup of coffee for the ward clerk, or help a patient get dressed in clinic - or are those all jobs for someone else?

How do you listen with a servant heart?

Do we have time to listen? Maybe we just have time to listen to someone's complaints and take a history. But what about listening to them as people? Hippocrates said, 'It's much more important to know what sort of person has a disease than to know what sort of disease a person has.'

People are living history. Years ago I remember a man of 93 on the medical wards at the John Radcliffe; a little frail man with a catheter. So is he a bit of old crumble that might benefit from surgery to his prostate? Or is he a man born the same year as the Queen Mother who woke up one morning aged 16 on a British battle ship to see the mist clearing and the German fleet in the distance at the start of the Battle of Jutland?

Unless you are very fortunate, if you meet the Queen it will probably be only for a short time. You can be sure the Queen won't be texting or looking over your shoulder to see who else is in the room or who would be more interesting to talk to. For those few moments you would have had her undivided attention and it will be something you remember for the rest of your life. Let's treat our patients like that.

How do I speak with a servant heart?

Communication involves listening and speaking. Most medico-legal cases arise from lack of communication. We need to be gracious and respectful when we speak of Christ to patients. But one can always drop something into the conversation like a fisherman dropping a fly above a trout, to see if they come up and take it.

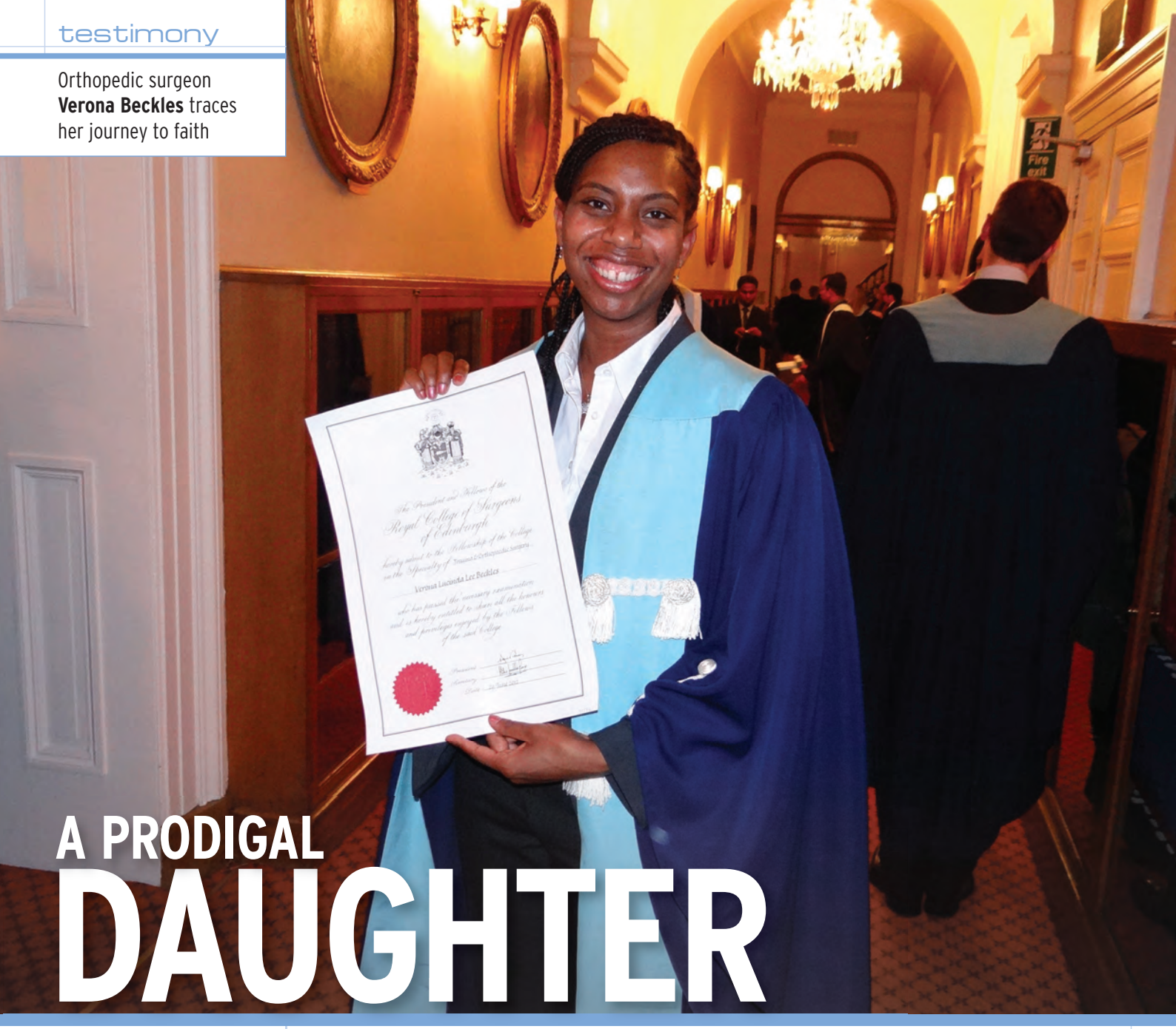
The late Professor John Blandy, from the London Hospital, included these words in one of his surgical textbooks: 'Tender the wind to the shorn lamb. Dilute your frankness with gentleness and wherever possible give hope.' As the old aphorism says, the role of a doctor was to 'cure sometimes, treat often, comfort always'.

***David Cranston** is a consultant urologist in Oxford. This is based on a talk given at the CMF 'Caring is Costly' Conference, November 2012*

Tender the wind to the shorn lamb. Dilute your frankness with gentleness and wherever possible give hope.

Hippocrates

Orthopedic surgeon **Verona Beckles** traces her journey to faith



A PRODIGAL DAUGHTER

key points

An unexpected moment at the bookstall as a CMF Students Conference blew me away.

People who knew me before and after often comment on the change.

Wherever a Christian doctor is, that is their mission field.

My full name is Verona Lucinda Lee Beckles. The 'Lee' part is a common Chinese name and it's part of my ancestry. My mother's maiden name was Wong. Her maternal grandfather came from Hong Kong, my paternal grandfather was born in Sierra Leone, a son of freed slaves from Barbados. They found life in West Africa tough so eventually returned to the Caribbean. So my roots are multi-cultural.

I have a visionary father. It seems he could see quite early where his kids were gifted. He saw I had potential to be good at public speaking, maybe because I'd talk all the time. I remember he would get me to stand in a space between the dining room and the kitchen and practise reciting poems. At a very young age I won competitions run in association with the Jamaican community in London. I'm now restoring the cups and other things I won. Talking at a conference or giving media presentations doesn't phase me as it does some of my colleagues. Now I preach regularly at church. As a teenager I wouldn't have dreamt I'd be doing that, but when you see it with a God-plated 'retrospectoscope' it's obvious how it goes back to this childhood experience. I go to a medium-sized Baptist church in the northern suburbs of London. I'm a big believer in being part of a church I can walk to. It's very multicultural. Our International Sundays are amazing.

My mum used to take us regularly to church. Then during our teens my parents started their own grocery store and it was open on Sundays. Going alone to church as a teenager was not easy. I kept asking difficult questions; I got confirmed and all that. But my questions were too difficult for the people doing the confirmation classes. So in my late teens I gradually stopped going to church. Certainly I'd stopped altogether by the time I got to medical school.

At Imperial I met lots of Christian students who were in the Christian Medical Fellowship. They would go on about this amazing CMF National Students Conference. I would go to all sorts of stuff with them: All Souls' Church in London, dialogue suppers, anywhere there was food. But it didn't impact me. I knew I would have to give up some of my way of life and I wasn't willing to do that. I was part of a singing group doing spirituals. I simply saw it as a kind of music. The others wanted to use it to witness and since I wasn't wholeheartedly with them they asked me to leave. That hurt. It wasn't until my final year (after doing my BSc fifth year) that I went to the CMF National Students Conference. It was quite different from anything I'd been to before: the size of it. I remember the music being amazing.

Then came a moment that completely blew me away. I found my eyes suddenly 'full of water' (as Jamaicans say). Browsing at the bookstall I found myself reading the back cover blurb of Philip Yancey's *What's so Amazing about Grace*. It went something like, 'There is nothing I can do to make God love me more... nothing I can do will make God love me any less'. Tears came suddenly, unexpectedly. I knew immediately I would have to change the way I was living. I think of myself as a prodigal daughter. I had been having a big party. I was spending my inheritance. But God had definitely seen me from far off, had run towards me and scooped me up. Literally. People who knew me before and after often comment on the change. Today I'm at Stanmore doing spinal neurosurgery, doing tumour work. Some of these patients are paralysed but they are amazing.

I was going to leave medicine after completing house jobs. I was tired. This was before the European work directive. You could start on Friday and work through to Monday. I was struggling to get a job. A friend suggested I contact CMF, maybe offer to do some filing. The reply came back, 'What about looking at some Relay Work?' It meant supporting a regular student staffworker based in Birmingham and making links with the new medical school in Warwick. I remember being amazed at the Christian students and their zeal for the Lord. It left me feeling a bit bereft that I didn't have that faith as a student.

I found myself helping students work out what faith means in their practice. Warwick students were trying to do a medicine course in four years after finishing another degree. Many were stressed trying to keep up. Many of them had previous failed ambitions, having not got into medicine straight off and somehow not feeling they were truly good enough. I hope I was able to support them through this, telling them, 'God thinks you're important and has put you here. You are capable and he can give you strength to keep going.'

I visited Malawi for two weeks with a friend in 2004. By then I had an SHO job at Barts hospital. My friend wanted orthopedic experience in the developing world. We spent a week at a hospital in Blantyre and we spent the second week at two orphan centres. I did a longer visit to Malawi in 2008-9.

I've been back to Africa several times: Nigeria, South Africa, Rwanda and Zambia. It's made me realise I'm a Londoner and I love London. I love the sights and sounds. I love the river. I love the South Bank. I could walk the bridges all day. In Africa I found myself missing the night lights. I felt very British in Africa. In the UK I'm perhaps more Jamaican.

I would say wherever a Christian doctor is, that is their mission field. There are so many parts of the world that need doctors. So if people are struggling to get a job here I don't see a problem with being abroad. With most pediatricians, infectious disease practitioners or gynaecologists it's recommended that they spend time in places where there are more issues in their field than they would meet here. I would say people have to work out how they are being disciples and making Jesus known here and now, then you can look at whether there are other places in the world you can be doing that.

I remember being in the bank the other day. I was cancelling an appointment with a financial adviser. He wanted to find out who this person was to encourage me to rebook. He kind of looked at me and then he looked all around the bank. I knew what it was and I just stood there until the woman with him told him who I was. I get that quite a bit. I think patients get over it quite quickly when they realise I'm capable. But it's a bit of a shock initially. I often think it's because I'm a woman, and if I'm not wearing makeup maybe I look younger than I actually am, so maybe they think I don't have enough experience to deal with their problem. But being black comes into it because it's not how they normally see a black woman.

My identity in Christ means I can be defined by what he says I am... I am his child, a co-heir with him, his workmanship, his masterpiece, created in his image. I am forgiven. He died for me so I am worth that much. It frees me not to be defined by my culture or race. It's these truths I'm so glad I know now.

Veronica Beckles *is an Orthopedic surgeon in North London*

I had been having a big party. I was spending my inheritance. But God had definitely seen me from far off, ran towards me and scooped me up

Paul Robertson recalls a London curate's pioneering work

GERM THEORY & CHOLERA

key points

In 19th century Britain, cholera was a deadly foe and it seemed nothing could be done for its victims.

Germ scepticism was for a long time a dominant voice.

Careful observation by Henry Whitehead, a London curate, helped find how cholera was spread.

The boy's diarrhoea had started. So far it was infrequent, but his parents didn't expect him to survive. His baby sister hadn't. The family had been praying, the local curate had visited, but Broad Street was gripped by cholera and everyone knew there was nothing else to be done.

The impact of cholera in 19th century Britain is almost impossible for us to grasp fully. In 1831 it appeared suddenly, ravaging coastal towns in England. Cholera killed 14,000 people in London in 1849 alone. But as the 19th century drew to an end, so did the threat of cholera. History remembers one man as the vanquisher of cholera in London, Dr John Snow, an anaesthetist to Queen Victoria, and pioneer of the germ theory of disease. However, there is more to the story than that.

Controversy

The Earl of Shaftesbury, a commissioner in the newly formed Central Health Board in London, had for some years failed to persuade the authorities that improving housing conditions and sanitation might have a role in controlling cholera epidemics. The reason for his failure was heated controversy over the cause of cholera. In 1853 *The Lancet* opined: 'What is cholera?… all is darkness and confusion, vague theory and speculation.'[1] Cholera was attributed by the best medical minds of the day to miasma, an invisible mist-like, disease-spreading presence. However, doctors such as Snow were beginning to suggest that microscopic 'germs' passed from person to person were responsible.

Snow had noted that the closer together people lived, the more likely they were to contract cholera, particularly if they shared a single water source. However, housing or sewerage reform would be expensive and disruptive – and futile if the germ theory of cholera was wrong. Snow lacked sufficient evidence to convince the powers that be, until he found an unexpected ally in a local curate.

The Rev Henry Whitehead was the curate of St Luke's Parish Church in Soho, a particularly impoverished area in London at that time. In August 1854 his parishioners bore the brunt of London's worst cholera outbreak; around 700 lost their lives. Centred on Broad Street,[2] the outbreak famously led to one of the earliest demonstrations of the waterborne spread of disease. Snow lived in nearby Piccadilly and was able to observe events closely. He had argued that cholera was spread through water and convinced a reluctant council to remove the handle from the local water pump.[3]

Evidence

From the outset, Whitehead was sceptical of germ theory, not least because he had used pump water to dilute his brandy with no ill effect. He hoped to disprove Snow's hypothesis. Over the next months, after the outbreak had abated, he meticulously conducted detailed interviews with everyone who had lived in the parish at the time of the outbreak. He demonstrated that 58% of people who had drunk pump water developed cholera, compared with only 7% of those who had not. Further circumstantial evidence came to light. Two fatal cases in Hampstead were linked to water bottled from the Broad Street pump. The local brewery, which had its own well, saw no cases. Whitehead realised that Snow had been correct. Sadly, Snow died in 1858 before he could see his ideas become widely accepted. Whitehead continued to work in London, tackling further cholera outbreaks, before moving to a quieter country parish in later life.

Whitehead's involvement in controlling cholera in London epitomised the changing focus of evangelicalism during the nineteenth century. An increasing importance was attached to living out an 'incarnational' faith – a faith prepared to get its sleeves rolled up and its hands dirty in practical demonstrations of the gospel among the needy, rather than merely preaching it from a distance.[4] 'He [Whitehead] was the only gentleman, indeed the only person above the rank of a day labourer, in the parish… and he lived in a parsonage built on the site of the ancient parish rubbish heap.'[5] He rejected the prevailing 'laissez-faire' approach to poverty. According to this view, common among some evangelicals at the time, cholera was simply one of the many consequences of poverty. Poverty, in turn, was seen as a moral disease, the result of laziness, uncleanliness and ungodliness. Undoing the consequences of poverty was to remove the 'God-ordained' checks and balances necessary for motivating people out of their poverty. Against this attitude Whitehead wrote: 'The more one studies human nature… the more one is able to perceive that no one, not even a street beggar, is deemed to be out of the pale of sympathy.'

Solutions

He had rightly perceived that, as the causes of poverty are complex, so must be the solutions. Practical assistance must go alongside calls to reform morals; food, clean water and adequate housing must accompany Bible study and prayer meetings. And he believed that the Church should be at the forefront of working towards those solutions. This approach is wholly consistent with the nuanced view of poverty, and the manner in which God's people should respond to it, presented in the Bible. Some verses might be taken to support a right-wing, capitalist approach where the poor are responsible for their state. 'Lazy hands make for poverty, but diligent hands bring wealth' (Proverbs 10:4). Others sit more comfortably with a more left-wing, socialist approach where the poor are victims of unjust systems. 'Your rulers are rebels, partners with thieves; they all love bribes and chase after gifts. They do not defend the cause of the fatherless; the widow's case does not come before them' (Isaiah 1:23). A faithful following of the Bible neither endorses a view that the poor are wholly responsible for their poverty, nor are they purely victims. Instead both aspects are held in a realistic tension.

Henry Whitehead was willing to work with secular institutions for the common good of the community he lived and worked in. His authentic and practical demonstration of love for the people in his community meant that he was respected beyond church circles, even though his work unwaveringly reflected his Christian beliefs and values. He was able to see his medical work as an expression of his faith and an extension of his ministry, rather than being something separate. If an ordained minister can value medical work and integrate it to his faith, can we not do likewise?

Bridge

Undoubtedly British culture has moved on. The nineteenth century Church bore greater responsibility for public health and social care; wider society was more sympathetic toward Christianity, and Whitehead's scientific interest and ability was greater than most ministers today. Nevertheless, Whitehead, through living out the Gospel incarnationally, put flesh on his Christian faith and helped bridge the widening divide between the church and medicine as he worked for the common good of the city he lived in.

A simple curate's work was influential in establishing the germ theory of disease that led to improvements in the quality of housing in cities across the UK, substantially improving the lives of many of the poorest in Britain. This is work that is part of God's mission to restore a fallen creation. How might we and our churches do likewise in our times?

Paul Robertson *is a microbiology specialist trainee at Glasgow Royal Infirmary*

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Whitehead perceived the causes of poverty are complex; so must be the solutions

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4. Whitehead was also a gifted preacher and valued the importance of good preaching.
5. Rawnsley; 1898, 80

Vicky Lavy on the strategic role of faith-based organisations

FAITH-BASED ORGANISATIONS AND GLOBAL HEALTH

key points

- Caring for the sick has always been a hallmark of the Christian Church
- Priorities have moved from service provision to teaching and training
- Both faith-based organisations and the local church have important roles in health and healthcare

We have come a long way in the past 175 years. In 1840 Dr John Illott was sent out to West Africa by the Church Missionary Society. His farewell instructions told him that his duties were confined to the health care of the missionaries and did not include the health care of the African people amongst whom they worked. Nor did they include any part of the missionary activity engaged in by his colleagues. He was told in unambiguous terms, 'You are not, strictly speaking, a missionary.'[1]

Happily, attitudes have changed. Mission societies, which initially sent only ordained men to save souls, began to realise that caring for the sick was an integral part of bringing Christ's presence into a needy world. Today it is estimated that faith-based organisations (FBOs) provide 40% of the healthcare in Sub-Saharan Africa,[2] and it is reported that in India, 80% of Christians relate their conversion to a mission hospital experience at some point in their family history.[3]

Early days

Caring for the sick and dying has been a hallmark of the Christian Church over the centuries. In AD 259 the Christian community cared for plague victims in Alexandria, often losing their lives in caring for those infected. In the middle ages, monasteries provided hospitals and leprosaria all over Europe. Some early pioneers travelled across the world to bring care in Christ's name; in 1568 two Jesuit priests built the first Christian hospital in Japan and in 1699 Bernard Rhodes of Lyons, a monk trained in medicine and surgery, took his skills to China. There are records of other brave individuals but it was not until the middle of the nineteenth century that mission agencies started sending doctors in greater numbers. It is estimated that over 1,500 British doctors went to serve overseas between 1850 and 1950.[4] Over 200 of these were women, who pioneered obstetric care in Asia where women were shut off from the help of male doctors, starting with Fanny Butler who set off to India in 1880.

Present day

Since 1950, hundreds more doctors have served overseas, many of them from CMF. A third of the membership responded to a survey in 2010 and of these, 230 (20%) had served overseas long-term in the past. Currently almost 200 members are working in resource-poor settings in 56 countries around the world. Hundreds more make short-term contributions, most commonly to train and teach.

In 2008 the Gates Foundation commissioned The African Religious Health Assets Programme (ARHAP)[5] to carry out a wide-ranging study looking at the contribution of religious entities to health in Sub-Saharan Africa.[6] They found that the proportion of services provided by faith groups of all kinds varied across the continent, ranging from 25% in some Francophone Muslim countries to as much as 70% in parts of East and Southern Africa.[7] Mission hospitals and church-based clinics are the main providers of facility-based services.

In addition to facility-based care, faith-based entities provided training centres for the health workforce (eg 60% of nursing training in Uganda), community activities such as home-based care, advocacy, and a channel for funding. A study by PEPFAR of USAID[8] highlighted the enormous contribution that FBOs have made in the fight against HIV, with a wide range of programmes, skills and knowledge, a clear

commitment to serve local communities and the capacity to mobilise an army of volunteers in any corner of the globe.

There are very few studies analysing the care given in faith-based hospitals and clinics and more research is needed. One study published in the *International Journal of Obstetrics and Gynaecology*[9] looked at the role of FBOs in the area of maternal/newborn health care in six African countries. It was found that the services provided by FBOs were similar to those offered by governments, but the quality of care received and the patients' satisfaction were reported to be better, due to better service quality, staffing levels, supplies and cleanliness. The ARHAP study contains much anecdotal evidence that people prefer to be treated in mission hospitals, where they feel staff are motivated by their faith to treat patients with dignity and respect, give spiritual care and have a commitment to serve the poor.[10]

Experiences from Malawi

This was certainly my experience during the ten years I lived and worked in Malawi. Most people, including Christians, Muslims and others, wanted to be treated in mission hospitals. They were more confident of receiving safe, compassionate care at mission hospitals than at the government facilities, where staff were often demoralised and supplies were erratic.

My husband, Chris, was involved in building the Beit Cure International Hospital, a Christian hospital providing surgical treatment for disabled children. One of the international donors was anxious about funding an overtly Christian hospital in a country with a Muslim president, fearing that it would create tension. However, on the ground there was no problem; everyone welcomed the advent of free care for these needy children who would otherwise never receive treatment. Muslim businessmen donated funds towards the building of the hospital and non-Christian patients were happy to receive prayer. I remember asking the Muslim watchman why he attended staff prayers and he said he was happy to be at a place where faith was valued. I think he also enjoyed the singing!

Changing roles

Many Christians working overseas in low-income countries today are not working in faith-based settings, but in government hospitals and universities, or secular organisations. They may be involved in teaching, research, policy development and disaster response as well as in day-to-day clinical care.

Many mission hospitals have been handed over to governments, others are run by the national Church rather than a foreign mission agency. There is a greater emphasis on primary health care and community development alongside hospital-based care. The early pioneer missionary often worked in isolation, a 'jack-of-all-trades' and sole provider of health care, but now that most countries have medical schools, there is a need to provide specialist training and to integrate with national institutions and structures. In the early days, the missionary had all the knowledge and power, but now works in partnership as a servant and guest.

Local church

The Christian contribution to healthcare does not consist only of work done by health providers; the local church plays a big part in the health and well-being of individuals and society. Worldwide, the local church is present in more communities than any other organisation and it is often a focus for community action and social cohesion, which form the bedrock for development and community health. It has wide coverage, reaching marginalised groups who often fall under the radar of larger organisations, and immense sustainability; the church will still be there when donors and aid organisations have moved on and moved out.

Local congregations are involved in many kinds of health-related activity: home-based care for HIV sufferers, refuges for the homeless, care of orphans and vulnerable children, as well as disseminating health information, changing attitudes and promoting healthy living. Tearfund has worked with local churches in its disaster relief work in twelve different emergency situations around the world.[11] When disaster strikes, it is the local church that is first on the scene. Tearfund's partners played vital roles, doing everything from distributing relief materials to digging water channels, to praying for victims and lobbying governments.

Faith matters

It is encouraging that the UK government's Department for International Development is increasingly recognising the role of FBOs and the need to work in partnership with them. Their 'Faith Partnership Principles' paper begins:

'Faith makes such an important contribution to development...Most people in developing countries engage in some form of spiritual practice and believe that their faith plays an important role in their lives. Faith groups can inspire confidence and trust. They are often seen as a true part of the local community and more committed to it than other groups. Indeed, they are often the first group to which the poor turn in times of need and crisis and to which they give in times of plenty.'[12]

God is at work in the world through his people. They have made an enormous contribution in the past and are transforming lives in the present. What of the future? The international health agenda is under discussion, as we approach the deadline for the Millennium Development Goals in 2015. CMF has recently contributed to the discussion with a paper, 'Faith Matters – the contribution of faith to health and healthcare in the post 2015 agenda.'[13] We have argued that whatever the specific development goals may be, the importance of faith must not be neglected, and the contribution of faith-based organisations must be encouraged and supported.

Vicky Lavy, *CMF Head of International Ministries*

The importance of faith must not be neglected, and the contribution of faith-based organisations must be encouraged and supported

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David Chaput de Saintonge
on maintaining empathy

KEEPING OUR COMPASSIONATE NATURE

Failure of compassionate behaviour in healthcare workers is an active public concern in the UK and a topic of research. The professionals who people look to for sensitive personal care are failing to provide it. Worse than that, patients are being actively mistreated. One particularly distressing piece of evidence is the fact that medical students tend to lose their sense of compassion as they progress through the course.[1] What is happening here?

How can we prevent loss of compassion? This question has prompted me to offer ten tips to keep yourself compassionate.

1. Stay away from cynics

Keep away from people who are always grumbling, criticising and pessimistic about the fundamental goodness of human nature. If you stay with them, you risk becoming like them.

2. Stay close to your patients

Listen to them and try to understand their sufferings so that it is easy to identify with them. One of the major causes of lack of compassion is a sense of distance between yourself and the sufferer. This may be caused by differences in race, language, religion, cleanliness - or just about anything. If you find yourself without compassion for a patient, ask yourself what is causing the distance. To remain fully present in the face of suffering requires maturity and both internal and external resources. These are provided by the three 'F's – faith, family and friends.

3. Remember your wounds

There is a saying: 'never trust a doctor who does not bear a wound'. How often have you had people say 'I know just how you feel' and you have thought 'Oh no you don't. You have never experienced what I'm going through right now.' Although your physical, mental and spiritual wounds will cause you to suffer, they are a valuable cause of compassion for your patients. They will help you reduce the distance.

4. Stop for the one

You can always make a difference to someone; you can never make a difference to everyone. It's tempting to rush on by and be overcome by business. Time pressure often has a devastating effect on altruistic behaviour which may only be shown when social norms permit. This is illustrated by a nice experiment on the failure of good Samaritans.[2]

5. 'Rejoice with those who rejoice and mourn with those who mourn'[3]

Don't be afraid to express your emotions. That is what makes you human and not a machine. Patients want to be treated by humans. The evidence suggests that patients feel supported by displays of emotion by their doctors, especially anger if it is on the patient's behalf.

6. But remember their suffering is not your suffering

Compassion fatigue is a real problem for the empathetic doctor who becomes overwhelmed with the suffering of his patients and cannot escape. Make sure that you are well resourced and exercised physically, mentally and spiritually.

7. Be thankful for all the blessings you have

This will help keep you both compassionate and content.[4] Some people write a short note to themselves at the end of each week simply listing the things for which they are thankful in their lives.

8. Work closely with good role models

Cultivate compassionate relationships, both medical and non-medical. It seems likely that a combination of your mirror neurons activity and neuroplasticity will gradually alter the way your brain is structured and the way it works. Both good and bad attitudes can be learnt in this way. In the same way, if you practise compassion yourself, the structure of your brain will change and so will you as a person and as a doctor.

9. Make conscious judgements of which actions show compassion and which do not

It helps to scrutinise yourself and others. This use of your emotional intelligence keeps you alert and tuned in to what is happening and keeps you on track.

10. Admire what is good, oppose what is bad

You have the power and the responsibility to develop a caring environment where you are. You are a role model and an influence for good, not just with your students and your peers but also those who are senior to you. Several times in my life my students have set me straight when my attitude was not as it should have been.

***David Chaput de Saintonge**, Director of Education for PRIME and a former senior lecturer in Medical Education and Director of Clinical Skills at St Bartholomew's and the Royal London Hospital Medical School.*
Article first published in the PRIME Wholecare Bulletin, *June 2012, reproduced with permission.*

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letters

Foodbanks and poverty

As usual your articles (*Triple Helix*, Winter 2013) are stimulating and helpful, but I was disturbed by the article on Feeding the Poor as it raises many issues, which have continued to exercise me greatly over the past decades.

'The poor' and its definition. We read 'Today, about 13 million people in the UK live below the poverty line. That is one in every five people.' I do not know how poverty in the UK is defined. Where I live [Switzerland], it is a certain percentage point (I think somewhere between 10-20%) below the medium income, so in a relatively rich country the poor may be relatively rich too. I have seen poverty, real poverty for instance, in the slums of Chittagong and elsewhere. I think it can be misleading to talk about poverty when we are told that 'the single biggest reason' for referral to foodbanks was 'benefit delay'. It seems a society that depends on such benefits does not quite match up to a country that put on the Olympics in 2012 which cost millions of pounds.

***Stephen de Garis**, Baselland, Switzerland*

Organ donation

There are plenty of complex ethical issues around organ transplantation. The recent BMA review[1] and the discussion and referendum in Wales about changing the law are bringing the issues to the fore again. Philippa Taylor (*Triple Helix*, Autumn 2012)[2] suggests adopting a system of presumed consent is ethically tricky and unnecessary and I disagree.

All the reports she quotes acknowledge the multifactorial nature of improving transplant rates, but the conclusion that therefore, one of those factors is unnecessary, is flawed. And something being ethically tricky is not a reason to take (or not take) a certain course of action. I don't think God is a pedant.[3,4] I think he is sovereign in the 'ethically tricky' areas and that he approves of medical science that relieves suffering. Organ transplantation does that, and a soft presumed consent system may well increase the organ transplant rate.

We all know that people don't like talking about death, and we know that, when asked, 90% of people would be happy to donate organs, but only 27% have registered as donors. Soft presumed consent, which is proposed in Wales, means that relatives can prevent the transplant occurring if they feel strongly about it.

Currently thousands of organs are wasted because conversations about using the organs cannot take place. In practice, the proposed change in Wales means that, in a tragic situation, a transplant coordinator can say to a family (who may have never thought about or discussed it) – 'some good can come out of this, because your loved one's organs could help save someone else's life, even though they are now no use to them. Is that OK? If you don't think it would be, just say so.'

I also worry about use (and arguments around change in use) of the words 'donation' and 'consent'. These are not core issues. Organ transplantation is not good because it is a donation, it is good because it is a sound treatment for organ failure. And no doctor can argue that consent is a concrete concept. Time, external influence, patient interest and abilities all influence consent. Consent is not different in nature for organ transplantation than it is different to any other medical procedures. Just think about how often we presume consent in standard medical practice. It is not unusual, or unreasonable.

I worry that it is easy for small-state conservatism to be the driving force of our ethical proclamations and campaigns, rather than compassion. The argument 'we don't trust the state with our bodies, dead, alive or somewhere in between' is not a religious or even ethical argument, but a political position.

I recognise that neither Philippa Taylor nor myself can do full justice here to the many ethical, theological, scientific, professional and political issues that we must address when discussing this subject. But I am unconvinced that Christian doctors should oppose introduction of an opt-out or presumed consent system, and I strongly support it.

***Helen Morant**, Head of Online Learning, BMJ Learning, London (Written in a personal capacity)*

1. http://bit.ly/12ou3Es
2. http://bit.ly/Yvp3XM
3. Barth K, Church Dogmatics, London: Continuum, 2004, Volume 3:3
4. Isaiah 55:9

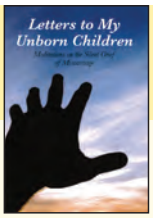
I wholeheartedly support measures to increase organ donation, and agree with Helen that it can be both a means of relieving suffering as well as altruism on the part of the donor. I also welcome the increase in registered donors. However there are many factors beside legislation that affect numbers of registered donors. Research and the experience of other countries does not offer a clear correlation between presumed consent legislation and increased rates of organ donation.

The main issue, however, is around consent. Consent is the golden thread running through most medical procedures, including the Human Tissue Act 2004 which covers organ donation. Helen says that we already presume consent for many standard medical procedures. However donation for transplantation is one of the scheduled purposes where specific consent is required. Likewise for most operations and medical procedures written consent is required. So why should consent for transplantation now be treated as less necessary than for other procedures?

If the situation in Wales were to be as Helen describes under 'soft' presumed consent, namely a gentle discussion that encourages a family to consider allowing their loved ones organs to be removed and used, then I would have fewer objections to it (although I would still be concerned that a lack of specific consent by the deceased actually indicates a lack of understanding rather than informed consent to the policy). However the Welsh draft Bill is clear that organs will be removed and a family has no legal right to veto or overrule 'deemed' consent. The accompanying memorandum (not the Bill itself) says that donation may be 'unlikely' to go ahead if there are 'very strong' objections or distress from the family, but it reiterates that the deemed consent of the deceased has precedence. This is neither credible soft opt-out wording nor even in the Bill.

I appreciate that presumed consent is an issue on which Christians will differ, because while we all agree that the ends are good, we will not all agree about the right means of getting there.

***Philippa Taylor**, CMF Head of Public Policy*



Letters to My Unborn Children

Meditations on the Silent Grief of Miscarriage
Shawn T Collins

- Quill House Press, 2012
- $11.00 (no UK price given) Pb 100pp
- ISBN 978-1-933794-58-7

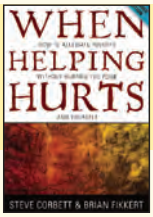
Miscarriage is unexpected before it happens, frequently unexplainable when it occurs and rarely discussed afterwards. Yet there can be little worse than losing a child.

Mothers and fathers will often grieve in different ways, and sympathy can be primarily directed to the mother, which can leave fathers with less support. This book is written by a father, and while it touches his wife's feelings it is primarily about the reality of paternal grief.

Shawn Collins wrote letters to his children after three of them miscarried. It was his way of saying 'hello' and 'goodbye'.

It is a short book, comprising letters to each child miscarried, two laments and a longer letter to all his children, including his three living children. Collins describes how the first miscarriage was about shock, the second about a shattered worldview and the third about despair. This book does not offer simplistic prescriptive solutions to painful and complex questions but will help people (especially fathers) legitimise the grief process and roller coaster of emotions from miscarriage.

***Philippa Taylor** is CMF Head of Public Policy*



When Helping Hurts

How to Alleviate Poverty Without Hurting the Poor... and Yourself
Steve Corbett and Brian Fikkert

- Moody, 2012
- £10.00 Pb 274pp
- ISBN 9780802457066

Who thinks Christians should help the poor? Most of us. Who has given much thought to how we should do that? Not many of us.

When Helping Hurts explores what it really means to be poor and demonstrates that churches and individual Christians often have faulty assumptions about the causes of poverty. Good intentions may result in strategies that do more harm than good. The book explains why the combination of the 'God-complex' of the rich, the inferiority complex of the poor and an over-simplistic view of poverty is an explosive combination which can cause harm and hurt in all directions. A path forward is found, not through providing resources to the poor, but by walking with them in humble relationships. The authors use case studies and stories to illustrate ways to help the poor without hurting them, and give questions at the end of each chapter.

This is the most thought-provoking book I have read for some time. It has challenged my thinking about the ways we serve the poor both here and overseas. It takes a hard look at short-term mission abroad and also at Church projects at home. Although it asks some tough questions, it gives some practical and inspiring answers. Everyone interested in serving the poor should read this book – so that should mean all of us.

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

Honouring Personhood in Patients

The added value of chaplaincy in general practice
Ross Bryson

- Whole Person Health Trust, 2012
- £7.00 Pb 72 pp
- ISBN 978-0-9544644-6-2

Enter here and enjoy a book that provides a unique insight into practical whole person care with an emphasis on patients' spiritual needs. The contributors offer wise consideration of spirituality as an integral component of persons and describe its place in holistic care based on extensive experience.

The role of the community healthcare chaplain is defined by a distinctive combination of eight 'key functions' and the personal qualities needed for their practice. Separate chapters describe the difference between spiritual care and counselling and the function of a prayer clinic in general practice - all set in the reality of urban clinical care.

The evaluation of such a service and its difficulty is tackled head-on using data from research on the impact of a community healthcare chaplain. From qualitative studies, spiritual care emerges as an important component of treatment, and a person's story as the centre of the health care process. Above all, these convey the deeply healing effect of spiritual care delivered with Christian understanding and compassion in the setting of holistic medical practice.

***Richard Vincent** is an Emeritus Professor at Brighton and Sussex*

Modern Psychotherapies

A Comprehensive Christian Appraisal
Stanton L Jones and Richard E Butman

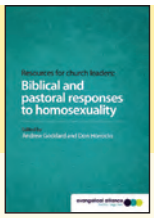
- IVP, 2011
- $32 (no UK price given) Pb 496pp
- ISBN-10: 0-8308-1775-1
- ISBN-13: 978-0-8308-1775-7

Have you ever wanted to read a Christian critique of all the major forms of psychotherapy – psychoanalysis, cognitive behavioural, person-centred, experiential, family therapy? This is the definitive version. Each school of psychotherapy is described, along with its philosophical assumptions and its models of psychotherapy, personality, health and abnormality.

The authors, who are from Wheaton Christian College, USA, state that all therapies contain some elements which are compatible with a Christian worldview and other elements which conflict with it. They do not believe that there is a specific 'Christian' form of psychotherapy, but they enumerate 18 criteria for 'a comprehensive theoretical approach to Christian counselling'. They believe that Christians should be eclectic and transform secular psychotherapies to conform to Christian revelation. As for Christian counsellors, they are called to show ten virtues – which may at times be in conflict with the approach of their secular colleagues – compassion, servanthood, accountability, transparency, love, stewardship, holiness, wisdom, integrity and a sense of community.

This is a classic which Christian counsellors, psychotherapists and clinical psychologists would do well to have access to.

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



Biblical and Pastoral Response to Homosexuality

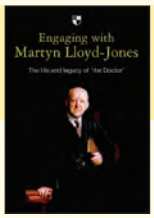
Resources for Church Leaders
Andrew Goddard and Don Horrocks (eds)

- Evangelical Alliance, 2012
- £7.00 Pb 144pp
- ISBN 9780957244801

This very useful resource is an update of the EA's 1998 report *Faith Hope and Homosexuality* (FHH). It will be of value to CMF members as well as the target audience of church leaders, not least for its extensive bibliography (which includes CMF publications). It aims to provide a contemporary theological and sociological commentary on ten affirmations restated from the original twelve of FHH. The final half of the book comprises nine case scenarios, all illustrating graphically the practical issues arising from the tensions between the affirmations, encouraging 'evangelical congregations to welcome and accept sexually active lesbians and gay men' and stating the belief that 'both habitual homosexual activity without repentance and public promotion of such activity are inconsistent with church membership' (p103).

One of the case discussions is on Oliver and William, a gay couple in a civil partnership, who have an adopted handicapped child. Oliver has recently made a profession of faith and the couple want to have a dedication service for their child. The book does not duck the issue on advising how the authors believe a church leader should respond.

***Trevor Stammers** is Programme Director in Bioethics and Medical Law, St Mary's University College, London*



Engaging with Martyn Lloyd-Jones

The life and legacy of 'the Doctor'
Andrew Atherstone and David Ceri Jones

- Apollos, 2012
- £16.99 Pb 376pp
- ISBN 978 1 84474 553 1

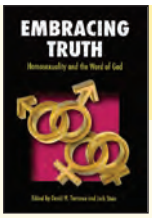
This is not a biography. Eleven academic historians and theologians have meticulously researched and copiously annotated this well written work.

It concentrates on 'several areas of his theology and legacy that remain hotly contested'. His links to the inter-war Calvinist resurgence and to Wales, his views on revival, the charismatic controversy, the demise of preaching, ministerial education, fundamentalism, Barthian theology, Roman Catholicism, the Anglican secession crisis and the Protestant past are all examined.

Of particular resonance is Lloyd Jones's reminder: 1. That humanity's ultimate need is not that he is sick, unhappy, poor or uneducated, but being in rebellion against God and consequently under the wrath of God. 2. That the Bible is God's announcement of how, through Christ's death on the cross, he has provided a means of forgiveness and reconciliation. 3. That the primary task of church and preacher is to proclaim this message.

At a time when churches are again being torn apart by conflict, Lloyd Jones's view that doctrinally pure churches as a vital precursor to religious revival, will again be scrutinised.

***John Wenham** works for the Royal Flying Doctor Service based in Broken Hill, Australia*



Embracing Truth

Homosexuality and the Word of God
David W Torrance and Jock Stein (eds)

- Handsell Press, 2012
- £6.95 Pb 256pp
- ISBN 978-1-871828-74-0

This is an interdisciplinary collection of essays with a Scottish flavour which grapples boldly with arguably the most contentious social and theological issue of our day.

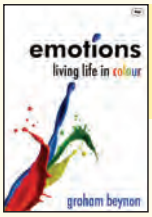
For many the subject is inherently confused and confusing. The opening essay by Andrew Goddard, offering an outstanding survey of the current state of play in this esoteric field, is therefore welcome.

There follows an array of perceptive essays by a range of academics and experienced pastors, including several notable Scottish contributors. The overall impression is one of convincing reasons to stand for truth against prevailing social and cultural forces which would seek to undermine the natural order.

Popular readers will find some essays more readable and relevant than others. However, this is an excellent general resource which provides a serious overview of the debate as it currently stands. There is also much for those who wish to engage more deeply.

The paperback edition has almost sold out but it is available on Kindle.

***Don Horrocks** is head of public affairs at the Evangelical Alliance*



Emotions

Living life in colour
Graham Beynon

- Hart Publishing, 2011
- £ 8.99 Pb 176 pp
- ISBN 978-1-84474-589-0

'Emotions are unimportant', or so I once famously remarked as a somewhat naive medical student, probably in reaction to what I perceived as excesses in the opposite direction. God soon disabused me of this notion through a variety of interesting circumstances, but this book would have been really helpful at the time. Emotions may not be everything, but they are certainly not nothing.

Graham Beynon's easy and accessible writing style is matched by biblically-balanced content, to help us think through the important issue of our feelings. Through ten chapters he establishes some basics about emotions, leading on to a consideration of various practical issues. In addition to focusing our attention on Jesus as the perfect man, with feelings as God intended, he also addresses areas such as depression, and emotions in worship. He seeks to help us liberate and celebrate the God-given emotional aspects of our lives, that we might become redeemed whole people with integrated thoughts, feelings and actions, and that we might respond to God with all that we are.

I found this book very useful in addressing some of my unbalanced theology, and encouraging in helping me to regard feelings in a more positive and God-honouring way. I recommend it.

***Everett Julyan** is a psychiatrist in Ayrshire*

eutychus

Pharmacists' right to say no

University of Hertfordshire academics want removal of the right of pharmacists to refuse to distribute the morning-after pill. They argue it is 'the power of veto over the liberty of others, and over the implementation of public policy'. Pharmacists can refuse to sell the pill but must direct the customer to another provider. The counter argument is that professionals must have a right to act according to their conscience and this change would risk pharmacists being reduced in status to vending dispensers. (Gallagher C *et al*, *J Med Ethics* doi:10.1136/medethics-2012-100975, 30 January 2013. *http://bit.ly/12eVKiL)*

Best for baby?

The baby food industry seems to be constantly under scrutiny. While launching new campaigns to persuade the government to require baby milk formula packaging to warn that 'breast is best', Save the Children UK, has been giving attention to East Asia and the Pacific. It says the region is perceived as a lucrative new market for the industry. Thanks to aggressive marketing strategies the proportion of women there who breastfeed fell from 45% to 29% in just three years. (ref: *http://bit.ly/Y2NQpu* and *http://bit.ly/VvgvW0*)

Gun violence: The mental health factor

14 December's shootings in Newtown, Connecticut, where 20 children and six teachers died, has reverberated globally. One issue emerging in the US is the mental health factor in gun violence. The White House is facilitating a national dialogue. *The Lancet* comments that high-quality research and safeguarding of lines of communication between patients, doctors and law authorities is essential to ensure success of the dialogue. (*The Lancet*, 26 January 2013, Volume 381, Issue 9863, *http://bit.ly/Y3NCNd)*

Horse sense

Jokes abound over horsemeat sold as beef. For many consumers, however, this is no laughing matter. Is this a deception akin to dodgy weighing scales – something 'God detests' according to Proverbs 20:10? A Consumer Intelligence survey reveals that one in four adults (24%) say they would buy less processed meat in the wake of the scandal, while 22% said that they would no longer buy any processed meat. Although 24.6% said they were now buying more unprocessed meat, 19% said they would like to, but could not afford to. (*BBC News* 18 February 2013. *http://bbc.in/15nWMJn)*

Self-help with depression

Self-help books provide effective treatment in the face of a growing incidence of depression, says a new study. Patients offered books and sessions advising how to use them had lower levels of depressions one year on than those offered the usual care by their GPs. '*More than 200 patients who had been diagnosed with depression by their GP took part in the study, half of whom were also on antidepressant drugs*,' said the BBC. (Plos One, Williams C *et al*. Guided Self-Help Cognitive Behavioural Therapy for Depression in Primary Care: A Randomised Controlled Trial. 11 January 2013. *http://bit.ly/U8blfx)*

Ethics by numbers

Can we clone a Neanderthal? Is this desirable? Yes on both counts says George Church, Harvard Professor and a founder of the Human Genome Project. He told German magazine *Der Spiegel*, '*I tend to decide on what is desirable based on societal consensus. My role is to determine what's technologically feasible.*' In other words let's do ethics by numbers. But why shout about this idea from the rooftops? This kind of cloning is illegal in most countries and the ethical and safety concerns are legion. But high-profile media pronouncements can serve to soften up public opinion to the unthinkable. It won't hurt the search for grant funds either. (*Der Spiegel* 2013/3. 14 January 2013. *http://bit.ly/11NjWIK)*

HIV infection rates static despite advances in testing

Despite massive improvements in treating and testing for HIV there has been no dent in numbers of infections in gay and bisexual men in England and Wales, says a new study. There were signs, too, of a return to risky sexual practice. New infections stayed at the same level – about 2,300 a year – between 2001 and 2010, despite better early diagnosis and greater take-up of medication. There is an 'all time high' in the spread of HIV among men who have sex with men, said the Health Protection Agency. (*The Lancet Infectious Diseases*, Early Online Publication, 1 February 2013. *http://bit.ly/14uSgr9* HPA. *HIV and sexually transmitted infections*. *http://bit.ly/Sr7wkF)*

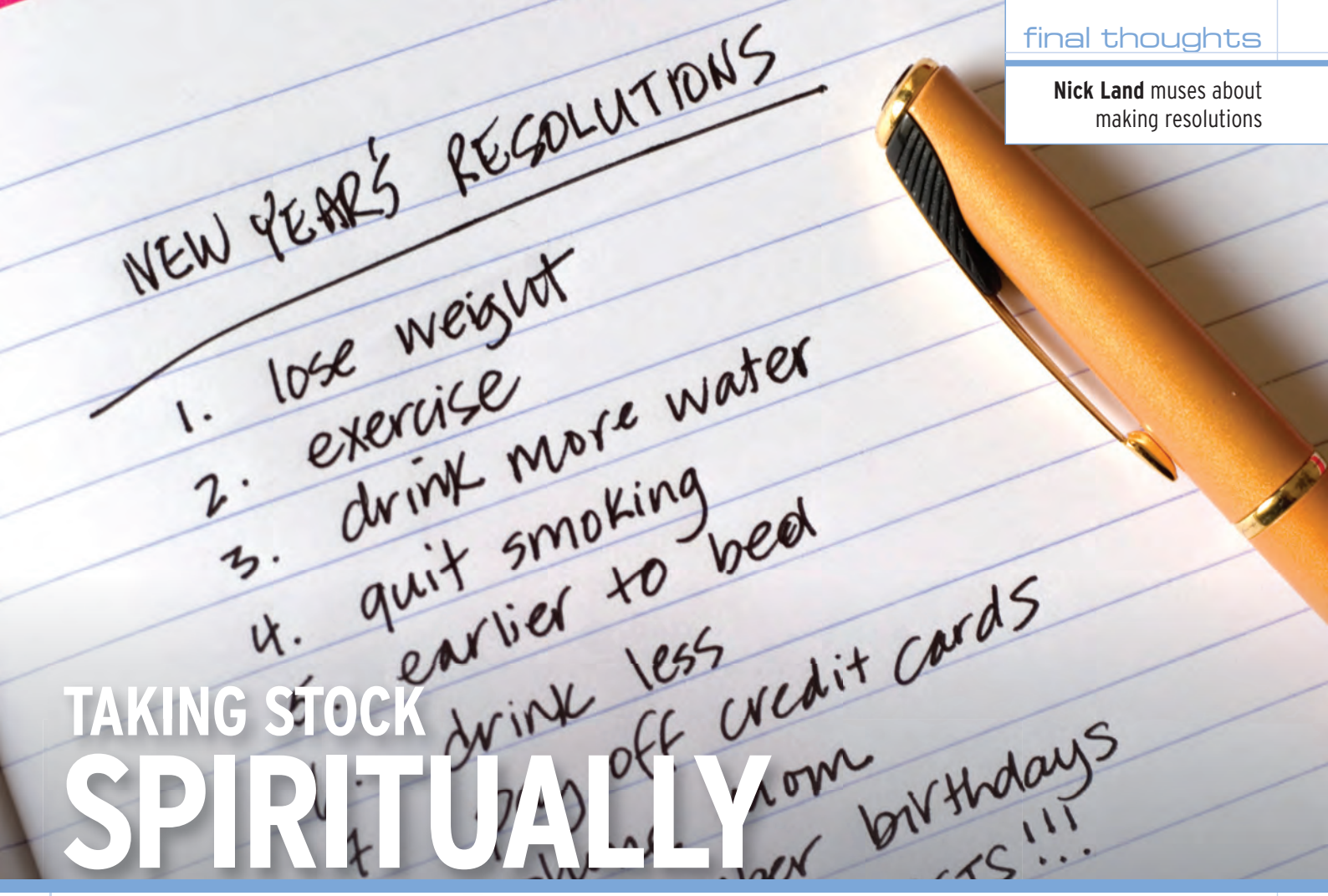
Restore compassion, please

The new Chief Nursing Officer for England, Jane Cummings, has added her voice to those expressing concern over falling care standards in the NHS. She wants to see nursing recover its core values: particularly care, compassion, courage, commitment and communication. The issues are deep-rooted including nurse-patient ratios and how new recruits are taught about compassion alongside other core competencies. In a system driven by performance targets, there is little clarity about how care is measured. Is wide-ranging culture change possible? How can sharing the story and role model of Jesus contribute to the discourse? (*BBC Today Programme*, 4 December 2012. *http://bbc.in/12f5724)*

Now it's quadruple helix

CMF thought itself innovative when coining the name *Triple Helix* for this magazine, a God-ward echo on ground-breaking work by Francis Crick and James Watson on the double-helix structure of DNA. Now Cambridge scientists are heralding discovery of four-stranded 'quadruple-helix' DNA in human cells, which they claim may lead to new cancer drugs. Julie Sharp, of Cancer Research UK, project funders, says: 'It's been 60 years since its structure was solved but work like this shows us that the story of DNA continues to twist and turn.' (*Varsity Online*, 28 January 2013. *http://bit.ly/Uyc3CK)*

Nick Land muses about making resolutions



TAKING STOCK SPIRITUALLY

At various times in the year, the first week of January, or as Lent and Easter approaches, I find myself discussing whether making resolutions is biblical. On the one hand '*it is by grace you have been saved, through faith – and this is not from yourselves, it is the gift of God – not by works, so that no one can boast*'.[1] So we know that no efforts or resolve on our part can save us from the consequence of sin. Praise God that Jesus has already paid the price for this through his death on the cross. On the other hand Hebrews challenges us to '*throw off everything that hinders and the sin that so easily entangles. And let us run with perseverance the race marked out for us, fixing our eyes on Jesus*'.[2] We certainly cannot become more Christ-like in our behaviour without the Holy Spirit, but getting rid of sinful habits and establishing good ones does require some effort on our part.

These landmarks are as good a time as any to take stock spiritually and consider who God wants us to be and what he wants us to do in the year ahead. So perhaps I can share with you three biblical resolutions to consider.

'***Consider how we may to spur one another on towards love and good deeds***, *not giving up meeting together, as some are in the habit of doing, but encouraging one another*'.[3] The Christian Medical Fellowship is a *fellowship*. It is individual Christian medics encouraging one another; praying together; studying God's word together and reminding one another of the goodness of God. It is this that builds us up as the body of Christ. If this is going to happen it is up to each one of us to give time and effort to encouraging one another. This is why CMF has set out a vision to have a Christian 'link' for every locality, workplace, speciality, church and deanery. If there is no link in your place of work perhaps we shouldn't just hope for someone else to do it – think about starting something.

'***Do nothing out of selfish ambition or vain conceit***. *Rather, in humility value others above yourselves, not looking to your own interests but each of you to the interests of the others*'.[4] In your relationships with one another '*have the same mindset as Christ Jesus:*

who, being in very nature God, did not consider equality with God something to be used to his own advantage; rather, he made himself nothing by taking the very nature of a servant'.[5]

As our health service undergoes massive change it is crying out for servant leaders, women and men who will put patients, carers and colleagues first – rather than prioritising their own personal convenience, or defending their professional privilege. Challenging though this may be, there have seldom been more opportunities to take on clinical leadership positions. We are commanded to be 'salt and light', so should we at least consider if we are called to be servant leaders in our practices, clinical commissioning groups, hospitals or deaneries?

'***In your hearts revere Christ as Lord***. *Always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have. But do this with gentleness and respect.*'[6] For many in the health service, patients and staff alike, life seems very uncertain and hope is in short supply. As Christian doctors we have hope in Christ Jesus, an anchor for the soul, firm and secure.[7] As we live out this hope serving our patients and our colleagues we will be asked to give the reason for the hope that we have. We really do have good news that is worth telling. Perhaps we can all resolve to consider how we can do this more effectively.

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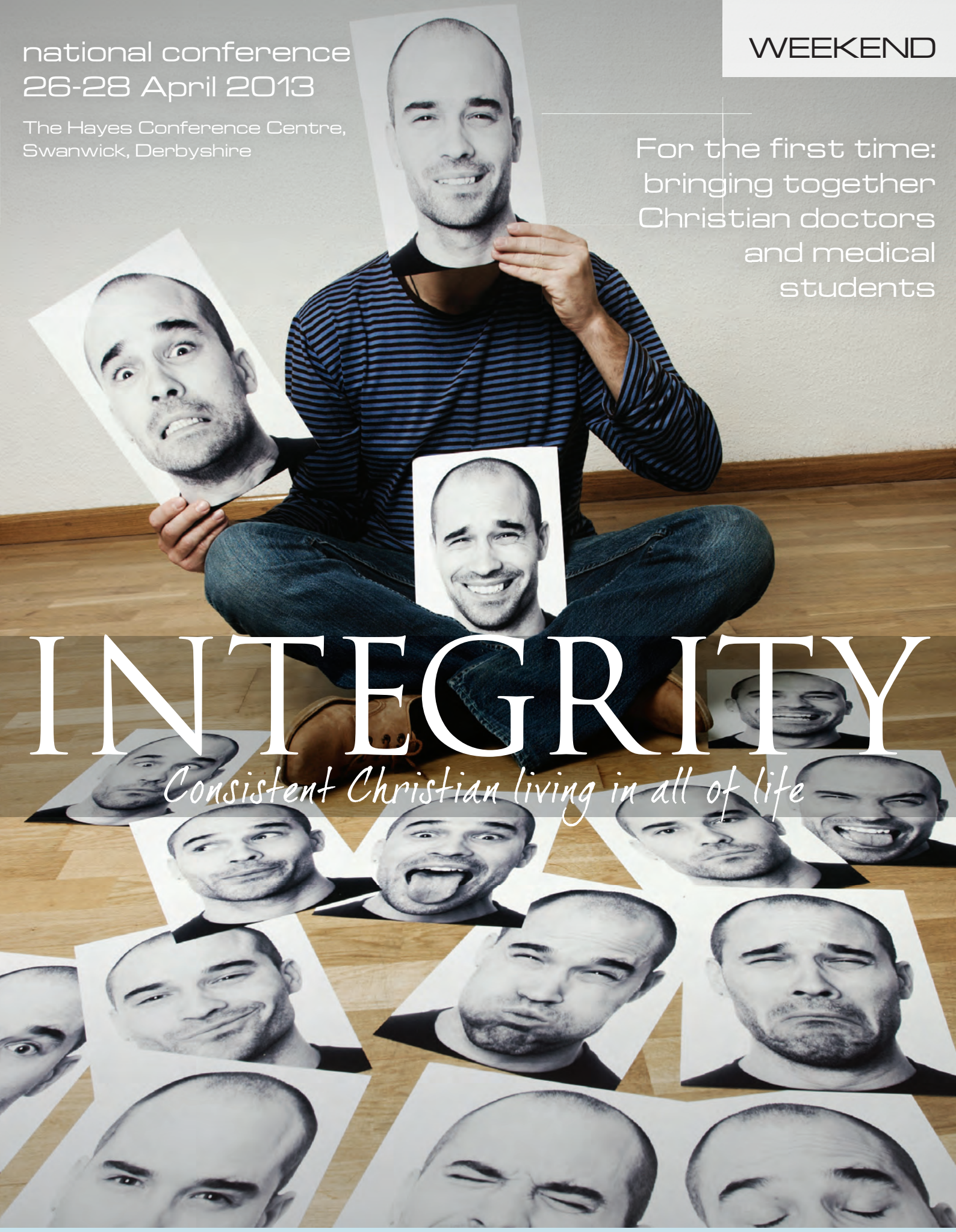
references

1. Ephesians 2:8-9
2. Hebrews 12:1-2
3. Hebrews 10:24-25
4. Philippians 2:3-4
5. Philippians 2:5-7
6. 1 Peter 3:15
7. Hebrews 6:19



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