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for today's Christian doctor

triple helix

compassion needed

medicine behind bars, in it for the long term, testimony, encountering depression, tolerance, junior doctors in a new era, reviews

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Christian doctors under pressure

Economic and political changes, increasing health needs and a growing hostility to Christian faith and values add up to one thing: doctors, and especially Christian doctors, are under pressure.

Like most issues of *Triple Helix*, this one covers a broad range of topics but pressure is the unifying theme. Tim Lyttle, in his Rendle Short lecture speaks of the pressure to perform in an atmosphere of NHS debt and distress. His prescription is an avalanche of compassion. Naomi Pritchard describes the pressures on junior doctors posed by relocation, career choices and the disintegration of the team system. Mark Pickering and Jane Bates address the pressures of medical service in hard places, in prison and the developing world, whilst Elizabeth Procter addresses the pressure of facing depression and Robin Fisher describes the unusual route, through the army, by which God led him to a career in medicine.

Then there are the pressures brought by the increasing secularisation of society. Helen Barratt describes the tyranny of the 'new tolerance' leading to marginalisation of Christianity, and three of our news reviews deal with areas where Christian values are under threat – abortion, euthanasia and faith sharing in the consultation.

Earlier this year Christians in Parliament, an official All-Party Parliamentary Group (APPG), chaired by Gary Streeter MP, launched an inquiry called 'Clearing the Ground', which was tasked with considering the question: 'Are Christians marginalised in the UK?'

The inquiry was facilitated by the Evangelical Alliance[1] and the report was published in February 2012.[2] I gave both written and oral evidence[3] to the inquiry on behalf of CMF.

The inquiry's main conclusion was that 'Christians in the UK face problems in living out their faith and these problems have been mostly caused and exacerbated by social, cultural and legal changes over the past decade.'

With the rise of secular humanism and, in particular, the 'new atheism', there is in British society generally a loss of historically held belief in: the existence of a transcendent communicating God incarnate in Jesus Christ, biblical authority and biblical ethics; combined with an active agenda to impose an alternative secular world-view through our laws, institutions and media.

This is leading to an erosion of laws that were based on a biblical worldview and to some loss of Christian freedoms.

Conflicts arise when Christians are prevented from sharing, expressing or manifesting their beliefs, required to perform tasks or conform in ways which go against their beliefs, excluded from consultation or decision-making or advisory roles or prevented from meeting on public or institutional premises for worship and prayer.

The most influential recent laws have been the Equality Acts 2006 and 2010 which outlaw discrimination on grounds of religion and belief and sexual orientation although the Abortion Act 1967 and the Mental Capacity Act 2005 also still exert influence.

Guidelines based on these laws by the DH, NHS trusts and professional bodies like the GMC and BMA also have an impact on how legal policy is interpreted and implemented and sometimes mean that public bodies over interpret the laws when they come to apply them in specific situations. All this adds up to an increasing number of complaints against Christian doctors on the front line.

Secularism has impacted art and entertainment, government, science, business, media, the judiciary and education and all of these 'mountains of culture' have an influence on medicine and healthcare. In parallel with this the formation of new oppositional activist groups and the strengthening of existing ones advocating euthanasia, abortion and gay rights mean that we are fighting a number of public policy battles simultaneously on a variety of fronts, and we are seeing more examples of Christians being targeted or made the subject of vexatious complaints.

None of this should surprise us. Jesus promised us that, along with the joy and satisfaction of loving and serving him, we would face tribulation in this world.[4] We should expect opposition, difficulty and pressure. But he also assured us that he was building his church and that the gates of Hell would not prevail against it.[5] Our future security is certain. A new heaven and new earth is coming.

So let's take the shield of faith, the sword of the Spirit and all God's armour[6] as we stand together amidst pressures old and new. Let's continue to practise Christ-centred medicine and Christ-centred compassion as we minister together to our colleagues and patients. Our vision is that in every workplace, church, locality, foundation school, medical school, deanery and specialty there will be Christian doctors actively witnessing to Jesus Christ by their words and deeds. Let's work together to make it a reality.

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

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BMA resists move to go neutral on 'assisted dying'

Christian doctors must remain engaged in this debate

Review by **Peter Saunders**
CMF Chief Executive

The BMA has overwhelmingly rejected[1] a motion calling for it to adopt a neutral position on 'assisted dying' at its annual representative meeting at Bournemouth on 27 June. In so doing it has upheld its opposition to any change in the law to allow either assisted suicide or euthanasia.

Members of the pressure group 'Healthcare Professionals for Assisted Dying' (HPAD)[2] had flooded the BMA agenda with nine almost identical motions calling for neutrality from which the agenda committee had crafted a composite motion to be debated.

The move was part of a carefully orchestrated campaign[3] aimed at neutralising medical opposition ahead of a new parliamentary bill calling for legalisation. HPAD is closely affiliated to Dignity in Dying, the former Voluntary Euthanasia Society. It had also been supported by the *British Medical Journal* editorial which gave international prominence to a poll allegedly showing that 62% of doctors supported neutrality.[4] However the wording of this poll conducted by Doctors.Net is now under investigation by the Market Research Society[5] and a subsequent BMJ Online Poll showed that 83% of respondents were against the move.[6]

Motion 332 read as follows: 'That this Meeting i) believes that assisted dying is a matter for society and not for the medical profession; ii) believes that the BMA should adopt a neutral position on change in the law on assisted dying'.

The proposer, Prof Tallis, argued that the current situation was 'morally repugnant' and said that the BMA should adopt a policy of 'studied neutrality'.[7] But Baroness Finlay said that the public would not understand why the BMA won't express a view on the prescription of potentially lethal drugs.

BMA Ethics Chairman Tony Calland argued that it was important doctors stayed engaged in the debate whilst BMA Chairman Hamish Meldrum added that a position of neutrality was the worst of all positions and urged the meeting to reject the motion.

Both parts of the motion were subsequently lost. In rejecting this move the BMA has sent out a strong message that doctors must play a leading role in this debate which could otherwise be far too easily swayed by celebrity endorsement and media outlets.[8] I have previously considered the arguments against neutrality in more detail than is possible here.[9]

Lord Falconer, in conjunction with Dignity in Dying and the All Party Parliamentary Group on Choice at the End of Life, has since published a new bill[10] aiming to legalise assisted suicide for adults who are mentally competent and terminally ill which he hopes to introduce into the House of Lords next year. Meanwhile there is a consultation on the 'safeguards' in the draft bill which closes on 22 November.

The cost of freedom is eternal vigilance and it is imperative that Christian doctors stay engaged in this debate both by opposing any change in the law and in championing good palliative care.

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Christian doctor reprimanded for sharing faith

But the duty to provide appropriate spiritual care remains

Review by **Peter Saunders**
CMF Chief Executive

On 14 June the General Medical Council's Investigation Committee reprimanded a Christian GP who shared his faith with a patient at the end of a private consultation.[1] Dr Richard Scott has now been issued with a warning which will remain on his record for five years and further serious or persistent failure to follow GMC guidance will put his registration at risk.

The full judgement is available on the GMC website[2] and the Huffington Post[3] gives more detail of what Dr Scott said in his defence. I have also written a detailed commentary on the case and its implications.[4]

The case has aroused controversy because the GMC made their assessment based on two varying accounts of what actually happened, but seem to have preferred the patient's testimony over that of Dr Scott where the two accounts conflicted. Also the initial complaint was made by the patient's mother who was not a witness to the consultation and transcripts of Dr Scott's radio interviews were gathered by the National Secular Society, who undoubtedly had an ideological vested interest in the outcome.

The GMC committee concluded that Dr Scott 'caused the patient distress which [he] should have foreseen' by the way he expressed his beliefs and that he also 'sought to suggest [his] own faith had more to offer than that of the patient' and in so doing 'sought to impose [his] own beliefs'.

They claimed that his actions were in direct conflict with paragraph 19 of its supplementary guidance: Personal Beliefs and Medical Practice and also with Paragraph 33 of 'Good Medical Practice'.

The GMC defended its issuing of a warning by saying it was obliged 'to lay down a marker as to expected standards and to maintain public confidence in the profession.' But it added that 'the discussion of religion within consultations is not prohibited' and that this case 'relates to the manner in which religion was approached during the consultation'.

This was later confirmed in a letter from David Horkin, GMC Investigation Officer, which made it clear that the GMC had no objection to faith discussions per se providing they were carried out 'in an appropriate and sensitive manner' with the patient's consent and that the doctor did not 'belittle/disrespect the patient's own faith' and did not 'impose his views' on any patient who 'does not want to discuss such matters'.

Many will have misgivings about the way this case was handled both by the GMC and the media but it would be a great tragedy if, as a result, Christian doctors shrunk back from providing appropriate spiritual care or from sharing their own Christian beliefs in a sensitive way, when appropriate, and when the patient had welcomed it.

To the contrary, good doctors have a professional duty to practise 'whole person' medicine that is not concerned solely with physical needs, but also addresses social, psychological, behavioural and spiritual factors that may be contributing to a person's illness.

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BMA backs pre-abortion counselling

Extending choice to women, not limiting it

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

In June the BMA held its annual representative meeting, where a motion supporting the universal availability of non-directive counselling for women considering abortion was passed by an 'overwhelming majority' of members.[1,2]

This is a small but significant step, recognising the need for women who have an unplanned or unwanted pregnancy to be able to access unbiased counselling before they make a decision to have an abortion.

CMF member, Dr Mark Pickering, proposed the BMA motion and explained his thinking behind it: '*On an issue that is often heated, emotive and controversial I've tried to put forward a proposal that people from all viewpoints can support.*' He acknowledged that while some women will definitely want an abortion, and not want counselling, there will be others who: '*... are less certain, and perhaps be looking for a safe space to think through the options and the implications for them. We owe each one of them a duty to ensure this opportunity is available... When I've seen women as a GP... one of the most common phrases I've heard is "I feel I have no choice". Instead, any woman should know that, if she wishes, she can get counselling through the NHS.*'

Another part of his motion called for counselling to be independent of the abortion provider. Pickering explained: '*By no means would all women want this separation for them but it should be an option. If a woman may feel more comfortable discussing her situation elsewhere then surely this should be offered... this motion is about extending choice to women, not limiting it.*'

Due to wording technicalities, this particular part was not passed as policy but was passed as a 'reference to Council'. In other words, the meeting was supportive of the spirit of it, and the BMA is still mandated to take the motion and do what they can to enact it, but is not bound by the exact wording.

A third part of the motion, also passed as reference, commits the BMA to working with the Department of Health to develop national guidelines for counselling, as there are currently none.

Overall, this is a great outcome in view of recent debates on counselling in Parliament, in the media and the promised public consultation on independent counselling provision.[3]

Many people assume that women considering abortion have access to independent counselling and advice. However there is no legal guarantee that they do. The drive to make abortion swift and easily accessible has meant that many women enter the process rushed, confused and panicked. Abortion is not always a fully informed, rationally made decision.

Many women are unaware of, or unable to access, truly independent counselling from providers who are not tied into the abortion industry, and can feel that they are on a conveyor belt towards just one option, abortion, rather than considering adoption or keeping the baby. It is right that independent counselling is offered to all women experiencing an unplanned pregnancy, and it is encouraging that the BMA now recognises and supports this principle.

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Industrial action and the Christian doctor

Who are the real losers?

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

Pension arrangements considered 'unfair and unnecessary' prompted the BMA to call its members out on the first industrial action since 1975. The walkout on 21 June followed a strong response to a recent ballot.[1]

Public support for the strike was weak as headlines publicised the pension levels some (admittedly very senior) doctors would enjoy on the new scheme. Many commented: 'I would be happy to earn half of that!' At the same time other public sector workers face similar changes and far smaller pensions. It was also widely noted that the RCN was not taking industrial action, although that is primarily because of a very low turnout to their poll of members on the issue.[2] Apathy or resignation seems to be guiding the nurses' response, rather than higher ethics!

The actual day of action passed mostly without incident. Depending on whose figures you believe, between a quarter and a third of GPs held some kind of action, and between 9% and 25% of all non-urgent hospital procedures were cancelled.[3] Some even reported shorter waiting times as patients with non-urgent appointments stayed away from clinics. While noises at the BMA ARM in June suggested further action is likely, it will probably be jointly with other unions. At the same time both incoming and outgoing BMA Chairs called for further talks between government and unions rather than rushing headlong into further action.

There is little doubt that the medical profession in the UK feels anger at the government, though I suspect pensions may be just the final straw that is breaking the camel's back. This is borne out by the vote of no-confidence in Health Secretary Andrew Lansley (echoing last year's vote of no-confidence by the RCN). Mr Lansley is not feeling the love of the health professions right now, but this seems to be as much to do with the NHS reforms and cost savings as with the pensions issue.

As we continue to struggle with the consequences of the credit crunch, banking collapse, recurring recession and the breakdown of trust in all our institutions, Christians need to pause to think about our response. With rising prices, static pay and pensions, and collapsing social trust across the country, it is the poorest, the elderly and the disabled who are suffering most. Are we concerned with our own hardship or with those of our colleagues, patients, and above all, the most vulnerable members of our society?[4] The danger with the current bout of finger pointing and industrial action is that we can easily fail to see the bigger picture and who the real losers are.

The CMF Blog has looked at the issues around the strike and at some biblical principles behind the ethics of industrial action at *cmf.li/MTwF4I*

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Tim Lyttle gave the Rendle Short Lecture at the CMF National Conference. Catherine Butcher reports

COMPASSION: AN ANTIDOTE TO NHS DEBT AND DISTRESS

key points

Tim Lyttle's lecture highlighted the lack of compassion in the NHS using the story of Kieran Sweeney.

An avalanche of compassion is needed rather than more funding or reforms he suggested.

Servant leadership in the face of pressures in healthcare, would promote and model self-care

A call to compassion in healthcare was at the heart of the annual Rendle Short Lecture at the CMF National Conference. Tim Lyttle gave the lecture entitled: 'The NHS in debt and distress: an opportunity for Christian leadership'.

'Medicine is not solely a technical activity and pursuit. Medicine is about understanding and being with people at the edge of the human predicament,' he said, quoting from a video of Kieran Sweeney, former Honorary Professor of General Practice at Peninsular College of Medicine and Dentistry. A GP, Sweeney was diagnosed with malignant mesothelioma at the age of 57 and died at home on Christmas Eve 2009. Shortly before his death, he was filmed [1] talking about his experiences during his final illness.

He had left hospital and was at home before he read the discharge summary: 'likely malignant mesothelioma, patient aware of diagnosis'.

'There was a point when everyone in the team including my wife knew that I had mesothelioma and I didn't,' he said. 'That can't be right... most of the consultants were in their late 50s and our kids would be the same age... They just weren't brave enough to say "this is really bad news for you". Maybe they hid behind the science of their biopsy and pathology to avoid confronting the metaphysics of my predicament: I am a man devoid of hope.

'I just don't think that's good enough... Caring for somebody is more than a transactional activity where they do things to me. Everything that I've had done to me in our local hospital has been excellent. It's the relational care where I've felt that the experience has been less than satisfactory.'

A prescription for the NHS

Tim Lyttle took his cue from Sweeney in offering a prescription for the NHS. An avalanche of compassion, rather than more funding or reforms, was the key to transforming the health of the nation, he said. Kieran Sweeney's story played a part in provoking this insight, but Tim's own experiences in recently years were also a key factor in shaping his suggested solutions for the NHS.

Ten years ago Lyttle was a GP in rural North Wales. Following three years as Medical Director of a Welsh Local Health Board, he moved to get involved in the set-up of four new urban GP practices. At times he was working 70-80 hours a week.

An opportunity to get involved in a leadership course gave him the chance to step back from that frantic activity and look at his world more reflectively. He began to consider his own state of health and concluded 'you're not living pretty healthily yourself'. His father's death after renal failure also had an impact. Quoting a poem by Stevie Smith –'not waving but drowning' [2] Lyttle said: 'I wasn't enjoying all the frantic activity in being an activist in the NHS.'

Leadership needed

Servant leadership, rather than specifically Christian leadership was what is needed, he said. 'I don't want to draw distinction between what is Christian leadership and what is leadership. The NHS needs great leadership in this time, strong leadership, Christ-like leadership, and if people who are providing this leadership are Christian, then fantastic.'

He did not ignore the issues of finance and reform in the NHS. He reminded his audience that NHS finance has increased considerably in the past 60 years [3] but the era of increased spending was now finished. Quoting a *Health Service Journal* headline about Malcolm Grant, chair of the National Commissioning Board, he said: 'Expect years of fundamental change and austerity in the NHS.' [4]

An ageing population, obesity and diabetes were just three of the factors producing some of the pressures and, although the Department of Health was trying to portray a sense of optimism, the issues were complex.

'I genuinely believe that health secretary Andrew Lansley felt that simplifications could be made, and that bringing clinicians round the table to talk about the significant burdens of illness that their practices

were facing was very valid. But he didn't present a coherent reason for the changes he was bringing in. Then he got the wrath of everyone who did not like the changes.'

Turning from financial shortages and the need for reform, Lyttle gave an example from his own experience in hospital where the senior sister came onto the ward at 7.30am, spoke to the nurses, looked at the patients' notes at the end of their beds, but didn't say 'Hello' to any of them.

'The NHS is in debt, the NHS is in distress. Will we get out of it by reform?' he asked. 'If it's run better, maybe. Will we get out of it by finding more money? Well, there isn't more to find. What I want to suggest is that we're going to get out of the debt and distress by rediscovering humanity.'

Self-care healthcare

Lyttle pointed to three areas in which Christian leaders and others could make a difference by taking stock of the NHS.

'My prescription for the NHS in debt and distress is to say let's pause, and let's take stock. Of course the NHS does need attention, and I want to examine three areas in which we can, as Christians, respond.'

First, he considered what 'health' is, as opposed to 'healthcare'. 'Are we more interested in what we can do to patients than in the health they have and the health they can improve?' he asked.

Quoting the World Health Organisation's Ottawa Charter for Health Promotion,[5] he said: 'Health is… a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.'

'If we believe that, what would it mean for us? What would we challenge? What would we pursue in healthcare in our practice?' he asked, suggesting that a focus on self-care would be key. 'Are we focused on patients, in terms of the innate God-given resources that they have to improve their health: to eat well, to exercise, to live well; to look after themselves emotionally; to not work 70 or 80 hours a week? Are we interested in that aspect of patients?

'If we really promote self-care, we may get patients to take more responsibility for their medications and save us money.

'I want to suggest "health capital" can be used as a term to describe the resources, the assets, the abilities that we have to live well. Surely we, as doctors, should be trying to increase health capital in terms of emotional wellbeing, physical, relational and spiritual wellbeing.'

Priorities

Secondly he looked at look at funding priorities. 'Where should we put our priorities? This is a really significant area for Christian leadership, and for people getting involved in commissioning. This is going to be both a challenge and an enormous responsibility as we guide the NHS into how it spends its money. Is the NHS equitable? People living in poor areas not only die sooner but they spend more of their lives with disability. An average total difference in life-expectancy is 17 years.[6] Deprived individuals or families use the health service less. That was one of the drivers that led a number of us to establish new GP practices in a deprived area to try to do something about the balance of provision. As Christian leaders we can take on that challenge.'

He recognised that yet another reform was not the answer and called on Christian doctors and healthcare professionals to model positive behaviour in GPs practices and hospital departments paying attention to the biggest needs in society.

'If we as Christian do something good, it'd be recognised and what's recognised does get repeated.'

He also challenged leaders to consider sustainability – not in terms of 'being green… switching lights off' but asking 'Is that treatment, this medication, this investigation, in the best interest of patients? Or is it that we like to be in the forefront of medical treatment? I do believe we can find areas where the money is not being well spent. Are we pushing people into treatments, expensive treatments, when the benefit is not clearly there?'

Person-to-person

Thirdly, he pointed to the human factor: 'that emotional connection with people; that person-to-person relationship'.

'As Christians we need to be saying strongly that we can't reduce medicine down to technical, transactional processes. No, we have to make that emotional connection with patients...what we need is an avalanche of compassion. Not an avalanche of technically improved processes, but an avalanche of compassion in the NHS.'

Lyttle added a challenge for CMF: 'Are we as an organisation, as a network, as a movement, putting enough focus on compassion and creating that avalanche? Are we putting enough focus on how the NHS responds to debt deprivation and poverty? Are we giving Christian doctors support in making those difficult funding decisions?

'I believe we can make significant advances. We're going to have to step out with new ventures, with new social enterprises, new organisations, new initiatives; I'm asking CMF to support its members in doing that.'

Using a rugby analogy he added: 'Yes, we have to defend against secularism and humanism, but there are so many areas where we can be on the attack with this avalanche of compassion. But it's not about doing as I say, it has to be doing as I do. And for me, I've needed to have a time to step back and focus and take "me" time.'

He concluded by saying: 'It's not about activism; it's not just about getting out and doing things. It's about start with "me" and about what I do, setting role models as Christian leaders, because if we can't be healthy, then we're probably not the best people to bring transformation into the lives of others as we treat them, and into the organisations that we work with.'

***Tim Lyttle** is a part-time GP in Shropshire*

Tim Lyttle

Health is... a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities

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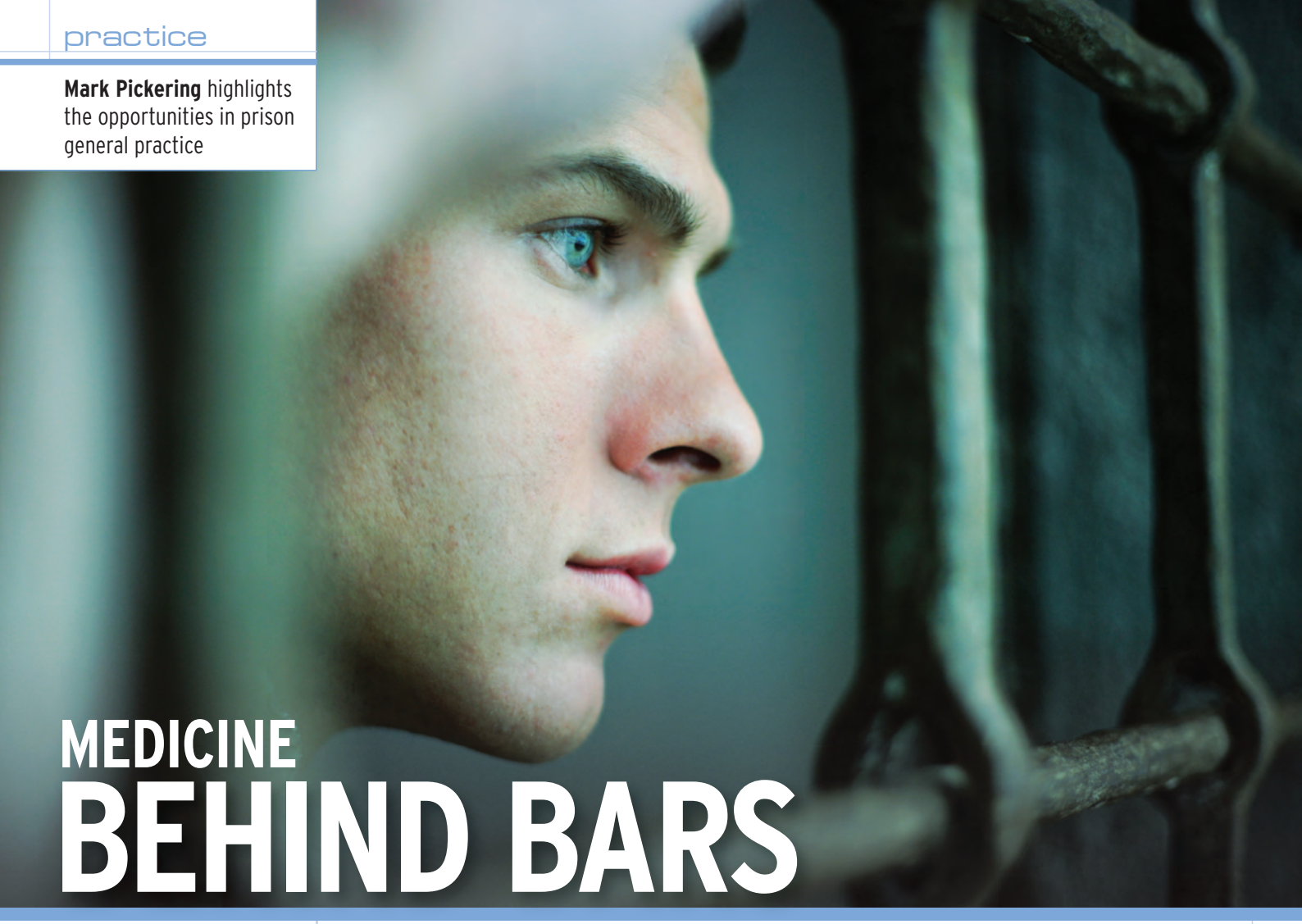
Mark Pickering highlights the opportunities in prison general practice



MEDICINE BEHIND BARS

key points

Prison GPs have replaced the 'prison medical officer' now that prison healthcare has become part of the NHS. This means there are more opportunities for GPs to get involved in prison work.

There are frustrating barriers to prisoners accessing healthcare. Patient advocacy is needed and doctors are a vital part of the rehabilitation process for people whilst they are in prison.

In prison people stop, reassess the downward spiral of their life, and ask for help. Being a part of the journey to physical, mental and spiritual wholeness is a privilege.

Prison medicine is a fascinating world of interest and challenge, with great opportunities to be innovative. There are plenty of reasons why Christian doctors can contribute positively to this vital area.

Sometimes it can be more like casualty than general practice, especially in a remand prison. There may be a dislocated shoulder, a slashed wrist needing suturing, a cardiac arrest, alcohol and opiate withdrawal, acute psychosis, an outbreak of a communicable disease and new diagnoses of HIV and hepatitis B and C. If you miss pathology and procedures, prison may offer refreshing opportunities to keep your hand in. Certainly your communication skills will be tested to de-escalate confrontation, or provide motivational interviewing for ambivalent addicts.

Changing times

Prison healthcare in England and Wales only became part of the NHS in 2006 (in Scotland it happened more recently, in November 2011) and this has brought a lot of change to the system. In England, Primary Care Trusts are currently responsible for commissioning, and this is likely to pass to the National Commission Board before long. This has meant a transition from the 'prison medical officer' – often long term, full time in prison – to the 'prison GP', often part time and mixing prison work with community GP work. One result of this is that there is a lot more opportunity for 'normal' GPs to get involved in prison work.

Contracts for prison GP work currently come from a variety of sources, such as PCTs, individual practices, groups of practices and private companies. Uniting prison medicine with the NHS has brought good opportunities to improve standards in some areas and provide greater 'equivalence of care' with other NHS patients. On the negative side there can be a high turnover of staff with consequent loss of experience and skills tailored to the secure environment. The variety of commissioning models can mean some fragmentation between the healthcare teams, for instance if nurses and GPs in the same prison are employed by different organisations. Contracts can move from one organisation to another with the subsequent loss of continuity, all of which have their effects.

Breaking down barriers

Security considerations are obviously paramount in a prison environment, but this can mean that there are often multiple barriers to prisoners in accessing healthcare. Although there is generally good access to GPs, for instance, patients may have much less control over choosing appointment times or which GP they see, and this presents problems for continuity of care. When it comes to arranging hospital appointments, imaging or surgery, processes can take much longer, often being subject to cancella-

tions for various security reasons. Many times prisoners can be under regular follow up at one hospital or have waited months for an appointment or operation, only to be moved to another prison in a different area and have to start the process all over again at the local hospital. This may be despite the best efforts of prison management, who are under many different pressures with the national prison population at an all-time high.

In these situations it is understandable that prisoners can express great frustrations at the healthcare system, especially when they are a population whose general coping skills tend to be low. Many a consultation starts with a few choice expletives and a complaint that the prisoner feels fobbed off. There is often a place for patient advocacy, doing what is possible within certain constraints to ensure that something gets done for them. Prison is the punishment – prison healthcare should not be, and we are a vital part of the rehabilitation process that goes on with people whilst they are in prison.

A broken image

Prisons are full of colourful characters. Some aggressive, violent and manipulative, some frankly pitiable who find coping with life a great struggle at the best of times. Some have committed hideous crimes, some have simply done something stupid in a moment of madness, or been led into crime through drug addiction. Many are relatively normal when you see them in the consulting room, and certainly do not appear that different from a lot of the people who regularly come through an average GP practice. Robin Fisher's excellent 2007 article in *Nucleus* gives some great flavours of life as a prison GP and I thoroughly recommend it.[1]

When I hear the all too frequent stories of broken homes and institutional care, dysfunctional families, childhood abuse, mental health problems, and alcohol and substance misuse that characterise many of the prisoners' life stories, sometimes it does not seem at all strange that they have ended up where they are. I reflect on the love and stability of my own upbringing and wonder how many of them would have turned out differently had they had the care and opportunities I had.

As a Christian I find it very helpful to keep in mind that every person, regardless of what they've done or how their lives and personalities have been twisted, is still made in God's image[2] and loved by him. That image may be scarred and obscured, but it is still there and by God's grace it can be restored. Compassionate healthcare can be a vital part of that process.

Spiritual issues

Prison can be a powerful place for helping people stop, reassess the downward spiral of their life, and ask for help. Sadly some turn to self harm and drugs (yes, they still manage to get hold of them even in prison), but for others it can be a place where they begin to look outside of themselves. Prisoners can find the support of a good prison chaplaincy very important and there are many stories of people coming to faith in prison. Being able to suggest and encourage chaplaincy involvement, where appropriate, can be very much appreciated, and a useful 'referral pathway'.

Part of Jesus' mission on earth was 'to proclaim freedom for the prisoners'[3] and although facilitating breakouts is never a good idea (and will get you into all sorts of trouble), being a part of the long process to wholeness – physical, mental and spiritual – is a great privilege.

But isn't it dangerous?

This of course was the first question my mum asked me when she heard I was going to work in a prison, and one I'm sometimes asked by other doctors considering it. Of course prison medicine is not for the faint hearted, and there is often verbal aggression and manipulative behaviour to deal with. But physical violence against healthcare staff is very rare and the environment is more controlled than a Saturday night city centre, or even an average GP practice. A colleague jokingly reminded me that if you press the emergency button in most GP surgeries, you might be lucky to get a cup of tea from a receptionist within ten minutes. But in prison, burly officers will come running from all directions. One colleague who'd recently had to press the alarm button remarked it was the first time she'd needed to do that in over three years of working full time in prison healthcare.

Is it for you?

I would love to see more Christian GPs getting involved in prison medicine. It is an area where firm compassion and targeted advocacy can make a big difference and help mend some of the most broken lives. I would be very happy to talk with anyone who is even vaguely interested. Equally you could speak directly to your local prison healthcare department and find out who provides their GPs.

If you're a hospital clinician then there may be opportunities to get involved with outreach clinics into a local prison, such as sexual health or hepatitis services. There may be room to streamline processes when prisoners come to A&E or for outpatient appointments. Good partnership between prison healthcare and hospitals will improve the experience for all concerned. And for those allied to medicine there are plenty of opportunities for nurses, dentists and physios, for example.

If you're already working in prison healthcare I would love to hear from you. A number of CMF members around the country are involved and if there is a need for networking and support then we would like to see how that can be facilitated. Contact me on *mark.pickering@doctors.org.uk*.

***Mark Pickering** is a part time prison GP*

Training and Support

The RCGP has a Secure Environments Group with regional networks providing support and education.

The RCGP Substance Misuse and Associated Health unit provides certificated training on drug and alcohol misuse, harm reduction, management of Hepatitis B/C and other issues relevant to prison health. See *www.rcgp.org.uk*

Lincoln University has recently launched an MSc in Healthcare in Secure Environments. Individual modules can be built up to make a Certificate, Diploma or full MSc. See *www.lincoln.ac.uk*

Prison is the punishment - prison healthcare should not be

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Jane Bates asks 'Is long term work overseas an outdated concept?'

IN IT FOR THE LONG TERM?

key points

Jane starts by considering the assumption that contemporary travel and communications have made long term medical mission a thing of the past.

She recalls the encounters which prompted her to reconsider, and reflects on the advantages of long term medical mission.

Jane's personal experience has shown her the importance of building relationships and has convinced her that she should be 'in it for the long term'.

Your blog post completed, factor 50 sun cream packed, antimalarials started and the last of the jabs completed. People have given, prayed and waved you off, then three months later you're back at work in the NHS, photo adventures uploaded on Facebook and the feel of warm sunshine a distant memory. Why would anyone go *long term*?

At a recent Malawi Christian Medical Dental Fellowship national conference, Dr Bert Nanninga presented his lessons learned from 18 years of health work in rural Malawi. I was left stirred, quietly contemplating the contrasts with several recent articles in *Triple Helix* focusing on short term and even 'ultra short term' missions opportunities.[1] I had begun to wonder whether, with easy travel, modern communications and the current career demands in the NHS, short term missions are the 'way to go'. Perhaps we are at the end of an era of people choosing long term work overseas. But I was made to think again by a visitor from the UK who came to see me in my office. She was non-medical, working with a faith-based organisation that supports a variety of programmes including some health-related work. She said: 'I'm out here for two years now but would really like to think about long term, I think there's so much more you can achieve when you really get to know people.' So it seems there are still people choosing to be 'in it for the long term'.

How long is 'long term'?

When we first set off for a planned two years in a South African district hospital in 1999 it certainly felt like long term, but when we came to leave, we felt as if we were just about getting the hang of who was who, how things worked and what our priorities might be. A further year at All Nations Christian College in Hertfordshire confirmed that there was plenty to think about in cross-cultural life and mission. Should five years or more be considered long term? It's long enough to have to get your address changed with the Post Office.

It took me seven years in Malawi to manage a basic consultation in the local language, and as we near the ten year mark there's plenty to try to figure out almost every day. What would you expect if someone – let's say from Japan – arrived in the UK offering to 'help serve the health care system for one year'. How much time do you think they would need to get to grips with language, culture, local systems and practices, let alone bring about any change?

Is long term service realistic in the 21st century?

Having worked outside the NHS for some time it is difficult to comment on the current structures of training programmes and their relative flexibility/inflexibility, but every generation presents its own set of challenges to going overseas, and sorting out your approach to your career is certainly one of them. As Christians we are no longer to think with the

Dr Nanninga's lessons for long term service	What you may need to hold loosely as you go
Learn to laugh	Career
Learn to suffer well	High speed internet
Handle frustrations – learn to be real	Friends and family
Learn to have faith: God can be trusted	Shopping
Learn to serve with JOY!	Money/buying power
Learn to find your strength in the Lord	Longevity

same mindset as the world. We have been called by Jesus to give up 'everything' in order to be his disciples.[2] The great news is that firstly, God is 'faithful', and secondly, Jesus is 'the same yesterday, today and forever',[3] so if you feel God is calling you to long term overseas service, don't be dismayed by the seemingly insurmountable hurdles or the fact that everyone around you thinks you are nuts! There are certainly many examples in scripture of God using small people to do big things.

It is important to be adequately trained and prepared so that you can make a useful contribution to medical service, though not all of that preparation has to be, or even should be, in the UK. Opportunities for short term mission trips are useful as preparation. They build medical skills relevant for a non-UK setting whilst testing out other equally important issues such as your personality, your family's willingness to let you go, and perhaps how closely your dream of life abroad fits the reality.

Is long term service desirable?

Longer term commitment reaps far deeper rewards than short term trips. These are often about the 'go-er' and what they will learn[4] while someone somewhere arranges the logistics to make the short term time effective. As far as possible short term trips should be done with nationals, either in leadership or, at least, as equal members of your team. This will help you (and any intended impact of your work) in numerous ways: you share your technical skills whilst relying on local expertise and follow up.

Many non-UK cultures are heavily relationship-based. Duane Elmer, in his challenging book *Cross Cultural Servanthood*, quotes from a Canadian International Development Agency study which found that the number one factor determining overseas effectiveness was the ability to build long term relationships with local people.[5] People from the West (or more task-driven societies) may find this approach wrong or frustrating, especially when the needs (and possibly the solutions) are so 'glaringly obvious', but you have to spend time getting to know people – the nurses on the wards, the hospital director, your head of department – if you want to get things done. With time the 'glaringly obvious' may turn out to be something different to what you had initially supposed. It is easier to 'do no harm' in the host situation when time is not of the essence. How much are we in danger of disempowering the local community by our short term activity? It's part of developing respect for your host culture and learning some of your own cultural frailties in the process! By the power of the Holy Spirit we are moulded and shaped, hopefully bringing more of God's transforming wisdom, gentleness and love.

Is long term service really necessary?

There are many missionary tales from days gone by of courageous men and women who set off from these shores by steam ship; tales of heroism and sacrifice as people succumbed to a range of tropical illnesses in faraway places, with seeds of faith and prayer planted, resulting in changed hearts over many years.

So what about now? In Malawi many people have heard the gospel, and statistics reveal a thoroughly 'Christian-ised' country. At our hospital we witness nurses spending hours at the nurses' station reading their Bibles and patients assailed by noisy lunchtime prayers. Part of our role, working alongside our local colleagues, is to demonstrate the daily, practical outworking of God's love by providing high quality, ethical practice to patients and their families. The same basic principle is relevant in many overseas environments. Each place will present its own specific challenges; in many, open proclamation of the gospel may be very difficult.

Several aspects of medical service here in Blantyre, including the medical school, children's orthopaedics, palliative care, malaria and HIV research, have flourished as a result of partnerships between long term Christian medical workers and Malawian nationals. The medical school is still young and rapidly expanding providing a ripe opportunity for young Christian doctors to have their lives shaped by role modelling and friendship. What a privilege it is to be around long enough to see some of these fruits and to input them into the next generation of doctors.

Is long term service more biblical?

I started off thinking that long term service is superior to short term visits. On reflection that may be based more on my pride rather than scripture! Jesus managed his earthly ministry in three years. There is nothing superior in spending 40 years or so outside of your home culture, but being in the place that God wants us is surely best.

In it for the long term?

For me, being in Malawi for ten years has been enriching, humbling, challenging and immensely rewarding. We have put down roots and made friendships that have grown and deepened over the years. We plan to be there for several years to come – definitely 'in it for the long term.'

***Jane Bates** has spent the last 13 years working overseas, firstly in South Africa and subsequently in Malawi where she has established an adult palliative care service in the national teaching hospital in Blantyre. She is involved in the Christian Medical and Dental Fellowship of Malawi.*

Because we loved you so much, we were delighted to share with you not only the gospel of God but our lives as well

1 Thessalonians 2:8

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Robin Fisher describes his journey to faith, medicine and mission

CAUGHT UNAWARES

key points

At 25 Robin was awaiting a new army assignment, when a friend invited him to a Christian event.

With only two A levels and no science qualifications, medicine seemed out of the question, but God seemed to have other plans.

His career has taken him across continents and has opened doors, giving Robin opportunities to practise medicine and share faith in numerous contexts.

I was an army officer and enjoying every minute of it. The travel, the life style, and the sense of being involved in something that mattered. I had just arrived back from two years in Berlin, at that time the flashpoint of East-West politics. 'Guarding the free world from communism' seemed a worthwhile job, even if I was only a lowly platoon commander.

I arrived in my regiment's depot in Winchester for a new assignment. Brian, an old school acquaintance was also stationed there. He asked me if I would like to go to a meeting where there would be a 'Christian talk'. 'Fine', I thought. I was new in town, needed to make friends, and here was a really friendly face. The Christian bit could gently wash over my head; I could cope with that.

Brought up in a culturally 'Christian' home, I had been quietly indoctrinated into English Christianity. All true doubtless, but rather 'out there'. As I grew up I let its influence slip off like an old coat.

Battle

The ballroom of the Kensington Palace Hotel was where the Stewards' Trust, a group of London Christians, held their meetings. My friend Brian assures me that a worthy, but not particularly exciting Gospel talk took place. I remember none of it, except, curiously enough, the word 'Abraham'. I was aware only of a furious battle that had suddenly broken out in my head. 'I am here and I will not pass your way again' I seemed to hear. God had suddenly come round the corner and we had met face to face. I was terrified.

At the break for coffee I was conscious that there was a long drive back and it was already late. I was desperate to stay for what the speaker said was the short bit for people who wanted to know how to become a Christian. More furious conflict; at the end of this 15 minute talk I just had go up to the speaker and say 'I have become a Christian', whatever that meant.

On the way home I was conscious that life had already changed. A brief 45 minutes with our local vicar the next day, and it began to make sense. I took my first steps towards understanding the extraordinary thing that God had done for me in Christ; the thing that I have been trying to understand and appreciate all my life.

Two days later my deep experience of Christ was sealed by my complete release from smoking, something I had struggled with for two years. Lighting a cigarette after lunch just to say goodbye, I heard with the utmost clarity 'Put it out!' I did, and it stayed out.

But life became difficult. New challenges at work were demanding. It took me a long time to come out as an open Christian, and the conversion of my life style was a long time coming. But, difficult as life was, Jesus was present to me in a way that was palpable. The idea of mission in his service became the core part of my experience of him.

Long term?

Two years later, and now 27 years old, I was in Sharjah, in what were then the Trucial States, now the Emirates. Fun and exciting though it was, I knew that I was not really an army officer at heart, and it seemed incompatible with married life. Anna and I had been married for only a few months and here I was, in the middle of a desert, loving it and wishing with all my heart I could share it with her. I realised that long term, the Army was not for me. But what was? What did the Lord want for the two of us? And where did 'mission' come in?

I was caught unawares by the sudden and, this time, completely silent conviction that medicine was the direction that I should be taking. Caught unawares and shocked because it was actually impossible. Medicine required three A levels in science subjects. I had not even a single GCE science O level. Actually I could muster two arts A levels, the rock bottom requirement for university entrance.

Impossible too, because of geography. I was miles into the desert, working as a Desert Intelligence Officer (DIO). Communication was by flimsy blue airmail forms and took many days to arrive. How could I find out about university entrance, ask advice, discuss it with Anna, send in forms? It was March, and as far as I could see, UCCA forms had to have been in by October the previous year. 'OK' I said to myself. 'Next year. I could leave the Army, go to a technical college, do A levels and go to university the year after.' Then the silent sudden conviction. 'No. Not next year. This year. This October.' It was ludicrous. And impossible because three years at university was one thing; six years was quite another. How would we eat, start a family, what would our families think? Impossible because the Trucial Oman Scouts, the Foreign Office-run force with which I was working, decided unilaterally to extend my contract until the end of the year. Impossible too because, however convinced I myself was, what about Anna? If this really was from God, then God would have to speak directly to her.

Medical school

In June a letter arrived from Bristol University Medical School. 'We have a policy of accepting mature students. Please attend for an interview.' This was progress, but, how was I to escape from the Arabian desert to attend an interview in Bristol? And how was I to pay for the flight? My exasperated superiors gave me a week to make the round trip. An income tax rebate met the cost practically to the nearest penny. There was one seat left on the BOAC jet and I scrambled on board. At Heathrow I met Anna at the arrivals gate. Wonderfully, God had spoken to her and we were at one.

The interview took place in a room that, oddly, was almost full of stacked chairs. The dean was, I think, a little shocked that my application was the result of a sudden decision taken three months previously. But he took me very seriously. 'Would you like to ask us anything?' he asked smiling at the end of our absurdly brief talk. 'I need to know your decision now' I said, 'because if it is "yes", I have to go right away and tell my regiment that I am leaving'.

It was 'yes'. 'It's sink or swim' he said with the same smile. 'Pass the exams or you're out.' Back in the Gulf they agreed to release me just before the university term started. But only just. On Friday afternoon I took off from Sharjah as an army officer. On Monday morning I attended my first lecture as a medical student. What was my friend Brian's response? Robin at medical school? It's got to be a miracle!

Open doors

After this I never for one moment could believe that I 'owned' my medical qualification or the future that came with it. I was to learn that a medical degree was the key to opening doors for Christ in a multitude of cultures and places. I started TB work at Mafraq hospital in Jordan because its slowness and predictability allowed us to spend extended time with our patients. I learned there that in-depth evangelism can go hand in hand with state of the art medical care. Primary health care was a passport into Southern Sudan. General practice in Sparkbrook, Birmingham gave us an open door into the Muslim community there, and I learned that there is a choice to be made between making lots of money and godly Christian medical care. We experienced at first hand a God who loves to answer prayer for those who do not know him. In every case it has been what needed doing, rather than what we would have chosen. But it is an honourable and useful job as well as a passport and meal ticket. It is joy and fun as well as hard work.

But I never thought that God would use medicine to take us and the family to a mountain top in Yemen, the dust of Port Sudan, the humidity of Juba or the delights of a Kurdish restaurant in Sheffield. I never thought that the doors opened by medicine would have led to our starting a theological college, or my being ordained in the Sudanese Episcopal Church. I never thought that he would give us so many dear friends in so many strange places. Above all, I've had so many experiences of God and so many proofs of his extraordinary love and power, and of his sense of humour too.

Robin Fisher *works with International Christian Medical and Dental Association (ICMDA) in the Middle East and is a part time GP in Derbyshire*

I was to learn that a medical degree was the key to opening doors for Christ in a multitude of cultures and places

Elizabeth Procter
describes the Christian's experience of depression

ENCOUNTERING DEPRESSION

key points

Depression is prevalent in Christian circles and being a Christian can lead to added difficulties for the sufferer.

Often sufferers feel abandoned by God and desolate. Prayer can seem pointless.

Christian doctors have a role to promote a better understanding of depression, its treatment and cure

Life would seem to be a drag and I would feel tired. After a week or so it would settle and I would be my usual naturally cheerful self…in retrospect I was suffering from cyclothymia, a sub clinical form of cyclical depression… my cyclothymic episodes continued until the mid 1990s when problems in my work and family life combined to trigger my first really serious depression. It hit me like an express train. I had a few days of feeling stressed and miserable, and I was on a home visit with a patient who was telling me of her own problems, when I suddenly found myself in uncontrollable floods of tears. Clearly I could not work in that condition and within a few hours was feeling almost suicidal. After consultation with my GP and a referral to a consultant psychiatrist, I agreed to admission to hospital, as I knew I was not safe at home.' Andy, a Christian GP.[1]

This article comes out of work done by my husband and myself in writing a book for Christians with depression. The background research we did brought to light a great deal of anecdotal evidence that depression is prevalent in Christian circles. Almost wherever we turned people were quick to say that they knew of several people in their acquaintance who were Christians and depressed. We consulted Christian therapists and counselling services, ministers and churches, and our friends and acquaintances. It threw up a surprising number of cases of depression amongst Christians.

Depression is an extremely painful illness, and for Christians handling depression there can be added dimensions of difficulty. Not only are they wrestling with a very unpleasant and chronic illness, which affects family life, work life, social life and church life, they also struggle with their spirituality and wonder where God is in the darkness.

The depressed Christian is very likely to feel that their prayers are going unanswered. They may wonder why fervent prayers for recovery are not heard. They may feel abandoned by God and wonder why God is letting this happen to them. Surely God should be protecting, loving and caring for them, rather than allowing them to feel this desolation that has taken over their lives. Their sense of being in communion with God when they pray – that God is there listening and sending answers to their prayers – often disappears, so there is a feeling that prayer, which has been an essential fundamental feature of their daily life and their understanding of life's significance, now seems pointless. This deep sense of despair in a Christian's relationship with God is well expressed by the Revd Dennis Duncan in his moving book *Towards the Light*[2] written from his own experience of depression.

He writes: 'The dark night has indeed come. Morning and evening and night are all alike (I use the word again): desolate. My sense of abandonment is very real.'[3]

Sufferers from depression frequently have low

self-esteem and fear their condition is something they have brought upon themselves in some way. For the depressed Christian, this can be complicated by the Christian culture to which they belong. They may feel that Christians shouldn't get depressed, that the Christian is somebody who should be above such things and able to 'rejoice in the Lord always'. They may feel that the reason they have succumbed to depression is because they haven't had enough faith to secure healing or freedom from depression. If there is a strong culture of expectation that God can and will heal within their churches, they may wonder why God doesn't heal them. Perhaps they have put themselves in the way of prayer for healing many times. In our book, we quote Jennifer Rees Larcombe who says 'I had so much laying on of hands, it is a wonder I didn't go bald.'[4]

They may feel that their depression is attributable to some sin they committed or to something they did in the past which was wrong and about which they have guilt. They may even feel their depression is an attack of the enemy of soul, the Devil.

Professor Brian Thorne writes 'many therapists, myself included have often found their depressed Christian clients amongst the most difficult to help. For such clients it has often seemed that their belief system and the practice of their faith have proved impediments rather than aids to accepting the reality of their predicament.'[5]

Church will have been a vital place for the Christian who becomes depressed. In the church they may have found their strongest place of belonging, their deepest friendships and their most powerful sense of community. Much of this is routinely lost when a Christian person becomes depressed and it is grievously felt. Worship, singing, corporate prayers, and listening to teaching, which once inspired them may lose its savour and so leave them feeling bereft of spiritual inspiration. It is possible that too much involvement in many things, including their church, has led to them being overtaxed and contributed to their becoming depressed. Because of their depressed state, they may have had to let go of membership of the church council, or teaching the young people, or taking a central place in the social activities of the church and so on. This means that now they are not part of the 'in' talk and the regular companionship that comes with keeping abreast of current church activities. Maybe the depressed Christian has stopped going to church at all. Perhaps they feel resentful that the church doesn't care for them properly, after all they have done for the church in active membership.

They may also have been the victims of well-meaning but thoughtless handling by the church, whether from its leadership, or casual things said or done by church members. After suffering from post-natal depression, one young woman said the only comment by the church leadership was 'Oh, you've had the baby blues'. She felt angry, patronised and misunderstood. John Lockley's book *A Practical Workbook for the Depressed Christian*[6] is full of examples of thoughtless things said and done to depressed Christians in a church setting.

A role for Christian doctors

What are we to make of all this? As professionals we need to be well informed, and as Christians to have an appreciation of likely areas of particular difficulty, not forgetting that Christians are desperate and suicidal at times. As Christian doctors we should promote a realistic understanding of this debilitating illness, and its treatment and cure. Christians are still suspicious about 'therapy' and yet it can be very helpful. Cognitive Behavioural Therapy (CBT) in particular is extremely effective in rectifying negative and erroneous patterns of thinking. The National Institute for Clinical Excellence (NICE) recommends CBT as a first option for many with mild to moderate depression because it is so helpful and successful in improving mood. Many depressed people benefit from some form of listening therapy, and if they are reluctant to go to a secular therapist, there are Christian counselling services with suitably accredited counsellors, around the country. Christians can also be reluctant to take medication, thinking that they should rely solely on God, or worrying that they might get addicted to 'happy pills'. We need gently to remind them that depression is an illness, and that the right medication can really help.

In all our dealings with those who are suffering with depression, we need to be gentle and cautious so that we don't inadvertently add to their suffering. People can have absorbed negative and unbiblical beliefs about God which cause them deep suffering when depressed. By being aware that underlying, core belief systems deeply influence someone's receptivity to advice and treatment, we may need gently to challenge faulty views, such as 'Christians shouldn't get depressed'. Churches may need to be encouraged to help in practical ways and to be sensitive and cautious about prayers for healing. But above all we can be hopeful, for most depression does come to an end, and let us encourage all who are affected by depression, be it the sufferer themselves or their family, not to give up hope but to hang in there, believing that light will come.

Elizabeth Procter *has worked in psychiatry for 24 years, and has been a Consultant Psychiatrist for over 12 years, specialising in child and adolescent psychiatry. She is a mother of four adult children and has four grandchildren. Together with her husband Andrew, a clergyman, she has led prayer counselling teams, and is a member of the Diocesan Council of Health and Healing.*

In all our dealings with those who are suffering with depression, we need to be gentle and cautious so that we don't inadvertently add to their suffering

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Helen Barratt on the Christian response to tolerance

TOLERANCE – SOCIETY'S 'SUPREME VIRTUE'

key points

The Christian faith is facing 'gradual marginalisation' in Britain and the notion of tolerance has become a supreme virtue.

Under the rule of the 'new tolerance', there is no scope for a doctor to 'deny' a patient access to a clinical intervention on the basis of their own personal beliefs about either the procedure or the patient's lifestyle choices.

If recent trends continue, it is possible that things may lead to increasing conflict between a Christian doctor's conscience and what is perceived by society as our professional duty to be 'neutral arbiters of medical care'.

Christian views have come under growing fire in recent months. Doctors who refuse to prescribe contraceptives to unmarried women or refuse to provide sex-change operations risk being struck off the medical register, according to new draft guidance issued by the GMC.[1] More broadly, Britain is coming under increasing pressure to legalise same-sex marriage and a campaign against this, endorsed by many Christians, has received widespread criticism in certain sections of the media.[2] These are just two examples but, in many cases, the criticism of Christian views is less about the issue itself, and more about the perceived intolerance of the Christians who hold them.

Earlier this year Christians in Parliament, an official All-Party Parliamentary Group, chaired by Gary Streeter MP, launched an inquiry called 'Clearing the Ground', which was tasked with considering the question: 'Are Christians marginalised in the UK?' The inquiry's main conclusion was that 'Christians in the UK face problems in living out their faith and these problems have been mostly caused and exacerbated by social, cultural and legal changes over the past decade.'[3] High profile Christians, including Lord Carey, the former Archbishop of Canterbury, have also warned that the Christian faith is facing 'gradual marginalisation' in Britain.[4]

The 'new tolerance'

This marginalisation – or at least the removal of faith from the public square – is arguably the goal of the 'new atheists', such as Richard Dawkins. However, something wider than this is also going on in Western society, which has important implications for Christians. In a recent book, theologian Don Carson demonstrates how culture in the West has shifted from an 'old tolerance' to a 'new tolerance'.[5] In the traditional definition of tolerance, one may have disagreed with another's stance, but still acknowledged the right of the other party to express their view. In the 'new tolerance', one simply should not disagree with another's views. Carson argues that this notion of tolerance has become a supreme virtue, if not the supreme virtue for much of the Western world.

Today any questioning or contradiction of the view that all opinions are equal in value, and all worldviews have similar worth, constitutes intolerance. Carson notes that this is due at least in part to the influence of postmodernism: 21st century society increasingly thinks less and less in terms of truth and error, preferring instead to think in terms of differences of opinion or varying perspectives.[6]

The intolerance of the 'new tolerance'

Jesus was clear when he said 'I am the way and the truth and the life.'[7] However, in a post-postmodern

era, for many in society, all paths are equally valid. If Christians maintain that there is an exclusive element to their faith, which implicitly suggests that others are wrong, they frequently face charges of intolerance. Both referencing their own professed faith, David Cameron has said that Christians should be more 'tolerant and welcoming' [8] whilst Barrack Obama has argued that Christians should follow 'the Golden Rule… treat others the way you would want to be treated'. [9]

The enemies of the new tolerance are those, such as Christians, who adopt strongly asserted positions and claim to know the truth. For the new tolerance to work, society must – ironically – be intolerant of them. We see this most often when the principles of free speech and the principles of tolerance clash: free speech must lose. For example, sexual orientation is being given increasing protection under equality legislation, but this is often at odds with religious belief. Many proponents of the 'new tolerance' would argue strongly in favour of free speech, but at the same time will not tolerate those who oppose gay marriage or afford them the opportunity to express their views in the public arena.

The new tolerance in practice

Don Carson argues that a disproportionate part of the 'new tolerance' is directed towards Christians and Christianity. Examples of this in recent years range from the Christian couple barred from fostering because of their views on sexual ethics (the High Court ruled that laws protecting people from discrimination because of their sexual orientation should take precedence over the couple's right not to be discriminated against on religious grounds) [10] to the van driver facing disciplinary action for displaying a palm cross because it may offend those of other faiths. [11]

When the 'new tolerance' becomes shackled to growing claims for individual freedoms and the right to self-determination, this has direct consequences for Christian medical practice. A clinician's right to conscientious objection is enshrined in law and in professional guidelines. [12] However, others claim that a doctor who 'refuses to refer for a particular procedure, has fractured the trust and respect upon which a successful consultation relies. Patients rely upon doctors for their expertise and should be able to trust their doctor to be a neutral arbiter of medical care.' [13]

Under the rule of the 'new tolerance', there is no scope for a doctor to 'deny' a patient access to a clinical intervention on the basis of their own personal beliefs about either the procedure (consider for example abortion and – potentially – physician-assisted dying) or the patient's lifestyle choices. Christian paediatrician Dr Sheila Matthews was dismissed from her role on the local authority's adoption panel after requesting to refrain from voting when homosexual couples were being considered as potential adoptive parents. [14]

The 'new tolerance' and the state

As Christians we must 'understand the times' [15] both in terms of what is happening at a cultural level, but also at a higher level. The 'new tolerance' requires that the state must be intolerant of those who do not accept that all paths are equally valid. Christians are required to submit to the state [16] but sometimes the state can be a persecuting 'beast'. In Revelation 13, we see the beast of the state combine against God's people with a second beast which looks 'like a lamb' and represents the religious aspects of life. [17] We have seen the destructive combined force of the state and religion down through history. Now, arguably we see the ideology of aggressive secularism (anti-religion, perhaps) and the state combining against the Church in the form of the new tolerance. It is yet another irony that this often involves using the legislation of equality and human rights – concepts which owe their background to Christianity.

Our response

The vitriol against Christian views and the ridicule of those who stand up for them can be hard to stomach. [18] However, in the light of Revelation 13, we should not be surprised. We know that we preach 'Christ crucified - a stumbling block to Jews and foolishness to Gentiles'. [19] Jesus told his followers that, if the world hated them, they should keep in mind that it hated him first, [20] yet when the crowds hurled insults at him, he did not retaliate. [21]

We do not know what the future will hold but, if recent trends continue, it is possible that things will only get more challenging for Christian doctors. Developments in medicine, for example if physician-assisted dying is legalised, may lead to increasing conflict between our conscience and what is perceived by society as our professional duty to be 'neutral arbiters of medical care'. [22] However, Revelation 13 calls us to patient endurance and faithfulness, [23] and given the instructions of Romans 13, we should continue to submit to the state and participate in democratic processes such as government consultations. We must pray for our own endurance, wisdom and discernment, but also for those proclaiming Christian values in the public arena and all those whom God has called into places of authority.

The Bible is clear. We will eventually get to the end of Revelation when both beasts of Revelation 13 are destroyed [24] and the 'former things' will have passed away. [25] In the meantime, we must remember that Jesus is Lord and entrust ourselves 'to him who judges justly'. [26]

Helen Barratt *is a Clinical Research Fellow in Public Health in London*

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Naomi Pritchard describes the challenges facing today's junior doctors

JUNIOR DOCTORS IN A NEW ERA

glossary of terms

- **MTAS**: Medical Training Application Service – a national online scheme for job allocation launched in 2007 but now obsolete
- **MMC**: Modernising Medical Careers – the new system of specialty training
- **FY1 / FY2**: Foundation Year posts – replaces PRHO and 1st year SHO
- **CT**: Core Trainee – first years of specialty training, replacing SHOs
- **ST**: Specialty Trainee – senior years of training, replacing SpRs /registrars
- **EWTD**: European Working Time Directive – legislation limiting the number of hours worked per week to 48, averaged over a six month period.
- **Hospital at night**: a new staffing structure introduced to cover the hospital overnight, involving reduced numbers of doctors on site, with some junior doctor roles delegated to nurse practitioners
- **ARCP**: Annual Review of Competence Progression – yearly appraisal replacing the RITA (Record of In-training Assessment)
- **Work place based assessments**: system of forms to be completed by senior colleagues (either on paper or on-line) to provide evidence of clinical competencies. These include:
  - **DOPS** – Directly Observed Procedural Skills
  - **Mini-CEX** - Mini Clinical Evaluation Exercise
  - **CBD** – Case Based Discussion
- **Stand-alone posts**, not part of a rotation:
  - **FTSTA**: Fixed Term Specialty Training Appointments
  - **LAT**: Locum Appointment for Training
  - **LAS**: Locum Appointment for Service (non-training post)
- **GPVTS**: General Practitioner Vocational Training Scheme
- **CCT**: Certificate of Completion of Training

How can CMF support trainee doctors in the UK? That was the question behind a seminar entitled 'Bringing juniors and seniors together' which I co-hosted at the Graduates conference in April with Dr Richard Vincent, Emeritus Professor of Cardiology and Executive Chair of PRIME, and Dr Gemma Sheridan, ST3 Obstetrics and Gynaecology from Mersey, and CMF junior doctors' committee member.

After the introduction of the Foundation programme for newly graduated doctors in 2005, 2007 saw sweeping changes to junior doctor training, job applications and career progression. Doctors may well remember the angst amongst trainees navigating the new 'Modernising Medical Careers' application process and struggling to make any sense of the soon-abandoned MTAS website.

Consultants and GPs echoed Richard's experience of the training system. They recalled 72 hour on-calls for their wards of patients, feeling like they lived at the hospital, falling asleep at the desk or whilst taking someone's blood! The long hours could make relationships and family or social lives near impossible, but yielded invaluable opportunities to see and experience a wealth of presentations and have hands on, practical, procedural training. There was an overwhelming sense that, although they never wanted to repeat those years, there was good camaraderie and a sense of family in the firm when training.

There were stories of life in the Mess, supporting fellow team members though their house-jobs, and being entertained in the homes of consultants who took a keen interest in the progression and career aspirations of the teams who remained under their care for six months to a year. Job applications were often in-house events, or applications to individual hospitals, enabling more choice as to where you worked.

There are several key differences in the experience of today's MMC trainees.

The pressure to choose

During your F2 year (18 months after graduating) you must choose which specialty you would like to pursue. This choice is often made with no hands on experience in that field, although 'taster days' in different specialties may be available. A more recent development is that many doctors feel they must have part 1 of their speciality exams to be competitive at interview.

Relocation, relocation

FY1 and FY2 posts are usually rotations in different specialties, three to four months each, often rotating between different hospitals, often in different towns. Training has always entailed travel, commuting and relocating to take-up posts. Currently, anonymous applications are made at a national or deanery level so there are very few opportunities to select the region you work in, let alone the hospital.

Trainees often have to relocate great distances for each stage of training. Each new address means finding a new church and social support network. For many married juniors, or those with children, these relocations can be especially complex and stressful, particularly if both partners are going through the same application process. Is it any wonder CMF has difficulty keeping up with the location of junior members?

Team players

Due to financial constraints, modern hospitals often have staff shortages. With modern rotas and the European Working Time Directive (EWTD), the team structure and 'firms' within the hospital have been widely disrupted. Juniors often now find themselves in 'super-firms', working for a group of consultants spread out to cover the rota. Depending on who is on nights, on-call and on leave, you might find yourself working in a different team from week to week. This degradation in team structure naturally lends itself to a reduction in accountability, support and seniors taking a personal interest in your development and wellbeing. The more sinister side of this arrangement is, if you are not seen as someone's team mate, you also do not work under their protection or loyalty; you are simply 'another junior doctor' rotating through, and can be subject to neglect or bullying from seniors who feel no responsibility for you.

Lacking in experience

In our seminar, the prevailing initial opinion of modern training was that due to the EWTD, it was easier and less strenuous. Junior doctors no longer carry a bleep for 72 hours straight, however, the responsibilities and

roles of juniors during their on-calls have changed. Rather than being called to your own ward to see patients you are familiar with, now the small team, on-call out-of-hours, cover their specialty for the entire site and do whatever crops up, wherever it happens in the hospital. It is also common to do on-call for a specialty in which you have no experience due to cross-covering arrangements.

When we started, we all worked at night and remember learning to deal with 'proper sickies' for the first time at 4 o'clock in the morning. Due to the new 'Hospital at night' policy of staffing, many do not experience full night shifts until they are FY2s, whose specialist senior support may not be on-site.

Despite this, we are expected to take senior responsibility earlier. Gemma started as a registrar in ST3 with only two years obs and gynae experience; routine now, but at least a year earlier than under the old system.

When you take out weekends, nights and evening on-call shifts from the new hours-limited working week, the consultant contact training time has been vastly reduced. As an anaesthetist I have to show I have completed a certain number of sessions in different types of theatres, but have regularly found myself not taking allowed annual or study leave in order to rack up the required training time. It is a scary thought that you are going to be a consultant sooner than ever before, with less experience along the way.

A form-filling exercise

With the introduction of new training pathways come new ways of measuring competency. Many doctors are familiar with 'workplace based assessments': forms and websites that need filling in to sign off that you are capable of performing practical procedures and certain patient interactions. Ever adapting, many of the curriculums have been developed as trainees navigate through the process, with different colleges moving the goal posts as to what is required to pass Annual Reviews of Competence Progression (ARCP) and move to the next year of the training. These yearly meetings with the training programme directors in the deanery are also progressing from an exercise in form filling, to online e-portfolios; a new tool seemingly designed to baffle educational supervisors.

It must be so frustrating to be keen to teach a trainee a new skill or technique, or spend your time discussing a topic, only to have them ask you to fill in a DOPS for the chest drain they've just inserted, or a CBD on that conversation you had about the COPD patient yesterday. It seems to degrade what used to be a meeting of minds and a passing on of knowledge and skills, to a mercenary act of opportunism on the part of the trainee. Trainees dislike this routine just as much as the consultant rolling their eyes, but the Post-graduate Medical Education and Training Board (PMETB) have the last say.

With reduced training hours and staffing levels, the opportunities to see, and be taught to do certain procedures, or supervised once deemed competent, are also reduced.

I spend much of my time stalking dark corridors at night, intubating people in cardiac arrest, or inserting epidurals for labour analgesia. A novel 'catch 22' situation often rises when a consultant refuses to sign me off as competent for a procedure as he or she is not there to observe my practice, then requests that I carry it out unsupervised, often in the middle of the night.

Dead ends

Although most juniors access training posts, some will find themselves on LAS posts, or struggle with exams and have to take time out of their programmes. Once out, it can be difficult to get back in, and it must be so frustrating doing the same job as your peers, but not gaining the same recognition.

CMF's role

CMF's junior doctors' committee have made great efforts to remain connected to and support doctors in training throughout the UK. We attend the national student conference every year and obtain permanent contact details for all final year medical students. We have set up social media networks to help link people, and host the yearly junior doctors' conference with relevant, topical seminars.

The annual MMC Career Day Conference provides juniors with careers advice from consultants in a wide range of specialties. The Values Added programme, a partnership with PRIME, offers local ongoing support and training to help juniors to infuse their daily practice with a Christian worldview (*www.values-added.org*). We are passionate about providing chances for contact and local support for junior doctors, and are excited about the plans for developing links with every hospital and foundation school. We have just published *Foundations* which is reviewed overleaf. Contact CMF for your copy.

There are many ways CMF members can support junior doctors. The juniors' page on the CMF website (*www.cmf.org.uk*) lists all our events - please pray for us. You can volunteer to share your experiences at the future MMC Career Day Conferences; join or host an Open House or Values Added programme for juniors in your area; become a mentor, a link person or follow us on Facebook. Sarah Maidment, another JDC member has written a superb article giving an excellent account of life and experiences of a junior doctor, and how seniors can support junior colleagues. It's available on our webpage *cmf.li/MVBcoG*

The new training structure may seem like a Goliath that needs to be faced. It takes precious time to get to grips with the new assessment process and job titles for junior colleagues, but junior CMF members need the spiritual support, fellowship, and educational encouragement of senior members. In turn, we trust that CMF will benefit as junior doctors thrive and mature as part of a united and flourishing fellowship. It will be difficult for senior graduate members to swim against the tide of the training culture, but junior doctors will appreciate the help and support as we all seek to be salt and light in the NHS.

***Naomi Pritchard** is an ST4 in Anaesthesia*

career paths

- The modern-day training pathway: after graduating from medical school, all newly qualified doctors enter the Foundation Programme, organised in Foundation Schools, to complete Foundation years 1 and 2 which have replaced the previous pre-registration house officer and first year SHO posts respectively.
- Terms such as Senior House Officer and Registrar have been replaced with 'Core Trainees' (CTs) usually referring to the first two years/ pre-membership exam period, and 'Specialist Trainees' (STs) the new SpRs in hospital specialties.
- The number on a doctor's badge, (eg CT2 / ST4) denotes the year.
- Depending on the specialty, after completion of ST years you can gain your Certificate of Completion of Training (CCT) and apply for consultant posts.
- GP training schemes: after foundation, you can enter GPVTS training, (two years' hospital based training as CT1/2 GPVTS) then do the final year as a GP registrar in a practice.
- Also new: some roles are either Stand-Alone, such as LATs (locum appointment for training) and Fixed Term Specialty Training Appointments (FTSTAs). Trainees completing the required workplace based assessments can have that period of time counted towards their CCT, however there is no guaranteed post to progress into. They must reapply for the next stage or a series of FTSTAs.
- There are also non-training posts, LAS (locum appointment for service) which carry no training recognition at all, although the day-to-day job very closely resembles those done by any other practitioner. This band of jobs tends to be grouped with the trust doctor grades and lead into Staff grade and associated specialty posts, without potential for progression to consultancy.
- Visit the Welsh Deanery site *careers.walesdeanery.org/map* for an overview of all of these career paths, including those taking the 'academic route' or going into research.

Foundations
A survival guide for junior doctors
Laurence Crutchlow (ed)

- CMF, 2012
- £20.00 Hb 158pp
- ISBN 978 0 90674 743 8

Several years in the making *Foundations* has finally been published. It was worth the wait.

First, a note about the title… You may be mistaken for thinking this book has been written exclusively for junior doctors in their Foundation Years. Whilst it is an essential read for newly-qualified Christian doctors, it is equally relevant for junior doctors of all grades, as well as final year medical students and those further on in their careers.

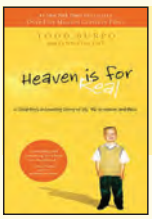
Foundations is helpfully split into four sections: Live, Think, Act and Work and covers over 70 topics, ranging from spiritual issues to ethical dilemmas; conflict in the workplace to working overseas.

Beautifully presented and laid out, *Foundations* is split into easily-manageable, bite-sized chunks, making it perfect for dipping into over a cup of coffee, or flicking through at the end of a busy day.

Each double-page spread looks at a topic from a Christian perspective, examining what the Bible has to say, offering helpful, practical advice, prayer points and some 'food for thought'. And if you've ever felt like you're the only person who has faced a given situation, or struggled with a particular issue, you'll be encouraged by the testimonies from 'real' junior doctors.

So buy a copy for yourself, one for a friend and one for a final year medical student graduating this summer. Read, re-read and pass it on. You will not be disappointed!

***Sarah Maidment** is a trainee GP in Oxford*



Heaven is for Real
A little boy's astounding story of his trip to heaven and back
Todd Burpo

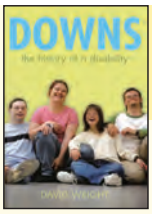
- Thomas Nelson
- £6.50 Pb 156pp
- ISBN 978 0 84994 615 8

We talk of heaven, but is it for real or is it just a nice idea? In 2003 Todd and Sonja's little boy (not quite four years old) almost died from a ruptured appendix. After his recovery, Colton began talking spontaneously about heaven – how the angels sang for him and how he had sat on Jesus' knee. Over the next 18 months amidst childhood games and the rough and tumble of family life, his parents gradually pieced together a story of what Colton had seen and heard there. This book is an account of the child's glimpse of heaven.

You have to find your way through the setting of Mid-West American family life, but the record is, in John Piper's words, 'compelling and convincing' and remarkably true to what the Bible says about heaven. It will encourage those who doubt, and thrill those who believe. We read it with tears in our eyes. It would help us as Christian doctors to see our work in its wider context and it would help many patients who fear what lies beyond.

In the words of one commendation, 'If you're ready to go to heaven, this book will inspire you. If you're not ready for heaven allow a little child to lead you'.

***Peter Pattisson** is a retired GP in Hampshire*



Downs, the history of a disability
David Wright

- Oxford University Press, 2011
- £14.99 Hb 256pp
- ISBN 978 0 19956 793 5

David Wright is a Professor of History at McGill University in Montreal specialising in the history of medicine, disability, philosophy, social history and law. He outlines the history of Down's syndrome from medieval to modern times.

Wright is particularly interesting in his tracing of social attitudes which in the late 20th century led at first to 'normalisation', and later to community care when asylums were closed. In modern times, the consideration of human rights for Down's has risen. He traces the role of the Kennedy family in the USA who fostered special summer camps out of which evolved the Special Olympics. This raised the public profile of people with Down's and showed their achievements.

In an otherwise excellent account of the scientific findings, Wright does not mention the current research into dementia and the amyloid theory linked to the 21 chromosome. It would also have been interesting to have had some information on attitudes in developing countries where people with Down's are concealed at home as if they were a disgrace.

This is a very readable book with an extensive bibliography and glossary. The author has a sister with Down's who has married and lives independently with some support, and works in a sheltered workshop. As an historical account of changing attitudes this book is highly recommended.

***Anthony Cole** is the former Medical Director of the Lejeune clinic*

Hitting the Rock
Chris Maggs

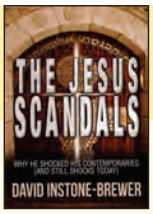
- Purple Plum Books Year: 2011
- £6.99 Pb 310pp
- ISBN 978 0 95700 680 5

This is Chris Maggs' cancer journey, written in three parts: 'Jesus has Chemo', 'Jesus has Chemo again', and 'Matters of the Heart' - intriguing headings. The book gives an honest account of his illness and his experiences as an NHS patient attending five different hospitals over the course of his treatment. Chris writes about his thoughts and feelings about hitting rock bottom, and the way it affected him and his faith. There are detailed accounts, some traumatic but some humorous, of his experiences. He reflects on these and the impact his illness made on him, his faith, family, and church. In particular, he shares how intimately he was aware of God's presence, and God's love expressed through his 'body' the church.

Written by a non-medical person, the book reveals what it is really like being a cancer patient in the NHS today; long waits, delays in diagnosis and treatment, but gratitude for the skill and care given. It is a deeply reflective account, with helpful sections on his physical, emotional and spiritual journey. He gives many profound insights and useful nuggets of wisdom.

I recommend this book to you.

***David Towers** is a retired GP, now living in Cheltenham*



The Jesus Scandals
Why he shocked his contemporaries
David Instone-Brewer

- Lion Hudson, 2012
- £7.99 Pb 192pp
- ISBN 978 0 85721 023 4

Don't be put off by the front cover and title, suggestive of yet another tale in the 'religious conspiracy' genre. The 'scandals' it refers to are the very scandals of Jesus' life, relationships, ministry, and teaching; the author is a scholar in Rabbinics and the New Testament who writes elegantly and accessibly.

The contemporaneous Jewish background to familiar biblical history deepens the reader's understanding of Jesus' words and ministry, and their appreciation of its first century impact. Each chapter addresses a different subject with medical and related themes including healing, alcohol abuse, mental illness, suicidal despair, marital abuse and the pathology of death by crucifixion.

The book would be a valuable tool for group discussion and learning, with restrained use of 'Notes' to the text, and helpful 'Further Reading' and 'Index' sections.

Among much else, I learned that Jesus' statement that 'Where two or three are gathered in my name, I am in their midst' was a claim to divinity. If that's news to you, too, then do read this book.

***Julian Churcher** is London Staffworker for CMF*

Changed Agents: Nine Years in Nepal
Nick & Ros Henwood

- Grosvenor House Publishing Ltd, 2011
- £8.99 Pb 287pp
- ISBN 978 1 90844 756 2

Years later holding hands when we returned to England felt almost conspiratorial' - one of the many memorable phrases from Nick and Ros Henwood's iconic book on cross-cultural living in Nepal.

This is the most insightful and readable account of cross-cultural mission to have hit the market for many years. It's also incredibly honest. It is written in simple, well-defined chapters, with Nick and Ros alternating their own insights and perspectives.

The Henwoods must have made meticulous notes from day one to give this detailed account of the delights and the dangers, the 'blending and the blundering', the crises and the resolutions of living and working both with a Christian mission organisation and with a secular agency.

The book is packed with insights, humour, and variety. For those of us who have had equivalent experiences it elicits wry smiles. For those who have yet to respond to a God-given or humanitarian call to work abroad, this is the best personalised manual for cross-cultural living they could put their hands on. It could become a classic. Nick and Ros have taken the trouble to document their version of experiences that have significance in a day when more missionaries than ever are working abroad.

Whether you have worked abroad yourself, are planning to hit the trail, or want an engaging and enjoyable read, buy this book, and share it with others.

***Ted Lankester** is Medical Director of InterHealth and Community Health Global Network*

The Primary Care Guide to Mental Health
Sheila Hardy and Richard Gray

- M&K Publishing, 2012
- £22 Pb 102pp
- ISBN 978 1 90553 910 9

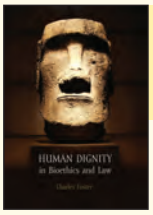
This book does what it says on the tin - teaches about common mental health problems in primary care, with an emphasis on what generalists rather than specialists need to know. Each chapter gives an overview, the epidemiology, common signs and treatments, and also some pointers on how to screen.

As such, the chapters on stress, sleep, dementia, and overall health, are prominent with less text space given to conditions where management is often initiated from secondary care. Helpfully however, the role of the GP is highlighted in these illnesses, where the person's physical health can be neglected and a wider approach missed.

The target audience is within the UK. There are better books on the market for the developing world. For a book that is aimed at non-specialists, there is little on alternative and patient-led approaches to staying mentally well, including an almost complete silence on the role of spirituality and community.

This book is a simplified and partly primary-care orientated look at a range of mental health problems, but fails to deliver a holistic primary care punch.

***Rob Waller** is a Consultant Psychiatrist, NHS Lothian*



Human Dignity in Bioethics and Law
Charles Foster

- Hart Publishing, 2011
- £30 Pb 183pp
- ISBN 978 1 84946 177 1

Human dignity has become a much maligned term partly because it is seen as undefinable and inherently theological. Charles Foster's book, which argues that dignity is the only sustainable 'Theory of Everything' in bioethics and law, swims bravely against this tide.

Foster argues that dignity is the direct route to the right answer in most bioethics problems and actually underpins each of Beauchamp and Childress's four principles. He contends that its meaning can be derived from a study of what makes humans thrive. The book takes up this theme and examines dignity in a range of contexts from human enhancement technologies, through to more everyday problems such as the provision of single sex hospital wards. He argues that dignity is ubiquitous because dignity is to be found wherever there is a human being.

Foster references Judaeo-Christian interpretations of dignity, from Aquinas to modern day writers such as Luke Gormally. However, his exploration of the topic does not take an explicitly theological perspective. Given the dismissal of dignity by secular commentators, this serves to make his case stronger.

Foster's writing is wide-ranging and erudite. His call to the bioethics community to reconsider dignity is timely and makes for an engaging read.

***Helen Barratt** is a Clinical Research Fellow in Public Health in London*

eutychus

Baby boxes back in Eastern Europe

A court case in Germany where a mother was prosecuted for killing her baby by throwing it from a fifth-floor balcony is boosting demand for baby boxes across Central and Eastern Europe. Germany already boasts 99 baby boxes; a heated box, monitored by nurses behind a stainless steel hatch with a handle. Inside the box there are blankets for a baby and a letter explaining who to call if the mother or other guardian changes her or his mind. Critics of the system include the UN Committee on the Rights of the Child, which states that children have a right to know who their parents are and that right is denied to the foundlings left in baby boxes. The backers say that baby boxes save lives and so increase rights. (*BBC News*, 26 June 2012, *bbc.in/Q6Cyex*)

Love is addictive

Love and desire are matters of the head not the heart according to a new study. Psychology professor Jim Pfaus, a co-author of the study, said: 'Love and desire activate specific but related areas in the brain.' The area activated by sexual desire is usually activated by things that are inherently pleasurable, such as sex or food. The area activated by love is involved in the process of conditioning by which things paired with reward or pleasure, are given inherent value. That is, as feelings of sexual desire develop into love, they are processed in a different place in the striatum. This is also the part of the brain associated with drug addiction. Pfaus explains there is good reason for this. 'Love is actually a habit that is formed from sexual desire as desire is rewarded. It works the same way in the brain as when people become addicted to drugs.' (*The Journal of Sexual Medicine* 2012;9:1048-1054 *bit.ly/z7jlav*)

Carers' health suffering

Two in five unpaid carers are sacrificing their own health by putting off medical treatment to care for an ill, frail or disabled loved one a survey for *Carers' Week* has shown. The survey, completed by 3,400 carers, showed that caring had a negative impact on 83% of carers' physical health, with 36% of carers sustaining a physical injury (such as back pain) through caring. A further 87% said caring for a family member or friend has had a negative impact on their mental health. The eight *Carers' Week* charity partners say this is further evidence of a growing care crisis and are calling for better financial and practical support for the 6.4 million unpaid carers in the UK. (*Carers' Week* 18 June 2012 *bit.ly/KMIV3H*)

The weight of nations

Increasing obesity could have the same implications for world food energy demands as an extra half a billion people living on the earth according to research published in the journal *BMC Public Health*. The team estimated the total weight of people on the planet and found that North America, which is home to only 6% of the global population, is responsible for more than a third of the obesity. Researchers calculated that if all countries had the BMI distribution of the USA, the increase in human biomass of 58 million tonnes would be equivalent in mass to an extra 935 million people of average body mass, and have energy requirements equivalent to that of 473 million adults. (*BMC Public Health* 2012;12:439 *bit.ly/Lzpfjg*)

A father's love

Fatherly love is critical to a person's development according to research about the power of parental rejection and acceptance in shaping our personalities. The report published in *Personality and Social Psychology Review* looked at 36 studies involving more than 10,000 participants. The authors found that in response to rejection by their parents, children tend to feel more anxious and insecure, as well as more hostile and aggressive toward others. The pain of rejection – especially when it occurs over a period of time in childhood – tends to linger into adulthood, making it more difficult for adults who were rejected as children to form secure and trusting relationships. (*Personality and Social Psychology Review* 2012;16;103-115 *bit.ly/LZq1sz*)

Mental health costs

Mental illness now accounts for nearly a half of all ill health suffered by people under 65 and it is more disabling than most chronic physical disease. Yet only a quarter of those involved are in any form of treatment according to a report published by the London School of Economics. The report presses for new priorities in commissioning to overturn the inequality within the NHS in the way it treats mental illness as compared with physical illness. The report states 'More expenditure on the most common mental disorders would almost certainly cost the NHS nothing... This is mainly because the costs of psychological therapy are low and recovery rates are high' and because 'effective mental health treatment can also generate other large savings to the government, for example by increasing employment or improving the behaviour of children'. (*The Centre for Economic Performance's Mental Health Policy Group*, June 2012 *bit.ly/KeysfS*)

Measles eradication

Global efforts to cut the number of deaths from measles have fallen short of World Health Organisation (WHO) targets. Despite rapid progress in measles control from 2000 to 2007, delayed implementation of accelerated disease control in India and continued outbreaks in Africa have stalled momentum towards the 2010 goal of 90% reduction in measles mortality. According to a report in *The Lancet* intensified control measures and renewed political and financial commitment are needed to achieve mortality reduction targets and lay the foundation for the global eradication of measles. (*Lancet* 2012;379:2178 *bit.ly/JwZwen*)

Born to be wild?

There are many environmental causes of anti-social behaviour in adolescents, however an article in *The Lancet* explores recent research findings that there are significant genetic pre-determinants for the likelihood of adolescents developing antisocial behaviour. The research goes as far as suggesting it may be possible to determine the likelihood of criminal activity later in life. This begins to sound eerily like the plot of *Minority Report*, a film in which criminals are apprehended before they commit a crime and raises questions of free will and determinism. (*Lancet* 2012;379:395 *bit.ly/zxAILZ*)

Andrew Miller explores the healing of the woman suffering from menorrhagia

DIVINE TRIAGE

Now when Jesus returned, a crowd welcomed him, for they were all expecting him. Then a man named Jairus, a synagogue leader, came and fell at Jesus' feet, pleading with him to come to his house because his only daughter, a girl of about twelve, was dying. As Jesus was on his way, the crowds almost crushed him. And a woman was there who had been subject to bleeding for twelve years, but no one could heal her. She came up behind him and touched the edge of his cloak, and immediately her bleeding stopped (Luke 8:40-44, see also Mark 5:22-29).

The chronic anaemia of this woman with dysfunctional uterine bleeding would have been severe enough to compromise her activities of daily living. So, as others before her (Mark 3:10), she touched the tassels of Jesus's cloak. So far, so good. She instantly recovers, and Jesus continues to the life-threatening emergency. Or does he...?

'Who touched me?' Jesus asked. When they all denied it, Peter said, 'Master, the people are crowding and pressing against you.' But Jesus said, 'Someone touched me; I know that power has gone out from me.' Then the woman, seeing that she could not go unnoticed, came trembling and fell at his feet. (Luke 8:45-48, see also Mark 5:30-34)

This poses the first riddle – why did Jesus force this woman to reveal herself? This took some time, during which the emergency at Jairus' house became a fatality. Later Jesus needed to bring her back to life, causing unwelcome sensational publicity. To resolve this we need to explore the second riddle - why was this woman not rejoicing that she had indeed been 'instantly healed'? Why was she terrified of owning up to this life-changing experience?

Because of her menorrhagia, this woman had been religiously unclean (Leviticus 15:25) for years. The law clearly stated that this affected all the furniture she used (Leviticus 15:20-23), severely restricting her social life. She would have been unable to join in the life of the synagogue and the festivals at Jerusalem (assuming she had enough energy to get uphill to them); indeed, in many Orthodox churches today a menstruating woman is excluded from the Eucharist. It would have caused major marital problems with her husband (Leviticus 15:24; Ezekiel 18:5-6), so she might well have been divorced. This is why she surreptitiously touched Jesus' cloak from behind.

Therefore, as well as the physical limitations caused by this condition, her family, social and religious life would have been profoundly compromised, explaining her desperation in ruining herself financially to seek any medical help. This was then a common, major, life-ruining condition for women, hence there were several suggested rabbinical remedies; all were expensive.

The effect of this apparently minor medical illness was therefore catastrophic. Jesus realised that physical healing was not enough for her - her damaged psyche and emotions needed attention too. He therefore insisted that she be located to be forced to emerge and look Jesus in the face.

Jesus said five remarkable things that she needed to hear: *'Daughter, your faith has healed you. Go in peace and be freed from your suffering'* (Mark 5:34). But why remarkable?

1. Daughter: in all his dealings with women this is the only time Jesus is known to have said this, and even in his many healings of men he only once said 'son' (Matthew 9:2).

2. Your faith: although some commentaries commend her great faith, in reality Jesus was her last desperate hope; she needed to have this tiny spark affirmed.

3. Has healed you: A much better translation would be 'has made you whole'. Instead of using either of the two common words for physical healing (one already used here transliterates as 'therapy'), Jesus unusually chose the word 'save' - embracing soul and spirit. On at least three other occasions Jesus chose the same words to bless and affirm the transformation that had happened in a person's life: a sinful woman, a Samaritan leper, and a blind man (Luke 7:50; 17:19; 18:42).

4. Go in peace: Jesus is only known to have said it once before, to another woman excluded from society (because of immorality - Luke 7:50). Now this woman could at last experience real peace, not just both with her family and society but more importantly within herself.

5. Be freed from your suffering: this last word is rarely used for sickness, instead being translated 'scourging' (as in John 19:1). Not only was Jesus blessing her physical healing, but he also fully acknowledged how devastating her 'suffering' had been.

This is why Jesus felt compelled to stop. This is the ultimate expression of whole-person medicine.

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