Summer 2013

for today's Christian doctor

triple helix

a beautiful life

Why STI rates are rising, the true cost of Down's screening, servant leadership in the NHS, fast if you dare, calling or stewardship?

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contents

The erosion of Christian civil liberties

Keeping a biblical perspective

Last 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] on behalf of CMF.

Its 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.'

Key developments in 2013 have further underlined this reality.

Two British Christians who refused to act contrary to conscience lost their legal battle at the European Court of Human Rights in May in a move that demonstrates that under British law 'gay rights' now trump 'conscience rights' when the two conflict.[4]

Gary McFarlane and Lillian Ladele had their appeals to the Strasbourg court rejected in January and had sought to resolve the matter in the court's Grand Chamber, its final arbiter. However, judges at the court rejected their request, in effect ending the legal battle.[5]

Ladele, 52, a local authority registrar, was disciplined by Islington council in London for refusing to register civil partnerships for gay couples. Islington accepted that it had enough registrars to provide a civil partnership service to the public without requiring Miss Ladele's involvement. But managers at the council refused her request, and demanded that she carry out civil partnership registrations against her will.

McFarlane, 51, a Bristol relationship counsellor, was dismissed by the charity 'Relate' for saying he might object to counselling same-sex couples about their sex lives. His dismissal for gross misconduct was on principle and it was irrelevant whether he could have been accommodated. A dismissal for gross misconduct is the most severe sanction available to an employer.

In both these cases reasonable accommodation could have been made, but the respective employers decided instead, backed by the law, to put these two employees in an impossible situation. At a stroke this puts at risk the job of any employee objecting to helping homosexual couples in activities they believe to be wrong (eg celebrating a civil partnership, adopting a baby, having sexual counselling etc).

Whilst neither Ladele nor McFarlane were healthcare workers, the same principles will certainly apply to doctors, nurses and others who find themselves in similar moral dilemmas.[6]

The decision of the Grand Chamber has understandably prompted calls for more robust protections to be put in place for Christians in the Government's Marriage (Same Sex Couples) Bill[7] but at the time of writing, with the bill about to pass unamended through both houses of parliament, this is looking increasingly unlikely.

If this latter bill goes through, those who refuse to endorse or recognise gay marriage (eg teachers, council workers, healthcare workers) could also find their jobs to be at risk.

However, it is not all bad news. The General Medical Council's new guidance on 'Personal Beliefs and Medical Practice' (PBMP),[8] published in March, recognised a doctor's right to conscientious objection to certain procedures[9] and gave scope for sensitive faith discussions within the consultation.[10]

However it applied a very narrow scope to the conscience clause on participation in abortion, holding that it only applied to those directly involved in the procedure.

Ironically the GMC may now have to modify this guidance in the light of a court ruling in a case involving two Glasgow Catholic midwives in which the judge found that 'the right of conscientious objection extends not only to the actual medical or surgical termination but to the whole process of treatment given for that purpose'.[11]

In a Britain increasingly hostile to Christian faith and values, Christian doctors need to be aware of where they stand before an evolving law so that they can prepare for conflict, show courage in the face of fire and also work hard to ensure that unjust laws and regulations do not go unchallenged.

The Bible tells us that 'everyone who wants to live a godly life in Christ Jesus will be persecuted'.[12] It is part and parcel of following Christ and should not surprise us.

As Christians contemplating possible conflicts we need, like the prophet Daniel and his friends[13] and the Apostles,[14] to draw a line in the sand and not be intimidated.

But we also need to trust God and leave the eventual outcome in his hands knowing that, whether we are vindicated or condemned by others, he will be glorified.

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

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news reviews

Unsafe sex

Why STI rates continue to rise

Review by **Trevor Stammers**
Programme Director in Bioethics and Medical Law, London

Public Health England (PHE) has released figures showing the highest annual levels of sexually transmitted infections (STIs).[1] There were 448,422 recorded hospital clinic diagnoses – a rise of 5% from 2011, with under-25s experiencing the highest rates. Chlamydia accounted for 46% of the total diagnoses. The rise in gonorrhoea diagnoses of 21% is a particular cause for concern as it will fuel the problem of antibiotic resistance highlighted earlier this year.[2]

Dr Gwenda Hughes, head of STI surveillance for PHE, said 'Too many people are continuing to have unsafe sex'.

If by 'unsafe sex' Dr Hughes meant sex with a partner you have only just met, then this makes good sense. If Hughes merely equates 'unsafe sex' with 'sex without a condom' which is how most of her audience will understand it, then this is not such sound advice. Sex with a condom may be safer than sex without one, but a lot depends on the sexual partner too and the sexual activity involved. Both taboo subjects, it seems, for PHE.

Such coyness wrecks lives. Spin about the rather modest effectiveness of condoms for many non-HIV STIs continues to be the norm in literature. The latest edition of the Faculty of Sexual and Reproductive Health Guidance on Barrier Methods for Contraception and STI Prevention (August 2012)[3] is typical of the blithe reassurances proffered on the flimsiest of evidence. For example, page 7 asserts 'the two most rigorously designed studies provided evidence to support a reduced risk of syphilis transmission with consistent use of male condoms'.[4] What the guidance fails to say is that the single reference given reviews twelve studies and the only one showing a statistically significant reduced transmission of syphilis was in a sample of Bolivian sex-workers[5] – hardly a comparable risk-group to UK population.

Until young people understand that mutual virginity before marriage, and faithfulness within it, is the only way to enjoy truly safe sex, STI rates will continue to increase.

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Hunger: not part of God's plan

Global malnutrition is becoming an epidemic

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

It is sobering that in the 21st Century we still face a malnutrition epidemic affecting millions. In 2011, according to recently published figures in *The Lancet*,[1] 3.1 million under-fives died from under-nutrition – 45% of total child deaths. This is improving, but much too slowly. However, the impact goes wider; malnutrition in adolescent girls affects the health of their children (and grandchildren) born years later, while malnutrition during pregnancy has an even more dramatic impact. Malnutrition in the first two years of life leads to permanent physical and mental stunting of children, increases their vulnerability to obesity and non-communicable diseases, and reduces job and educational opportunities in later life. Under-nutrition today causes health and economic problems for the next two generations at least.

A staggering 165 million children are affected by malnutrition. This is a global health problem of crisis proportions. The causes are complex – land controlled by vested interests driving off subsistence farmers, labour exploitation, financial austerity measures, fluctuations in global commodity prices (exacerbated by agricultural subsidies in the developed world) – the list goes on. The structure of global trade and food production is forcing many into hunger, often in areas where local food production is more than adequate to meet the need. The problem is systemic injustice, not a lack of food.[2]

The recent hunger summit in London (ahead of the G8) and the accompanying 'Big IF' rally in Hyde Park[3] aimed to galvanise global political commitment to make the policy changes necessary to end this kind of hunger. Critics commented that the rally and campaign did not address all the causative issues, and that the campaign and government policy seem very much in accord.[4] More seriously, it looks as if some of the measures being put forward (especially tax transparency) are being ably resisted by many governments with the help of big business lobby groups.[5]

The Scriptures remind us that hunger is not a part of God's plan for humanity – there will be no hunger in the new creation.[6] We are urged to feed the hungry, and to allow our surplus to meet the deficit of others.[7] However more than just caring, we are also enjoined to stand up for justice.[8] We will be picking up the pieces of these malnutrition-induced health crises all over the world for years to come. There can be no doubt that this cannot be allowed to continue; we need to continue to lobby for real action as well as to care for those affected.[9]

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Assisted suicide

Renewed pressure to change the law must be resisted

Review by **Peter Saunders**
CMF Chief Executive

The relentless pressure to legalise assisted suicide and euthanasia continues unabated in Britain. The Court of Appeal hearing of two cases of locked-in syndrome (Nicklinson and 'Martin') on 13-16 May was joined by a third appellant Paul Lamb, a 57 year old man with quadriplegia, who has taken Tony Nicklinson's place after the latter died last year.[1]

Nicklinson's widow argued that her husband being denied an 'assisted death' interfered with her right to a private life under the European Convention on Human Rights article 8. Lamb similarly used article 8 arguments but also argued that the legal principle of 'necessity' should allow a doctor to end his life without fear of prosecution for murder.

'Martin' also argued under article 8 asking the Director of Public Prosecutions (DPP), the Solicitor's Regulatory Authority and the General Medical Council to make clear in advance the extent to which solicitors and doctors could assist his suicide.

The judgment is still awaited at the time of writing but if any of these appeals are successful the case will go back to the High Court for consideration of more detailed evidence.

Lord Falconer introduced his new 'assisted dying bill' into the House of Lords on 15 May with a second reading (debate stage) expected to take place in October.[2] It seeks to legalise assisted suicide (but not euthanasia) for mentally competent adults with less than six months to live and uses a 'two doctors' signature' model similar to the Abortion Act 1967. The aim is to medicalise assisted suicide, making it a standard healthcare option.

Margo MacDonald MSP has published the results of her new consultation aimed at legalising assisted suicide in Scotland and has obtained the necessary 18 signatures that she requires to take a bill forward. She has announced that she plans to introduce it into the Scottish Parliament in the summer.

Alongside these moves, the Royal College of General Practitioners (RCGP) is consulting its members about whether it should abandon its long opposition to a change in the law and adopt a neutral stance.[3] The inquiry closes on 9 October.

The voices of three key groups – doctors, disabled people and faith communities – will be crucial in countering the encroachment of this culture of death. In particular, Christian doctors, as key advocates for those who are sick or disabled, will continue to have a huge role to play.

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The NHS number

Time for private abortion providers to be accountable

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

A Government consultation on the collection of national statistics on abortion may seem like a dry and uncontroversial topic. However, it has provided CMF with an opportunity to highlight an issue that has received very little publicity but which we believe is vitally important.[1]

In England and Wales, many abortions are not properly recorded on women's health records. This means there is no record of them for future medical treatment and care, nor is it possible for linkage research to be carried out on the outcomes of abortion for these women.

With over 200,000 abortions per year, this data is necessary to test the UK evidence of sequelae from abortion.

The problem arises because many abortions commissioned *outside* of the NHS are undertaken without use of the NHS personal number. The NHS number is an administrative identifier, used to match patients to their medical records.[2] The commissioned providers of abortion in England (mainly BPAS and Marie Stopes) are not routinely required to record the patient's NHS number, thus subsequent women's health events cannot easily be linked back to the abortion, and longitudinal research is almost impossible.

Outcomes of abortion and possible side effects (eg possible subsequent premature birth, mental health problems, infertility or other trauma) cannot easily be tracked in England. This puts England behind much of Europe regarding this evidence, including behind Scotland. In Scotland abortions are largely undertaken within the NHS, so good record linkage is available.

In 1991 the NHS funded 9,197 abortions carried out by the *private sector* – just 10% of private sector abortions. By 2010 the NHS funded 111,775 abortions carried out by the private sector – 93% of all abortions carried out by the private sector.[3]

By 2010 more NHS commissioned abortions were carried out in the private sector than within the NHS in England and Wales (59%).[4] Hence the problem with data collection, as the NHS number is not routinely recorded for the large numbers of private sector abortions.

It could be argued that women undergoing abortion require complete confidentiality and privacy protection, and might be identified through the collection of data via the NHS number. However, all good epidemiological longitudinal research is confidential, which would include research on the outcomes of abortion linkage with the female health record.

Routine record keeping of the NHS number for every abortion should be put in place. The problem is, while we may have the means to do so, there is little political will while publicly-funded private abortion providers enjoy a stranglehold over the abortion industry.[5]

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Martin Scott-Brown remembers Millie and the blessing her short life brought

LOVE POURED OUT IS NEVER WASTED

key points

- Millie: not a medical problem to be faced but a daughter, however imperfect, to be treasured and loved.
- There were many gains from sharing Millie in the church and community and not hiding her away.

'There's no easy way to tell you, so I'll just tell you straight. Your child has Holoprosencephaly.'[1] This may not be the textbook way to deliver bad news but the words from the consultant obstetrician at our 20 week antenatal scan left us in no doubt. There was a problem. Over the next few weeks we would learn more about it, from internet searches and from referrals for confirmatory second opinions.

The medical opinion was fairly overwhelming: '98% of parents in this position terminate the pregnancy', 'Are you sure you want to carry on, you do know what she will look like?' 'Your daughter is likely to choke to death, and will not recognise you as her mother', 'We can offer you a termination tonight, we can book you a bed to stay the night'.

Just days before, we would not have considered terminating a pregnancy. Now, we were in the difficult position of grieving the loss of our daughter whilst trying to make a decision that would impact both our lives and those of our two young boys.

> Millie has left her lasting impression on us, giving us an entirely new capacity to love, not only our other children, but other people in need

Having grappled with it for a few days we cried out in prayer 'God, what do we do?' and he spoke to us very clearly. Within twelve hours through a chance meeting, Frances was encouraged to read *The Shaming of the Strong* by Sarah Williams.[2] It is the story of another family from Oxford who had been faced with the same dilemma. The local Christian bookshop happened to have a copy, and in their window Frances' eye was caught by a sticker: 'Books change lives'.

The book spoke to us of our precious daughter who had been given to us by God, not of a medical

problem to be faced but a daughter, however imperfect, to be treasured and loved. We should have listened to our three-year-old son, who when first told that his new sister would not be very well, reassured us, 'Don't worry Mummy, I'll give her a hug when she comes out'.

Looking back we're not sure that we could ever have proceeded to a termination. However, we look back at those weeks of agonising and know that God led us through that time. It would have been possible to follow what we knew we should do and battle on through the tough times ahead, but when we cried to him he answered; he called us to receive the gift he had given us. Knowing his calling on our lives we had a great peace from the moment of our decision and throughout Millie's life, and then at the end of her short life were able to hand her back to his care.

'I'll lend you for a little time a child of mine,' he said,
'For you to love the while she lives, and mourn for when she's dead.
She may be six or seven years, or only two or three,
but will you, till I call her back, take care of her for me?' [3]

New parents are advised that having their first child will change their lives. Having Millie (our third child) really changed our lives. It was difficult to prepare for her birth. We did not know if she would make it to full term. Then planning for her life was even more difficult. How long was it likely to be? We had been advised it could be minutes, hours, days or months, but not years.

Everyday life was more of a challenge, NG feeding, multiple medications (antiepileptics, sedatives, antiemetics and antacids to name just a few), frequent vomiting and lack of weight gain, home oxygen and physiotherapy. Frances became very adept at NG tube placement and drug administration. We lived day by day, plans were made and changed.

We decided early on to share Millie with our community. She came to the school gates to pick up her brothers; she went to church and on family outings. We had many sleepless nights, until advised to take the nights in turns, one good night followed by a night with three hours of broken sleep.

Life had its challenges but its great joys as well. We reappraised our priorities. We gained new insights into life. Having lived a successful and relatively sheltered life, through Millie – her life and death – we experienced the depths of sadness and despair that many people in the world are living through, enabling us to come alongside them in a more meaningful way. Living with Millie resulted in a deepening of relationships with those closest to us.

Little did we know when we made that decision that God's gift to us was not just to care for Millie for 22 months. It was also the changes he would work in our lives that would last so much longer. As one friend put it after Millie died, 'Life goes on. You can see this family moving on and thriving, loving life and enjoying life and that's not because Millie's not there anymore, it's because Millie was there.'

Millie's grandfather, Graham Scott-Brown, came twice a week from when Millie was about ten months old to provide respite care overnight. We gained hugely from the love, support and prayers of family and friends and the practical respite support of Helen House and ROSY – Respite Nursing for Oxfordshire's Sick Youngsters.

At Millie's funeral Graham spoke about Mary Magdalene washing Jesus' feet with precious ointment and that the house was filled with the fragrance of the perfume. Some of those standing near asked 'to what purpose is this waste?' People may look at all the care and love that has been poured out on Millie and question 'to what purpose was all this done?'

Love is the most precious ointment in the world; love is made to be poured out and any love that is poured out is never wasted. Those who pour out love find that they have the capacity to pour more. If you don't pour out love you won't have the capacity to pour more; if you pour it out you will find that God gives you more love to pour out. You become a wider container and you are able to give more.

Millie in a wonderful way called out that sort of loving response from so many people. That love overflowed into the surrounding community. Many of the children and their families from her brothers' school classes attended her funeral, having been impacted by her short life. The fragrance of love filled our house as we loved Millie. We look back and see that it was God's love that was poured out for Millie, from us as parents and all those who came into contact with her.

It is amazing how God could take something that humanly was so tragic and turn it into something so beautiful. Millie has left her lasting impression on us, giving us an entirely new capacity to love, not only our other children, but other people in need, such as many of my patients facing the end of their lives with terminal cancer. We now have a capacity to love that we would never have had if Millie had not been part of our experience.

We are still seeing the impact of Millie's life today. As one friend put it, 'I don't think there was ever a time when I left their house and didn't reflect on life and just see the amount of good that has come out of Millie's life, like a huge ripple, and one day we will see that she has had an impact on people's lives that we didn't even know about.'

After Millie died the sister of a friend was encouraged by Millie's story to continue with a pregnancy that she had been advised to terminate due to the likelihood of severe disability. Their daughter was born completely normal six months later.

God called us to receive his gift of Millie for our lives. Through her life he poured out his love into her life and his love spilled over, and the ripples are spreading far and wide.

Martin Scott-Brown *is a Consultant Oncologist, University Hospital Coventry and Warwickshire.*

It is amazing how God could take something that humanly was so tragic and turn it into something so beautiful

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Christine Scott tells of her involvement with a local crisis pregnancy centre

ABORTION: THERE IS A BETTER WAY

A COMPASSIONATE RESPONSE TO THE ABORTION DEBATE

key points

- Coming alongside women at a time of difficulty and accepting them is what demonstrates Christ's compassion. What happens next is not our responsibility.
- Looking to the future, a key task is bringing the work of pregnancy counselling into the mainstream alongside the statutory services.

Abortion causes disquiet. As a GP I have listened to many women in troubling and difficult circumstances, and merely referring them to an abortion clinic or a colleague in the practice (whilst withholding my signature from the abortion form) has seemed the correct, and yet inadequate, response. Views about abortion are polarised and often vociferously expressed. Whilst I understand those who campaign against abortion, vigils outside abortion clinics seem to be targeting the wrong people. There has to be a better way.

The Crossway Crisis Pregnancy Centre[1]

Our parish contains one of the largest private abortion clinics in the UK. For many years Christians faithfully prayed about the issue of abortion locally. In 1997 a practical answer to those prayers, and to my personal discomfort, began to take shape as a group of concerned individuals met to undertake a training course, learning to provide support for individuals facing the abortion dilemma. CareConfidential,[2] a charity to which around 140 pregnancy counselling centres in the UK are affiliated, developed this 'Called to Care' course.

Our crisis pregnancy centre opened its doors in 1999. From small beginnings the work developed in response to the desire to provide a constructive and compassionate alternative to abortion. We became a charity in 2005 and now have a small part-time paid staff supported by volunteers. The centre provides options counselling for women and men facing the decision of what to do about an unplanned or other crisis pregnancy. In the surgery my time is limited and patients may well feel the need to persuade me of their certainty about the decision they feel they have to take. In contrast, in the centre listeners can offer frequent, unpressured appointments allowing plenty of time for women to explore their difficulties.

Whilst our listeners are not counsellors, they have extensive training and experience in helping women explore their options. Our aim is not to influence women's choices, but to facilitate and support them in making informed decisions. Women, couples and sometimes men on their own come to us in a variety of circumstances. We might see a teenager with an unexpected pregnancy afraid to tell anyone, a career woman in her late 30s who never really saw herself as a mother, a couple who had IVF now facing the news that their baby has a chromosomal abnormality. Whatever the situation we are clear that our place is not to judge but to listen, to help explore all the options and to help men and women come to their own 'least bad' decision.

Even in our society where abortion is presented as acceptable, normal almost, very many women find this is a painful normal. Though abortion may be seen as 'the right decision', it is often a decision made at considerable cost. At the centre we see women returning following termination to talk about their experience. Hence, in addition to spending time with individuals and couples as they consider their options, we provide counselling following termination. The Journey, also developed

Janice had recently had an abortion. Single, her partner about to go to prison and just having started a job, she felt she had no other option. It only took a few days for her to feel very differently. Undertaking the Journey programme at the centre was a vital part of her coping in the next few months. However, some time later she was pregnant again. Ashamed and desperate she once again booked into the abortion clinic, not believing that anyone would be willing to help this time. Fortunately the clinic questioned her decision and asked her to come and see us before going ahead.*

Emma spent several meetings with her, talking through the options and Janice eventually decided that she would continue her pregnancy. The pregnancy was not easy and nor is motherhood, but Janice is thankful to have her son and is now one of our most enthusiastic advocates.*

Emily and Bill were devastated to discover that their much longed for unborn child had Down's syndrome. In feedback they wrote: 'The centre helped by having an independent way of thinking about all the issues and helped us to sort through our thoughts and feelings. It allowed us to openly and safely discuss thoughts that maybe we didn't want to express at that time in case it upset the other…'.*

* Names and details have been changed to protect confidentiality.

by CareConfidential, is a ten-week programme helping women and men begin to talk about termination, understand their decision and ultimately come to a place of acceptance and peace. A further development has been the extension of the Journey to support those coming to terms with miscarriage or the pain of releasing a baby for adoption.

How can a faith organisation provide unbiased, non-judgmental counselling?

We had to overcome natural suspicion about our service and demonstrate to the community, and particularly GPs and the local abortion clinic, that a Christian organisation can provide non-judgmental unbiased help. I had to convince myself that we could really do this. God created us with freedom of choice. I am reminded of Jesus' dealings with the rich young man in Matthew's Gospel.[3] Jesus answered the man's questions, allowing him to see his own need, but put no pressure on him as he chose to walk away.

Our best adverts have been our clients. Their stories are our most effective publicity and the fact that women who we have seen in crisis return to us for support after termination speaks of their feeling accepted by the centre. It is difficult to watch someone make a decision that sits uneasily for you as a Christian and sometimes hear the pain that results. But the willingness of our volunteers to support women in this way is what is so valuable. We do not talk about our faith; instead we help our clients explore all the influences on their own decision-making. What happens next is not our responsibility.

How can a doctor help?

Being involved in this work means having to grapple with the ethical issues of abortion. How does abortion sit alongside the Christian's high view of the sanctity of life? Can this stand be held and yet God's compassion be shown to women? It has been wonderful to work alongside those from many backgrounds in setting up and running the centre. I chose not to be involved in face-to-face contact with clients as I felt this raised too many boundary issues for me as a local GP. Initially I sat on the steering group as the centre was planned, and served as a trustee when we became an independent charity later on. Throughout I have been able to use my teaching skills, helping to train listeners and I acted as a supervisor ensuring that the centre practises to high standards. Speaking out for the centre in front of my GP colleagues certainly motivates me to ensure that we maintain high standards in all we do.

CareConfidential provides overall support, training and resources for the many centres around the UK (though all the centres are independent and locally run). Many centres already benefit from the active participation of doctors and other healthcare professionals. However, many more would value the expertise that doctors can bring. A number of changes have had impact on the work of CareConfidential and the network of centres over the past few years. Most importantly there has been greater scrutiny of all organisations providing counselling services, particularly those run by faith-based organisations – and rightly so. This brings with it an increased need to ensure that we provide high-quality services and are completely transparent. There has been much publicity criticising this work[4] which as doctors we are well placed to redress.

Last year there was a move to enshrine the offer of independent counselling prior to abortion in the law. Advocates (most notably Nadine Dorries MP) pointed to possible conflicts of interest for abortion providers. Women requesting abortion may well feel the need to 'persuade' the doctor of their need and hence be reluctant to ask for counselling. Although the law was not changed and the government has dropped plans for an independent review, the debate about the need for counselling prior to abortion continues.[5,6] Christian doctors have an important role in this debate.

There is an important job to be done bringing the work of pregnancy counselling into the mainstream to provide much-needed support alongside the statutory services. GPs involved in CCGs are well placed to consider how this might work in practice. My desire is to see our service so valued and well known that we would be a routine part of abortion referral pathways, that would open the opportunity for all women to have time, space and the care that we are able to give as they face the abortion decision.

***Christine Scott** is a Locum GP in Middlesex.*
Views expressed are those of the writer.

resources

There are a number of helpful resources for anyone exploring work in this field:

- **Reannon's story** is an excellent DVD produced by CareConfidential. Reannon speaks eloquently and honestly of her experience as a young women who had an abortion. This is useful for anyone exploring their attitudes to abortion and particularly thinking about involvement in options counselling. *www.careconfidential.com/Reannons_journey.aspx*
- Clarke P. *A Heart of Compassion: Grace for the Broken*, Authentic, 2006 £7.99; Pb; 179pp ISBN 1850786631. An honest and challenging account of a GP's journey as he engaged with the abortion issue at a practical level. A 'must read' for all Christian doctors.
- **CareConfidential** – exploring this website will give you a good feel for the work of local Crisis Pregnancy Centres, *www.careconfidential.com/Default.aspx*

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Philippa Taylor assesses the costs of screening for Down's

YOUR MONEY, THEIR LIVES

key points

- Many more women are opting for antenatal screening than was originally expected.
- With screening techniques becoming more sophisticated, demand will increase further.
- Meanwhile few appreciate the true costs involved.

In 1992 it was predicted that no more than 60% of all women would take up antenatal screening for Down's syndrome and, with more older mothers giving birth, there would be an increase in the number of affected births.[1] How wrong this prediction was.

It underestimated the future power and effectiveness of new screening techniques. The prediction that more older mothers would conceive was indeed correct but the annual number of children born with Down's syndrome has remained fairly steady (and very low) because the numbers of babies aborted with Down's has steadily increased.

A recent parliamentary question by Fiona Bruce MP elicited the information from the government that the cost to the NHS to diagnose and screen for Down's syndrome in England and Wales each year has reached approximately £30 million.[2] Some of these costs are spent on women who, following diagnosis of Down's syndrome for their baby, choose to continue their pregnancy up until birth. These costs total £1.37 million. Therefore the total cost to the NHS for screening pregnant women for babies with Down's syndrome, who subsequently have an abortion, is approximately £28.5 million per year.

One striking figure is that part of the £30 million is actually spent on the screening and subsequent loss of healthy fetuses: it is estimated that the '*cost of healthy fetal loss*' is £100,000, which will primarily be babies without Down's syndrome who die because of spontaneous miscarriage after amniocentesis or chorionic villus sampling (CVS).

Another striking figure is that while the annual cost of screening ('searching' is perhaps a more appropriate word) for any baby that might have Down's syndrome is £30 million, once they have been 'found' it is then cheaper to abort them than allow them to be born. It costs around £0.5 million to screen and abort babies with Down's syndrome each year, compared to a total cost of £1 million screening and bringing to live birth the small numbers not aborted.

No wonder, from a pure cost basis, that in 2001 the UK National Screening Committee advised that *all* pregnant mothers should be offered one of the available screening tests for Down's syndrome. Sadly, it is unsurprising that so few babies with Down's syndrome make it safely through the screening process.

92% of mothers who receive an antenatal diagnosis of Down's syndrome have an abortion, a proportion that has been constant throughout the period 1989-2008.[3] Year on year antenatal screening has achieved higher rates of correct predictions and higher coverage, which will only continue as screening tests become cheaper and more sensitive.

Somewhat ironically, the same day that the Government published figures for the cost of screening for babies with Down's syndrome, the BBC reported that an even more accurate test for Down's syndrome, which can be given even earlier in pregnancy than current checks, has now been developed.[4]

To illustrate in another way the effect that this screening has had, if there had not been abortions of babies with Down's syndrome between 1989-91 and 2005-7, then the increase in the average age of mothers would have caused a 48% increase in births of babies with Down's syndrome.[5]

One of the consequences of so few births of babies with Down's syndrome is less incentive and demand for research into Down's syndrome (nor support or networks, but that is another story). While £30 million is spent on screening for babies with Down's syndrome, less than £2 million is spent on research for those that survive this screening process. These starkly contrasting figures came out of another question tabled by Fiona Bruce MP:

'To ask the Secretary of State for Health how much the Government spends annually on research into Down's syndrome.'

'In 2012-13, the Department's National Institute for Health Research (NIHR) spent £1.2 million on research relating to Down's syndrome through research programmes and research training awards. Total spend by the NIHR on research relating to Down's syndrome is higher than this because expenditure by the NIHR Clinical Research Network (CRN) on this topic cannot be disaggregated from total CRN expenditure. In 2012-13 the Medical Research Council spent £564,000 on research into Down's syndrome.'[6]

It is one matter to state all of this in abstract numbers and large sums of money. But clearly it is not just about money, it is also about individual lives. What do mothers who go through the screening process say? Is it really an unbiased 'choice'? What impact does screening have on family members? And on society?

As well as asking some probing parliamentary questions on this issue, Fiona Bruce MP is Chair of a Parliamentary Inquiry into Abortion on the Grounds of Disability.[7] This Inquiry has heard oral evidence from a number of people who either have Down's syndrome themselves, or who are parents of children with Down's syndrome or who are involved in running disability support groups.[8] Here are a few interesting quotes from several witnesses from one evidence taking session:

'I have heard it anecdotally that some obstetricians and gynecologists are saying to their patients: "…once we've discovered it has a fetal abnormality...if you insist on carrying on with the pregnancy, I won't treat you anymore".'

'There should be a requirement for at least a week's thinking time, because we still hear examples of somebody phoning up a mother, with a diagnosis of Down's syndrome and saying, "we've booked you in tomorrow for a termination". We still hear that. Well, that's absolutely appalling and it doesn't give people time to think at all.'

'I do know women aren't being given balanced information at the point of diagnosis in order to make informed choices, and are left with little or no support or counselling during testing, after diagnosis, before termination, after termination, if that's what they choose…Worse still, even after a decision to continue with a pregnancy, couples are being asked if they are sure at each scan or medical appointment, and are being reminded that a late termination can be arranged. I know families that have had to insist that notes are written across the top, a large banner, "please do not ask me any more about this".'

'The assumption is, if you get that diagnosis, you're going to terminate your pregnancy, and that's where everything is being pushed, in terms of information, in terms of support. You get plenty of support around a termination. There isn't other support.'

'I fear it's more a question of perceived cost or eugenics, in a society that stigmatises disability, and with support networks ever decreasing.'

These are not one off experiences either, as an article in the *Daily Mail*, again in the same week, illustrated. One mother said:

'The clinic called to confirm that our baby had Down's syndrome, then immediately asked: "Do you want us to look into organising a termination?" … at the hospital, the doctors wouldn't let the subject of an abortion drop, even after we made our wishes clear. It felt like water torture – there was a constant drip-drip-drip of negativity at every consultation or scan. One doctor told us: "Your lives will never be your own." Another said: "Some people will feel you're being selfish by having this child." Yet another: "Your other child will suffer as a result of this." …If I'd been a less strong woman, I might have been swayed.'[9]

The cost to society from paying the NHS to screen out 92% of babies that have Down's syndrome is, of course, far more than just monetary. The last words here should go to the mother of two daughters, one of whom, Natty, has Down's syndrome:

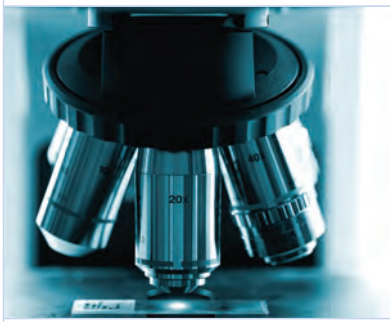
'Natty is six, an ambassador…She puts back far more into society than she takes from it, as she entertains, laughs, sings, dances, jokes, brings people together, brings family together…She has made me a better person.

'I found this written in a book in (her elder sister's) bedroom. I didn't know she'd written it:

'"To Natty, I love you so much and you're the best sister in the world and so precious to me. You're so important to me and if you weren't in this world my life wouldn't be the same and that would be terrible. I love you so very, very much and you mean everything to me. Your sister, Mia".'

And we are paying £30 million a year to remove such children from our society.

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



Few babies with Down's syndrome make it safely through the screening process...

Women aren't being given balanced information at the point of diagnosis in order to make informed choices

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John Wenham tells how beginning to fast triggered radical change

FAST IF YOU DARE

key points

- Fasting is a much-neglected spiritual discipline.
- It can bring to the surface the hidden desires of our hearts.
- It is a way to clear time for prayer and listening to God... but be ready to be surprised.

It was June 2011. I had been reading a copy of Richard Foster's *Celebration of Discipline*. The chapters on praying and giving had been satisfying as I recognised these as areas that I had spent plenty of time working on. Fasting, however, was a bit of a no-go zone for me.

As a CMF student I had heard a talk on Matthew 6, where Jesus said, 'When you give...when you pray...and when you fast…'.[1] In other words, these are activities Jesus expects his followers to be doing. They're not optional extras. Other than one or two occasions when I had worked through lunch as a junior doctor, I do not recall ever being obedient to this expectation.

I learnt a lot about fasting from Foster.[2] Firstly, fasting must 'forever centre on God'. We are not to use it to bribe God any more than we would with giving or praying. Moreover, fasting and worshipping should be done together. Then, fasting can bring the desires of our hearts to the surface; things that have controlled us silently will make themselves known. I found anger bubbling up in my first four fasts. After that I experienced a deep sadness as I understood more of God's view of my sin.

Foster offers a practical guide to fasting.[3] He advises not to run before you can walk. He suggests undertaking a 24-hour fast from the end of one lunch to the beginning of the next; using fruit juice for fluid along with water on the first couple of occasions before embarking on a full 24 hours with water only. As I have always been a breakfast man who needs to be fuelled before work, skipping that meal was a concern for me.

I began after Wednesday lunchtimes in July 2011, partly for the sake of my patients as I had no clinics

on Thursdays. Initially I didn't tell my wife Sarah as she was late home. Pushing through Bible study group on Wednesday evening and avoiding the cake offerings was quite difficult. Then one Thursday morning I had to turn down the coffee Sarah had made. I realised it would have been more loving to warn her about what I was up to.

Once the hunger for the evening meal had passed, I was ok. I found myself feeling quite cold at night. I needed to drink more water than usual. I resolved to use the missed evening meal time to spend extra time with God; reading the Bible, spending more time listening and praying.

God levied two specific challenges during that month. In the context of Luke 9:23-25 there was a direct question, 'What do you cling to?' Immediately my mind identified the Practice. I had been settled in as joint senior partner for six years. 'Would I be willing to give it up?' Given the time and money we had invested in becoming a training practice by July 2010, I wasn't too enthusiastic.

On three separate occasions, not necessarily days on which I was fasting, a quiet voice in my head said, 'Put your house on the market.' Initially I dismissed it as me losing the plot. I really didn't want to move, despite Sarah's one-hour commute to Blackpool which was making childcare and family time difficult. By the third time I was sure it was the Holy Spirit's leading. After discussion with Sarah, we decided to obey and put our house up for sale.

I continued fasting weekly throughout August. On the day we signed the contract, Sarah panicked because we hadn't identified where we were going. I reassured her that if an offer came too quickly we could stall. I told her, further, I believed it would become clear where God wanted us to be.

A mere ten days later during some idle internet surfing, I came across an advert for a post with the Royal Flying Doctor Service in Broken Hill, Australia. Sarah for her part seemed sure she was meant to be in Blackpool. I thought it unlikely there would be sufficient work for her in Broken Hill, population 20,000.

A month later we attended a wedding in Sydney and agreed to fly up to Broken Hill and check it out. We looked at schools for Esther, our five year-old. Sarah met the palliative medicine specialist nurse. Five years previously they had drawn up a job description for a part-time consultant. As is common in the outback they never advertised, knowing how specialists prefer the financial packages available in the big cities. I was interviewed for the post at the RFDS and after references were checked, I was offered the job in December.

Remarkably, these words were CMF's verse for the week in the middle of September while we were looking at all this:

Forget the former things;
do not dwell on the past.
See, I am doing a new thing!
Now it springs up; do you not perceive it?
I am making a way in the wilderness
and streams in the wasteland[4]

Since August 2012 we work in the middle of the desert, a six-hour drive from Adelaide and twice as far from Sydney. Saltbush, the church plant where we are members, is only two years old and recently appointed its own pastor.

God has some pretty amazing plans to reveal to us; the main problem is with us making the time to listen.

John Wenham *(pictured) works with the Royal Flying Doctor Service in Broken Hill, Australia.*

I resolved to use the missed evening meal time to spend extra time with God; reading the Bible, spending more time listening and praying

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Nick Land on how the Christian faith informs attitudes to work and leadership

RENDLE SHORT LECTURE 2013

BEING A SERVANT LEADER IN THE NHS

Nick Land addresses the CMF Student Conference.

key points

- Our work is a central part of our stewardship as Christians.
- All doctors in one way or another are called upon to be leaders.
- There are huge challenges facing the NHS: all the more reason for Christians to step up to the mark and take responsibility as servant leaders.

When I became medical director the response of some colleagues was 'So, you've gone over to the dark side.' Some of this came from within the Trust; a lot more came from Christian doctors I knew. I thought that was strange because when I became Chair of CMF no one asked if I'd gone over to the dark side. Nor did they ask this when I became Lay Chair of the York diocesan synod. So why was it that when I took up leadership in a National Health Service organisation, people thought I was doing something not in line with the gospel?

Those 'dark side' comments reveal an unhelpful division about what it means to be a doctor and what it means to be a Christian; that somehow these two things live in different worlds – that the Sunday world was different from the weekday world. In an earlier *Triple Helix* article I looked at the themes of work throughout history and how God views work.[1] I pointed out that for many Christians, our ideas about work are informed not by Scripture but by contemporary culture.

If the work we have been given is God's work, then surely we should be involved in its leadership and its organisation. The Bible gives reasons why Christians should seek leadership roles in any organisation. From Romans[2] we see that government and leadership are part of God's 'common grace'. Then, all life is God's and we are called to be salt and light. That may be involvement in healthcare, it may be as a school governor, or local politics or organising a foodbank.

Servant leadership

Nehemiah is one of the great biblical models of the servant-leader. Nehemiah hears of a need, he prays, acknowledges God's greatness, he repents of his sins and those of his community.[3] Then having seen a need he hears a call; he takes the risk of moving back to Judah to rebuild the walls of Jerusalem and faces lots of mockery. There are strong parallels in some areas of the Health Service today.

There are many other biblical examples. Jeremiah, prophet to the exiles, tells them to work for the prosperity of the city where God has placed them.[4] There are models of good practice, eg when Moses' father-in-law visits, finds him snowed under with work and teaches him principles of delegation.[5] Esther: a young woman who suddenly has to step up to courageous leadership. Joseph: apprenticed as Potiphar's steward; wrongly accused; sent to prison.

God lifts him up and his skilful leadership saves the entire nation of Egypt from famine.

You may be a first class clinician, but there may come a time when you're called to speak up as Esther was because there are problems, because people are suffering, because what has been done is not right.

So government, leadership and management are a means of common grace, given by God to deliver justice and to limit evil.

Leadership in our times

So, why is it so important now that people step up to the mark to be leaders in the NHS? First, there is the QUIP Agenda. This means every NHS organisation needs to find 4% saving year-on-year for the next five whilst improving quality. This is causing a lot of strain and requires considerable leadership. The Health and Social Care Act means massive structural change, huge uncertainties during transition, and increasingly complex management structures on the commissioning side. A huge number of people with a great deal of experience in the NHS are suddenly finding themselves unemployed or dislocated. People in public health now find themselves no longer in the NHS but employees of the local authority; huge changes. Next we have the Francis Report. No-one who has read even extracts cannot feel other than angry and distressed, but also wonder if they'd have done something different in the same situation.

There are broader issues. Big changes in the clinician-patient relationship, consumerism, postmodernism, bringing fundamental changes, massive ethical issues. I want to pay tribute to a small cadre of people in CMF who get involved with the BMA in order to ensure, for instance, that the BMA doesn't go neutral on euthanasia. Then there is the issue of unhappy doctors where the entire doctor-patient compact is changing.[6]

So big changes and great opportunities for Christian leadership. But there are dangers, real temptations to 'go over to the dark side'.

- **Selfish ambition**. Philippians 2:3 warns against 'selfish ambition or vain conceit'. It's very easy to become either very personally ambitious, or ambitious for your organisation. You can end up in some kind of unholy competition that's not about the best for the community or the patient.
- **Idolatry**. It's easy to let your trust or practice become an idol. Exodus 20:3 says, 'You shall have no other gods before me.' It's very common for doctors to be so committed to medicine, that everything else…their family, their faith…begins to slip away.
- **Dishonesty**. Proverbs is full of verses like 'God detests dishonest scales.'[7] John the Baptist tells tax collectors, 'don't cheat'.[8] God wants integrity in our financial dealings. It's so easy to slip into half-truth. It's even easier as you rise in seniority.
- **Anger**. If you really care about patients then you can get very angry. Of course there is such a thing as righteous anger. Jesus got angry with the moneychangers in the temple. But James says, 'Everyone should be quick to listen, slow to speak and slow to become angry.'[9] Lots of people come and give me accounts of things that on first hearing make me very angry. Don't get angry until you've got to the facts. Ephesians says, 'In your anger do not sin.'[10] Wait until the next day before you send that angry email.
- **Over-work**. It's easy to get so involved in our medicine, our leadership, that we stop going to our Bible study group, or begin to skip church. The chances are, if this becomes a regular habit, then we may have got the balance wrong.
- **Cynicism**. The dictionary definition: 'a distrust towards others' motives. A general lack of hope in humanity or social and ethical values; ridiculing other people's aspirations and motives'. In my view this is one of the greatest dangers in healthcare today.

Christian leadership in the NHS

I find I need read Philippians 2:3-7 every week: 'In your relationships with one another, have the same mindset as Christ Jesus: who, being in very nature God, did not consider equality with God something to be used to his own advantage; rather, he made himself nothing by taking the very nature of a servant'.

We are called to serve others and to be radical in our service is to be a servant-leader. I try to teach this to senior registrars.

Quality improvement

Let me share something about how our trust's quality management system which is based on the Toyota production system. It's called the Kaizen system of continuous improvement developed by Toyota. Cars are not people but this system centres on adding value to the customer or patient. If what you're doing doesn't add value you need to ask why you're doing it.

We involve everyone – patients, doctors, nurses, carers, porters – to look at a particular part of the service. They are freed up from all other work for a week. They redesign that service, going through a series of PDSA cycles where you plan it, try it, assess and do it again. By taking the waste out of the system you can both reduce costs and improve quality.

If we are servant-leaders; if we work with integrity and enthusiasm; if we have God's wisdom and we pray, we will bring hope into our practices and hospitals, our patients and our colleagues because we know we are grounded in the love of God and we have an inheritance that can never spoil of fade.

Nick Land *is Medical Director to the Tees, Esk and Wear Valley NHS Foundation Trust, providing Mental Health and Learning Disability Services. Based on the 2013 Rendle Short lecture: to hear an audio recording go to cmf.li/15dpWeo*

We are called to serve others and to be radical in our service

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Huw Morgan questions the way we think about working overseas

CALLING OR STEWARDSHIP?

Huw Morgan in action.

key points

- Emphasising 'calling' alone risks sidestepping the wider issue of the responsibilities of Western-educated Christian professionals.
- Christian stewardship requires that all Christian doctors respond in some way to the needs of the poor in our global village.
- Dare to step outside your comfort zone and spend time serving where the needs are greatest

How do Christian doctors know if they're called to work overseas? This question is often discussed amongst Christian medics and various aspects of what constitutes 'a call' are debated. I want to suggest that this is the wrong question. It sidesteps the wider issue of the responsibility rich, Western educated professionals have to serve their less fortunate neighbours in the resource-poor world.

Make no mistake; the global village we inhabit today means everyone is our neighbour, in the same sense that the Good Samaritan acted as a neighbour to someone of another culture who was in need, risking his own life and using his own resources.

Let us consider a few facts. In Europe there is an average of 25 doctors per 10,000 population. The figure is six for India and 0.2 for sub-Saharan Africa. Some 1.3 billion people, about 20% of the world's population, do not have access to basic healthcare. To meet this need around 4.3 million more

The global village we inhabit today means everyone is our neighbour

healthcare workers are needed in resource-poor countries. It is a scandal that 6.9 million children died in 2011 (20,000 a day), 70% of them in Africa and South Asia. Some 0.3 million women a year die in childbirth, two million people from AIDS, a further one million from malaria and 5.8 million from trauma, 90% of which occurs in resource poor settings.[2]

Then consider the numerous commands in Scripture to serve the poor. Starting with the Law,[3] they run through the Prophets[4] and into the incarnation of Jesus who proclaimed himself to be fulfilling Isaiah's prophecy of bringing good news to the poor, freedom to the captives, sight to the blind and release for the oppressed.[5] The epistles pick up

the theme, speaking of Jesus leaving the riches of heaven to die on the cross for us, becoming poor so that we might become rich.[6] John says, 'If anyone has material possessions and sees a brother or sister in need but has no pity on them, how can the love of God be in that person?'[7] Ron Sider comments, 'Concern for the poor is not merely an ethical teaching: it is first of all a theological truth, a central doctrine of the creed, a constantly repeated biblical teaching about the God we worship.'[8]

So we who are rich in money, material possessions and medical education, if we love Jesus, surely have an obligation to respond in some way to the healthcare needs of those in poorer countries; Scripture makes this clear.[9] Many of these are our brothers and sisters in Christ to whom we have a particular responsibility.[10] At a very minimum, we should support a Christian healthcare initiative or institution in a resource-poor country, as well as praying for their work. There's no shortage of mission hospitals and Christian community health programmes that we can help, and relatively small amounts of money can go a long way.

I believe all Western educated Christian doctors should consider spending at least part of their career serving in a resource-poor country. There are several points in a medical career when it is relatively easy to go overseas. The first is immediately after foundation training; going for six months or a year at this point is a great way to get some experience, provided you go somewhere where there will be support and supervision. A second opportunity comes after core training, and a third option is to take 'Out of Programme Experience' (OOPE) during specialist training; trainees are entitled to up to two years away and can then slot back into their training programme. Going after completion of training means you have skills and expertise to offer, but you will need to think about how you will get back into the NHS on return. It's possible to take a sabbatical year, or possibly a career break, from a substantive post in general practice or hospital medicine. This may be a challenging time to leave family and work commitments, but you go with more experience and wisdom and can contribute more in terms of education and management than when you are younger. My own first and life-changing experience of working in Africa was during a year's sabbatical after ten years of UK practice. Finally there is early retirement (or immediately after conventional retirement). Going at this point enables you to contribute at a senior level, possibly having a significant influence on policy, service development and medical education, which extends far beyond the individual patients that you treat.

Leaving a well-established life, elderly parents and possibly grandchildren, may make going at this point a challenge, but I can say from personal experience that it is well worth it. I left NHS practice at 50 to focus on overseas work with PRIME and other development agencies. Whenever you go, your involvement will hopefully have a long term influence on your giving, praying and global health perspective that will stay with you for the rest of your life. None of these opportunities to go, I suggest, require a special call. Rather they require an appropriate attitude of responsible stewardship of your education and skills in the face of the dire need for better healthcare globally – which should be a concern for all Christian doctors.

So what about 'the call'? If you are thinking about spending the majority of your career working in a resource-poor country, clearly you need a sense of particular calling to do so, as this will require family adjustments and challenges on a different scale to those raised by shorter periods overseas. There is still a place for doctors from developed countries who choose to spend most of their professional lives in less developed ones, and it has been my privilege to work alongside many such men and women in various countries over the last ten years.

You may have noticed that so far I have not used the words mission or missionary. I believe they can be unhelpful for Christian doctors considering working overseas. A missionary is one who is sent, and wherever you work, you should have the conviction that it is where you have been sent by God at that particular time. If you don't, think about going somewhere else! For most of us, it is more appropriate to think about where and when we should work overseas in terms of stewardship; stewardship of our education, our skills, and our ability to serve the poor.

So if you think that the fact that you don't have 'a call' to be a missionary in a less developed country means you can forget about the medical needs overseas, think again. Christian stewardship requires that all Christian doctors respond in some way to the needs of the poor in our global village. The CMF website (*www.cmf.org.uk*) is a good place to start looking for your opportunity. Or, if you are a medical educator, get in touch with PRIME (*www.prime-international.org.uk*)

Serving overseas is not all about sacrifice and hardship. It is an inestimable privilege to work amongst those who have virtually nothing in terms of material possessions and to help colleagues who are striving to serve them in difficult circumstances. This is the real world, where the light of Christ can shine brightly, undimmed by the deadening materialism and dross of our gaudy consumerist society.

Dare to step outside your comfort zone and spend time serving where the needs are greatest. We in the rich world have been given much, and as Jesus said, 'From everyone who has been given much, much will be demanded'.[11] Don't wait for a call, just be a responsible steward of what you have.

Huw Morgan *is a retired GP and GP Training programme director based in Abergavenny. He works with PRIME, and spent much of the last ten years in India and Nepal. He is chair of the CMF International Committee.*

My own first and life-changing experience of working in Africa was during a year's sabbatical

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4. Amos 5:11-12, Ezekiel 16:49
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11. Luke 12:48

Catriona Waitt and **Abi Randall** found short-term work overseas is as much about being as doing

CHALLENGING THE STEREOTYPES

key points

- Providing relief for a long-term worker is a valuable service.
- Taking children along can be a blessing, not a burden.
- Imaginative use of leave and holiday can free up time to go.

Catriona Waitt writes....

Until this year, I imagined people doing short-term mission trips as fresh faced, dynamic individuals in their twenties, without family commitments and probably yet to enter specialist training. I tended to think of those with 'hands on' skills in surgery, obstetrics or trauma. My husband Peter and I are towards the end of our medical registrar training. My role tends to be more academic than clinical, more suited to a teaching hospital or research institute – at times I have regretted not training in something more 'useful' for medical mission. But two months in the Gambia with three children in tow has changed my perspective.

A year ago, I was reaching the end of a complicated pregnancy that had required multiple hospital admissions and left me physically weak and spiritually discouraged – I certainly had no plans for short-term mission in rural Africa. But as I started to recover, Peter and I discussed the possibility of him taking the final three months of the 'maternity' leave now possible under the new legislation. We realised that if I were to take my accrued annual leave at the same time, we could have a couple of months off together, and wondered what would be the best use of that time. Two days later, we met a friend on leave from her mission hospital in the Gambia who told us of the urgent need for a short-term doctor for December and January. This would be the exact time we were free. And so we started to ask ourselves, was this a crazy plan or a God-given opportunity? In the eyes of the world, it was indeed a risky proposal: to travel to rural Africa in imperfect health, with three boys aged three and under. But to cut a long story short, God opened doors and we set off to Sibanor with WEC International.

As we are both doctors, we applied as a 'doctor and spouse' with the understanding that we would split the roles between us. While one of us worked in the clinic, the other would be exploring the village with the boys, going to the market, greeting friends in their homes. We were able to maximise our skills by changing roles when needed, and we could discuss complex cases together. Personally and professionally, it was challenging and fulfilling.

Hearing feedback from the team and the local church at the end of our stay, we realised that both roles were important. Rather than hindering 'real ministry', the children brought refreshment to many who were worn out; an injection of energy and enthusiasm for life. We were able to build relationships both in the clinic and in the village, the children often bridging the gaps between our different backgrounds and cultures.

Sometimes we have stereotypes of Christian service, not appreciating that simply living out our lives in a God-honouring way can have a greater impact than specifically targeted outreach or Bible studies. In the words attributed to Francis of Assisi, 'Preach the gospel at all times and when necessary,

use words'. This applies to all of us as Christian doctors, regardless of the country or environment in which we find ourselves; our time in Gambia was simply an encouraging reminder of this truth.

I would like to challenge you. Could God be calling you to short-term overseas service? Our individual circumstances are not barriers to the gospel, but rather can be unique opportunities which God uses to reach out to others. Pray about it today. In the words of Paul to the Ephesians, 'Now to him who is able to do immeasurably more than all we ask or imagine, according to his power that is at work within us, to him be glory in the church and in Christ Jesus throughout all generations, for ever and ever! Amen.'[1]

Abi Randall writes...

What do you do with two weeks of rota'd January leave, in lieu for working the preceding month on call? My husband David and I were feeling pretty miffed at having missed Christmas and New Year festivities. Our solution seemed obvious: get on a plane to a place where the sun shines and where vitamin D is in rich supply. But despite our best efforts to arrange a suitable holiday, we stopped short of booking one, not quite able to settle on any of the options.

We are on CMF's 'STAT' list (Short-Term, Able to Travel) which means we get emails when needs for doctors come up overseas. The emails usually end up in the 'Delete' box, as jobs, children and busy lives usually dispel thoughts of overseas travel. But as we were trying to plan our time off, we decided to delve into the 'Delete' folder and pulled out a request from a hospital in northern Pakistan for 'any doctor, of any specialty, for any length of time.' The email seemed to convey a ring of desperation – how could we not respond?

Our respective departments granted us an additional fortnight's leave, giving us each four weeks in total. After two months of shift-swapping and frenzied visa applications, we flew out to Kunhar Christian Hospital with our two young boys. Kunhar is a small 30-bed hospital with an outpatient attendance of around 50 patients per day. It was founded 17 years ago by Dr Haroon Lal Din, who had sent the plea for help – he had been the only doctor there for the past six months, and was struggling with discouragement and impending burnout. When we arrived we were quite taken aback at the love and hospitality shown to us by this lovely believer and his wife Miriam, who welcomed us into their home as if we were old friends. Our every need was provided in a way that was quite humbling.

Medical work and childcare we tried to share equally between ourselves. Patients pitched up from around 8am until noon. David is a renal registrar and I am in my second year of GP training: we worked as a tag-team, David working through patients until confronted with a child or a gynae-cology problem, when he would bail out and come back to the house, taking over the care of the boys while I continued with the clinic. The boys had a wonderful time toddling around collecting eggs from the chickens or watching workmen cutting wood with axes – all new experiences for inner-city tots.

Once the outpatients had all been sent on their way, typically by around 2pm, we had the after-noons to ourselves, being called only for sick people who showed up at the hospital gate, or for unwell patients on the ward (other than the maternity patients, there were only around three or four inpatients at any time during our stay).

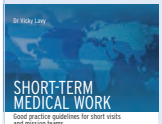
We enjoyed the stimulation of having to deal with a great variety of conditions, some of which we had only read about in textbooks, and others of which would in the UK be cared for by sub-specialists. From a non-medical perspective, it was a great joy to meet brothers and sisters in such a strongly Muslim part of Pakistan and see their quiet but faithful witness to God's goodness. It was a privilege to pray alongside Dr Haroon through the many burdens that he bears in the running of the hospital. One of these is loneliness and a sense of isolation from other Christians.

We had concerns about taking Robbie and Thomas, at the time aged 25 months and 14 months respectively, to an area of Pakistan where the UK Foreign Office strongly advises against all but the most necessary travel. The hospital is located 60km from Abbottabad, where Osama bin Laden was killed by American forces in 2011. We went ahead after much prayer, careful consideration, and advice from those living in the area. We thank God for keeping us completely safe. We saw nothing to make us afraid during our time in the country.

Perhaps above all, we were blessed in the confirmation that it was indeed the Lord who had arranged the circumstances of our on-call rotas, sending us to a situation where we were able to stand alongside some faithful believers working hard in a tough situation. To a pair of frequently half-hearted Christians, who spend much of our time thinking primarily about our own needs and wants, it has served as a great reminder that the Lord has a plan for our lives, and he wants to use us.

Catriona Waitt *is a specialist registrar based in Liverpool.*
Abi Randall *is a paediatrician based in London.*

Two months in the Gambia with three children in tow has changed my perspective



CMF has just published a new booklet addressing some of the issues around short-term medical visits. It's a must-read for anyone planning a trip.

Lavy V. *Short-term medical work – good practice guidelines for short visits and mission teams*. London: CMF, 2013

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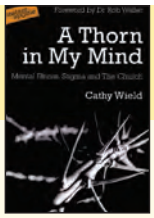


A Thorn in My Mind

Mental Illness, Stigma and The Church
Cathy Wield

- Instant Apostle, 2012
- £8.00 Pb 200pp
- ISBN 9780955913525

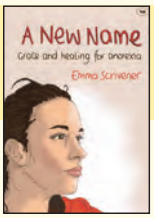
A good book to buy for yourself, or for someone whose family member or friend is struggling with mental illness. But don't be too quick to buy it for a depressed family member or friend. As the author says, there are many books on that subject; this is not one of them.

The first half is autobiographical. Cathy Wilde introduces herself, writes of the emergence and effects of severe mental illness on her and her family, varied reactions from those in the church, her experience of various treatments and how her illness impacted on her faith. It is written from a position of recovery with insightful observations of her own thoughts and the behaviour of those around her.

The second half shifts to mental illness itself – a brief history, occurrences in Scripture, its symptoms, classification and treatment, and mental health services. All this is with knowledge that comes from working as a psychiatrist, but written for those unfamiliar with medicine or psychiatry. It is accurate but not complex and succeeds, I think.

The subtitle 'Mental Illness, Stigma and The Church' is, in my opinion, an important and relevant subject. It certainly doesn't limit the target population of potential. An informative book for just about everyone.

***Richard Day** is a Clinical Senior Lecturer and Honorary Consultant Psychiatrist based in Dundee*



A New Name

Grace and healing for anorexia
Emma Scrivener

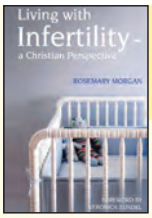
- IVP, 2012
- £7.99 Pb 176pp
- ISBN 9781844745869

A beautifully written autobiographical account, this book lifts the lid on the inner turmoil of anorexia in a manner which is highly illuminating and frankly terrifying. With great honesty Emma tells of her pressing desire to 'fit in' and the overwhelming quest for control which takes hold of her. An insidious start becomes an unstoppable juggernaut.

Anorexia becomes a religion promising freedom: fat is the unforgiveable sin, salvation comes through a relentless pursuit of diet and exercise. It is a gospel of works which leads to slavery and self destruction. Will recovery come through re-feeding and trying to be 'a good girl'? Where does God fit in? There are no trite answers. An easy but uncomfortable read, this book deals with the physical, emotional and spiritual issues with which Emma wrestled, and the breakthrough which came with the discovery that God was so much bigger.

Not every point will be transferable to each individual with anorexia, but many will. She deals with the inevitable trauma which the whole family face when one member has an eating disorder. Obsessive behaviour, to which anorexia is often linked, is also mentioned. I highly recommend this book.

***Maggy Spence** is a part-time GP in Chelmsford*



Living with Infertility

A Christian Perspective
Rosemary Morgan

- Bible Reading Fellowship, 2013
- £7.99 Pb 144pp
- ISBN 9780857460837

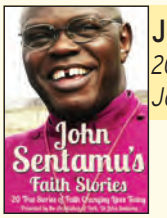
The key to this book is, unsurprisingly, in its title. Having read several books on infertility that focused on treatments and options available, and the rights and wrongs of each, I was half expecting the same of this. I could not have been more wrong.

The focus is purely on how to cope with living with infertility as a Christian. It is not full of answers on how to overcome infertility. Instead it aims to help readers deal with the emotional experiences infertility brings: the unanswered 'why', pain, anger, blame, jealousy, confusion and letting go (some of the chapter headings).

This book is born out of a journey that the author, a lay preacher, has made herself. It is a very personal account of the struggles she has, written within the context of her faith and deep trust in God, who cares and has answered, although not always in the ways she expected or wanted. Each chapter is built around specific emotions and considers the biblical perspective on those feelings, ending with a short prayer.

The author writes with a specific readership in mind – Christians facing or living with infertility – but undoubtedly this will be insightful reading for anyone wanting to understand and support couples, especially women, in such situations.

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



John Sentamu's Faith Stories

20 true stories of faith changing lives today
John Sentamu

- Darton, Longman and Todd, 2013
- £8.99 Pb 160pp
- ISBN 9780232529784

20 brief life stories in 135 pages – almost all from the North East of England – all from an Anglican background of varied churchmanship – nine of them ordained – five of them young – three doctors – surprisingly all white British (except the archbishop).

John Sentamu has written a brief introduction to each story. Although written in the first person they are ghost written by a single female author, which gives a certain predictability to an otherwise wide range of experiences.

As a snapshot of contemporary Anglican life in the North East and of God at work through ordinary people, it makes a good read. However the brevity of each profile inevitably leads to a rather superficial take on these dedicated lives.

As a book to give to others seeking meaning or direction it would be useful. It would fit well in a surgery waiting room or hospital chapel library.

***Peter Pattisson** is a retired GP based in Brockenhurst*

eutychus

The Lancet eats humble pie

At long last *The Lancet* has confessed it got Dr John Snow wrong. Snow, famous for finding the cause of cholera, found a foe in Thomas Wakley, founding-editor of *The Lancet*, who in an 1855 editorial dismissed Snow's work in no uncertain terms: 'In riding his hobby very hard, he has fallen down through a gully-hole …' and 'Has he any facts to show in proof? No!' 'We were perhaps somewhat overly negative' says the current editor. Somewhat. (*Lancet* 2013;381:1269-1270. See *Triple Helix* 2013;56:14-15 on Snow's work)

When in Rome

If you ever visit Rome, pause for thought by the Capitoline statue of the city's mythical founders, the abandoned twins Romulus and Remus, being suckled by a she-wolf. Ancient Rome allowed infanticide. Could we likewise contemplate a way of life that kills unwanted babies? Alberto Giubilini and Francesca Minerva, in 'After-birth abortion: why should the baby live?' suggest if abortion is allowable where the health of the fetus is irrelevant, then killing unwanted newborns is a logical development. Have they done a favour to 'scaremongering' pro-life campaigners? (*J Med Ethics* 2013;39(5) with subsequent contributors to the debate)

Dementia 'biggest challenge'

Dementia has replaced cancer as the biggest challenge facing the NHS, Health Secretary Jeremy Hunt has said. He has announced that vulnerable elderly persons will have a personal NHS worker responsible for coordinating all their health and care needs, based on a review of all aspects of later-life care with recommendations expected in the autumn. Among the measures included in the Queen's Speech was introduction of a £72,000 cap, ensuring old people will not have to sell their homes to meet later-life care bills. (*Independent*, 14 May 2013)

FGM in the UK

FGM (Female Genital Mutilation) is practised in 28 countries, mainly in parts of Africa with a strong Muslim influence. It is a UK problem too. The NHS clinic at Queen Charlotte's and Chelsea Hospital reports treating more than 100 women a year who have had their sexual organs cut or sewn up. UK residents often get round the law by shipping girls to relatives in north or east Africa. FGM is illegal in the UK but authorities believe it happens here, though as yet there have been no prosecutions. (*BBC Health*, 21 May 2013 *bbc.in/14NITT4*)

At risk on the streets

Sex workers in London are feeling the impact of recession according to a study by London's Westminster Council. An influx of new competition and a struggling economy is forcing them to cut prices sharply. Women working alone are accepting clients who appear dangerous, putting them at risk of rape, sexual assault, physical abuse and robbery. The report says the number of women working alone has increased considerably in recent years. Most are from Eastern Europe, South America – particularly Brazil – and South East Asia, especially China and Thailand. (*Reuters*, 12 April 2013)

New test to speed leprosy diagnosis

Leprosy (Hansen's disease) was a scourge in biblical times. Today it is treated with antibiotics with cases down 90% in the last 30 years. Nevertheless, it still lingers. India is top of the global leprosy table (127,295 new cases in 2011). Second is Brazil (33, 955). Worst affected are people from remote areas where leprosy often goes undiagnosed, causing permanent damage. Now 'for the cost of an ice-cream' researchers from Rio de Janeiro have developed a cheap test, enabling early detection. (*BBC Health*, 27 April 2013 *bbc.in/15ZzbAo*)

Climate change: agenda item for bioethics?

Public debate on climate change has focused on human rights and distributive justice, but rarely do health or bioethical issues figure, observes Cheryl Cox Macpherson of Grenada. Writing in the journal *Bioethics*, she says, 'Instead of neglecting climate change… bioethics should explore these issues; bring transparency to the trade-offs that permit emissions to continue at current rates; and offer deeper understanding about what is at stake and what it means to live a good life in today's world.' (*Bioethics* 2013;27(6):305-8)

The new slave trade

Rape and sexual violence against women in war zones has been labelled 'the slave trade of our generation' by the Foreign Secretary William Hague. He told the G8 Summit in London in April that violation of women is all too often not just opportunistic but 'a calculated weapon of war'. The victims, he said, are all too often children. 'It is overdue that we recognise this willful evil for what it is, an offence against the rules of war and the Geneva Convention.' (*Evening Standard* comment, 11 April 2013)

Expect discrimination with Parkinson's

New research suggests that nearly half of people with Parkinson's Disease face regular discrimination: their symptoms often mistaken for drunkenness. The research is based on a survey of 2,000 people commissioned by the charity Parkinson's UK. One person in 500 people is affected by the condition in Britain. The survey found that one in ten had been verbally abused or experienced hostility in public because of their condition. Around 62% said they thought the public had a poor understanding of how the condition affects people. (*BBC Health*, 11 April 2013)

Organ donation spikes

Figures from NHS Blood and Transplant (NHSBT) say organ donation has shot up by 50% within the past five years. NHSBT says since April last year 1,200 people in the UK donated organs, helping transform 3,100 lives. But it sees no room for complacency; many families still refuse to consider organ donation when a loved one has died. CMF supports the Church-backed 'Flesh and Blood' campaign encouraging Christians to make blood and organ donations part of their giving *www.fleshandblood.org* (*Mail Online*, 21 April 2013)

Andrew Fergusson writes

DOMINIC BEER
1956-2013, A TRIBUTE

***Dominic Beer**, consultant psychiatrist and pioneer in psychiatric intensive care, who served CMF fruitfully for over 20 years, died on 19 April 2013 aged 56.*

Medicine

Dominic went to Wadham College, Oxford in 1975 to study German and History, but even then was considering medicine. Discovering that having no science A-levels did not necessarily disbar him, he started 1st MB at Guys in 1978, and graduated in 1984. He developed an interest in psychiatry and began a training rotation at Guys, interrupting this with Wellcome Foundation support to gain his MD in the history of psychiatry.

In 1994 he was appointed consultant at Bexley Hospital, Kent, for a locked 15-bedded 'challenging behaviour' ward, and shocked by the lack of purpose and definition, the bad conditions, and the siege mentality, he and colleagues researched psychiatric intensive care units nationally. This led to founding the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) and to co-editing the first textbook in the field, *Psychiatric Intensive Care*.

As his career progressed until early retirement on medical grounds in 2011, he held many teaching, lecturing and examining posts within London University; published some 70 research papers; refereed for journals; took on more management and fund-raising responsibilities; and was recognised as a leader who modelled his concern that patients requiring psychiatric intensive care should be treated in 'a decent and concerned way'. That same colleague described his light touch in tricky situations ('extraordinary legerdemain'), his calming presence, and his being always unflappable. They still ask sometimes 'What would Dominic do?'

Mission

Dominic became a Christian at Oxford, with a conversion somewhat like that of C S Lewis. He was surprised to find people who had a credible intellectual basis for their faith, and with his objections of reason overcome, he discovered that Christians could be reasonable people too.

Dr Douglas Johnson, who founded CMF in 1949, used to say regarding the health of the Fellowship that 'if you take care of the students and of the literature, the rest will take care of itself'. This was certainly true in Dominic's case. Within a few short years he became President of the student Christian Union at Guys, and he served on CMF's Publications and, later, *Triple Helix* committees in the 1990s.

In 1995 IVP and CMF co-published the student-orientated *Christian Choices in Healthcare* he'd edited and which sold over 5,000 copies worldwide, and in 2006 CMF published *Mad, Bad or Sad?* which he had co-edited with Nigel Pocock. This heavyweight academic book became a surprise best-seller with more than 1,200 sales to date. When forced retirement freed up time, and despite worsening health, Dominic joined the CMF Board.

Dominic sat loosely to churchmanship and secondary issues. Over the years he chaired the PCC at an Anglican church in Bermondsey; was active in the Ichthus fellowship; was part of Churches Together in Lewisham, helping to launch a project with young people excluded from local schools; and at the time of his death he and Naomi were members of Forest Hill Community Church. His emphasis was always on community and love in action.

Marriage and family

Dominic and Naomi met at Guys in 1981 when he was giving the welcome address at the Freshers' Week lunch and she was the blonde newcomer in the front row smiling Christian encouragement at him. They were later able to dovetail their respective training rotations, and Naomi went on to become a busy GP principal in East London.

Marrying in 1985 they were to be blessed with four children – Charlie (1990), Josh (1992), David (1995) and Esther (1998). Family life was a permanent priority, and Dominic denied some career paths to be there for the children always.

Mycosis fungoides, a cutaneous T-cell lymphoma, was diagnosed in the mid-90s. At first indolent, even then Dominic was anticipating it would shorten his life and was 'processing' a Christian understanding of death and dying. As the disease progressed, his professional activities had to be curtailed, and as it spread systemically in his last months he and the family were upheld by the prayers and support of many.

The man

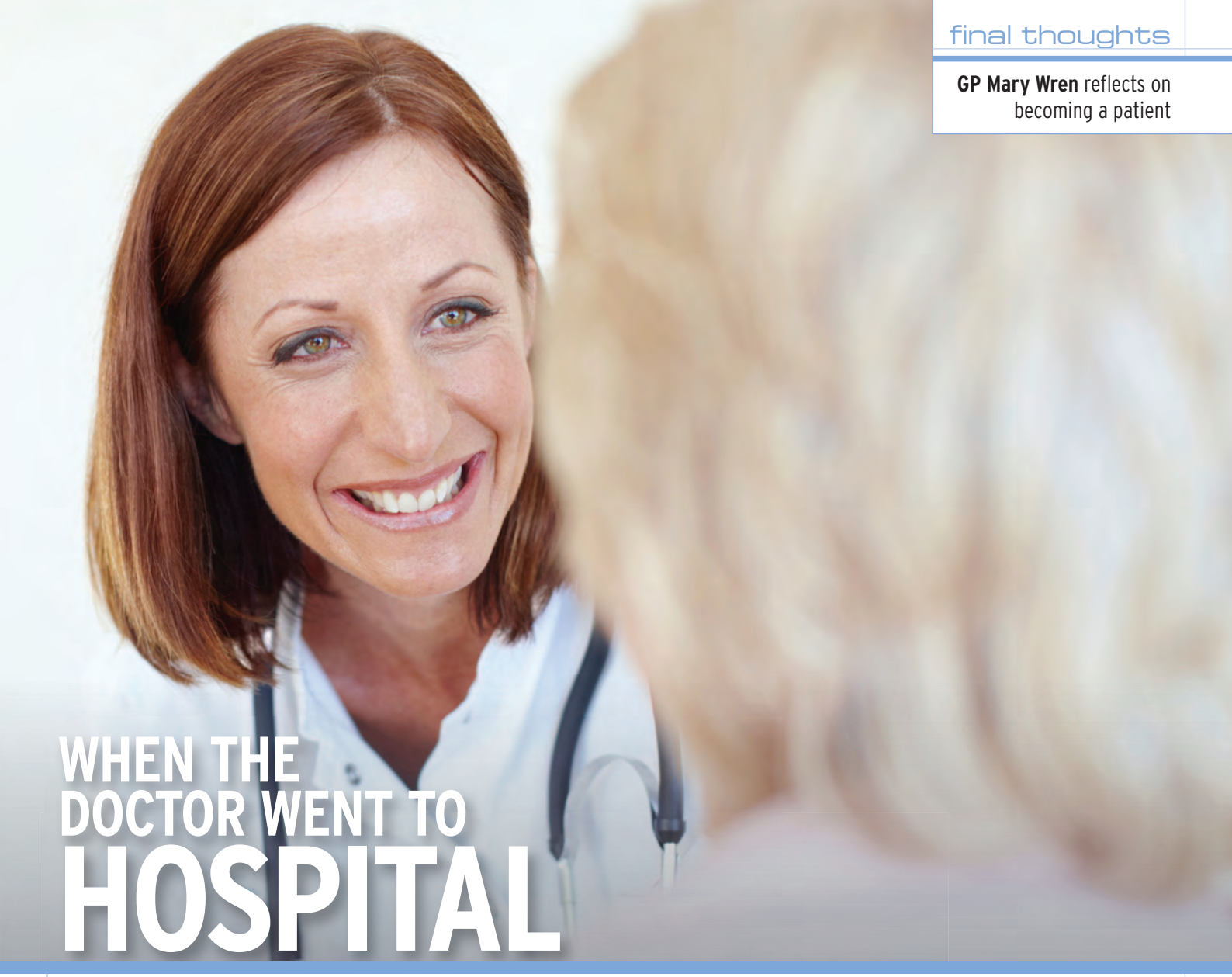
From schooldays at Leighton Park, he was an accomplished sportsman, captaining the First XI in each of cricket, hockey and football. Cricket remained a lifelong joy and he skied annually from 1997, yet his personal neuronal wiring never permitted riding, playing the violin, or ceroc dancing! In retirement he took up painting in the style of Kandinsky and Richter, and his online gallery may be seen at *www.dominic.beer.co.uk* He was humble, self-effacing, a great listener, a thinker rather than a speaker, and always gracious.

How did he fit it all in? Naomi says he was always focused, thinking through in great depth everything he ever did so that nothing happened by default. He made choices and stuck to them, and CMF will always be indebted for his personal 'Christian choices in healthcare'.

***Andrew Fergusson** was General Secretary of CMF from 1990-99 and Head of Communications from 2007-11.*

The 'Dominic Beer Memorial Trust' has been set up to support research or projects to improve the health and wellbeing of sufferers of severe mental illness. Donations to the trust, which may be gift-aided, can be made via the CMF Office.

GP Mary Wren reflects on becoming a patient



WHEN THE DOCTOR WENT TO HOSPITAL

From the moment you walk in the door it's as if something changes. You are now part of a surreal world of gowns, tubes, paper knickers and loss of control. Just 24 hours after working in the GP surgery myself, I am tied to a bed with several tubes coming out; pain, things being done to me, an out-of-reach buzzer for when I needed help.

Suddenly the topics of conversation are how full your catheter bag is, whether you've passed wind, how many vomits, what you have had done and why. No room for embarrassment here. With me are four very different women in the bay – all with their own stories, families, backgrounds, personalities, humour, houses and life outside the hospital. Yet it's as if none of that counts any more. Now I was the day-one hysterectomy with a fever.

The staff were very busy and worked very hard. They often seemed stretched and stressed, but masked it well. So many bleeping machines, vomiting patients, pain-relief requests, blood pressure checks.

The funniest experience was the day one bed bath administered by a very efficient, very competent team who 'went from top to bottom' left me feeling I had been through a car wash…but grateful. Second funniest was the patient opposite coming over to me as I lay in bed, dropping her pyjamas and asking me if her scar looked all right…and she didn't know I was a doctor.

So in the middle of all this activity, what I really noticed was that some people really cared and others didn't. All did the job ok. But some didn't look me in the eye, smile, squeeze my hand, or give time. I noticed the one nurse who asked the elderly lady next to me how her husband was getting on at home – it only took two minutes but made all the difference.

That hand squeeze, the compassionate look, acknowledgement of the person inside, two minutes to listen…it can make the patient feel good, peaceful, hopeful, valued, warm inside. The doctor who came and looked me in the eye and squeezed my hand as she told me all about what they found inside made me cry. Good crying. That was real, complete care of me the person, as well as my body.

I wonder how much difference that art of medicine, that soft immeasurable care, makes to the recovery of the person. I wonder if that hug or hand-squeeze would result in less pain relief being needed, less pressing of buzzers, patients getting home quicker.

The lady who showed me her scar told me how she had been too frightened to come into hospital for five years since her mum died there. She had a lot of pain post-op and was demanding to staff. I don't think any of the staff knew why her pain was so bad. Maybe it was more emotional than physical pain, but how many staff would think to ask or choose to take apparently more time to just sit and probe a little? Isn't it great if a person can go home not just with a physical op done but with an emotional wound healed as well.

Maybe if we focused on that bit more, the staff wouldn't be so busy and the NHS wouldn't be so stretched.

Mary Wren *is a GP in Sheffield.*

HEALTHCARE SUNDAY

20 OCTOBER 2013

PRAY FOR HEALTHCARE WORKERS
IN YOUR CHURCH AND NEIGHBOURHOOD
USE HEALTHCARE SUNDAY IDEAS AND RESOURCES
AT WWW.HEALTHCARESUNDAY.ORG.UK AND
WWW.CMF.ORG.UK/HEALTHCARESUNDAY

uniting + equipping Christian doctors

CMF
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