

for today's Christian doctor

triple helix



Tackling global health inequalities

robotics; teamwork; integrity in research; the UK law of consent

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contents

Editorial	3
When the foundations are being destroyed	
News reviews	4
Life is the gift of God... - <i>Steve Fouch</i>	
Death of a 20-year old - <i>John Martin</i>	
A call to arms - <i>Steve Fouch</i>	
BMA retains opposition to assisted suicide - <i>Peter Saunders</i>	
The nurse-physician relationship	6
<i>Pippa Peppiatt</i>	
Exporting British healthcare expertise	8
<i>Howard Lyons</i>	
New template for the UK law of consent	11
<i>Cheryl Chin</i>	
RENDLE SHORT LECTURE	
Tackling global health inequalities	12
<i>Andrew Tomkins</i>	
Robots and healthcare	15
<i>Trudy Simpson</i>	
Integrity in research	16
<i>Frank Wells</i>	
Gospel mission and medicine	18
<i>Richard Scott</i>	
Reviews	20
Eutychus	22
Final thought	23
Help with learning to walk	
<i>Peter Sidebotham</i>	

When the foundations are being destroyed



When the foundations are being destroyed, what can the righteous do?'¹ We live in times when the very foundations of our civilisation are being destroyed: the NHS with its burgeoning needs and shrinking budgets, mounting national debt, political and economic uncertainty following 'Brexit', the threat of Islamic fundamentalism, creeping atheism and secular humanism.

The mountains of our culture, those institutions which shape its trajectory – our parliaments, courts, universities, medical institutions and the worlds of art, media and entertainment – seem to be increasingly run by people who do not share our Christian beliefs and values.

Daily in our GP surgeries and hospitals we see the fruit of a society that has turned its back on God: family breakdown, educational failure, economic dependence, indebtedness and drug and alcohol addiction. Marriage and the family are threatened by same-sex unions, 'gender fluidity', internet pornography, gene editing, abortion and euthanasia. Broken families, broken communities, broken institutions, a broken country.

Of course, God's people have felt overwhelmed before. The Israelite slaves in Egypt were left with impossible tasks and inadequate resources, 'making bricks without straw'.² Moses once felt so drowned by the burdens he was carrying that he pleaded with God, 'kill me at once'.³ The Apostle Paul spoke of being 'so utterly unbearably crushed' that he despaired of life itself.⁴ Isaiah, in one of the Servant Songs, cried 'I have laboured in vain'.⁵

The Psalmist, seeing the foundations being destroyed, is taunted by his accusers: 'Flee like a bird to your mountain. For look, the wicked bend their bows; they set their arrows against the strings to shoot from the shadows at the upright in heart'.⁶

But instead of succumbing to the very real threats about him and withdrawing to safety he declares: 'In the Lord I take refuge... The Lord is in his holy temple; the Lord is on his heavenly throne'.⁷

He takes himself in hand and remembers that he serves the ruler of the universe, the judge before whom every knee shall one day bow, who 'is righteous', 'loves justice' and 'observes everyone on earth'. He reminds himself that 'the upright', those who he has justified by faith, will one day 'see his face'.⁸

Jesus announced the coming of his Kingdom in the Nazareth synagogue as coming with preaching, healing, deliverance and justice.⁹ He later commissioned his disciples with the words, 'as the Father has sent me, I am sending you'.¹⁰ But he also promised them his power,

presence and the gift of prayer. 'Come to me, all you who are weary and burdened, and I will give you rest.... For my yoke is easy and my burden is light'.¹¹ 'Ask the Lord of the harvest, therefore, to send out workers into his harvest field'.¹² 'You will receive power when the Holy Spirit comes on you; and you will be my witnesses'.¹³ 'Surely I am with you always, to the very end of the age'.¹⁴

We are not called to escapism, retreating to our Christian ghettos. Nor are we called to assimilation, merely blending in with the world around us.

Instead we are called, like Babylon's exiles, both to moral distinctiveness – 'shining like stars'¹⁵ – and to courageous and compassionate engagement with society – 'seeking the peace and prosperity of the city'.¹⁶ We are to be 'in' but 'not of the world'.¹⁷

The social reformer William Wilberforce, whom God used to end the British slave trade in the early 19th century, spoke of his Christian calling in this way: 'God almighty set before me two great objects, the suppression of the slave trade and the reformation of morals and manners.' But in reforming 'moral and manners' he was not advocating a mere fleshly legalism. He understood that it was the 'peculiar doctrines' of Christianity (salvation by grace through faith in Christ's death and resurrection) which led to 'true affections' (a changed heart), then to 'personal transformation' (an obedient life) and ultimately 'political reformation' (a renewed society).¹⁸

UK Prime Minister David Cameron resigned after the Brexit vote on 24 June without ever fulfilling his dream of a 'big society'. And yet, since he first came to power in 2010 we have, ironically, seen an explosion of Christian social initiatives in Britain. These include food banks, debt counselling, street pastors, drug and alcohol rehabilitation, parenting classes and crisis pregnancy counselling. Churches are touching the heart of our broken society's need.

But what if churches were to think even more like Wilberforce and his fellow Christian professionals from the 'Clapham Sect': Christian GP surgeries and hospitals, socially responsible businesses, legal advice and advocacy, schools and universities, serving in the political corridors of power? Might we, by God's grace, take Britain back? That is our challenge.

*'If my people, who are called by my name, will humble themselves and pray and seek my face and turn from their wicked ways, then I will hear from heaven, and I will forgive their sin and will heal their land.'*¹⁹

Peter Saunders is CMF Chief Executive.

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Life is the gift of God...

...but not according to the Royal College of Midwives

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

In May it came to light that for many years the Royal College of Midwives (RCM) has been inextricably linked with the leading provider of abortions in the UK, the British Pregnancy Advisory Service (BPAS).¹ So much so that Cathy Warwick, the RCM's CEO is also the Chair of BPAS. This revelation followed on from the RCM's public support² for the BPAS led campaign to 'decriminalise' abortion – ie removing the few legal safeguards that still exist and allowing abortion up to birth for any reason.³

As this story came to light, so did the (very quiet) publication of the updated RCM Position Statement on Abortion.⁴ It made it clear that midwives were obliged to be involved in all aspects of the care of women undergoing a termination of pregnancy. They were only allowed to opt out of the specific clinical procedures related to the

abortion itself on conscience grounds. This directly follows on from the ruling of the Supreme Court in the Glasgow Midwives case last year.⁵

These positions by the RCM were taken with no reference to the membership or to the college's governing body. MPs, members of the public and midwives have all been incensed. They have been roundly criticised.^{6,7} Cathy Warwick has sought to defend this position. But, given that the body for the profession (most involved with ensuring the safe births of children) is so closely allied with pro-abortion lobby groups, this position is proving increasingly difficult to defend. There are calls for a reversal of the policy and for Warwick to step down from at least one of her posts.

That a body whose motto is *vita donum dei* (life is the gift of God) should be taking such a pro-abortion stance reflects the

widespread drift (and, increasingly, active departure) from Christian values. It is time for midwives and others to stand up and challenge this reversal of such fundamental values.

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Death of a 20-year-old

Assisted suicide's relentless advance

Review by **John Martin**
CMF Head of Communications

What a tragedy. Another episode in the seemingly relentless advance of assisted suicide. This time a 20-year-old Dutch woman, a survivor of sexual abuse, persuaded doctors to administer a lethal injection. She reasoned that her life was untenable and death the only way out.

UK press reports said her symptoms included severe anorexia, chronic depression, hallucinations, and compulsions. It is claimed they left her *mostly* bedridden.¹ *The Daily Mail* quoted her psychiatrist who said 'there was no prospect or hope for her. The patient experienced her suffering as unbearable'.² To pronounce hope extinct is a frightening judgement.

Certainly, survivors of sexual abuse suffer from deep grief; was she offered the kind of support such a survivor needs? The first and obvious question to ask is whether a 20-year-old can claim sufficient knowledge of available treatment options to countenance death as the only viable path. Twenty is a very vulnerable age. My own personal memories of life at twenty might be relevant here. I faced the call up for service in Vietnam. The Australian government

conducted a lottery with birthdays drawn in a lottery ballot. My overwhelming sense was that I was seriously ill-equipped with knowledge and experience to think through the issues at stake.

'If death is sought/offered to escape the pain of sexual abuse, incest, rejection, loneliness, what kind of choice is that?' asks the Australian researcher Melinda Tankard Reist. She sees a 'slippery slope'. 'In the Netherlands and Belgium, the laws were originally very strict and limiting. But over time they have relaxed to include those people without a terminally ill condition: teens; children; babies; abused, lonely, isolated women.'³ Dr Yael Margolia Rice a sexual trauma counsellor comments: 'I would never say that, over the long term, anyone is absolutely untreatable.'⁴ The opinion of both Rice and Tankard Reist is that while the trauma suffered is excruciating and runs deep, people do recover even if it may require a couple of decades of help.

As Christians we have no choice but to believe that nothing is outside the scope of God's love and grace. Rick Warren once put it this way: 'What gives me the most hope every day is God's grace; knowing that his grace is going to give me the strength for

whatever I face, knowing that nothing is a surprise to God.' The tragedy here is that it's entirely possible that this young sufferer did not hear, or was not able to hear, the story of God's grace and may have entered a lost eternity.

Jesus said, 'Blessed are the poor in spirit.' The Catholic mystic St. John of the Cross once said, 'When you are burdened, you are close to God, your strength, who abides with the afflicted.'⁵ Our faith teaches us to discern the image of God in those who suffer; they are precious even if 'flawed masterpieces' (to borrow a phrase from John Wyatt).

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A call to arms

Church's role in care is underestimated

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

A recent report from the Oasis Trust¹ presented a challenge to the government, public sector and the church to work more closely and creatively together on providing services. A report from the Cinnamon Trust last year² showed that faith groups make a major contribution to all aspects of society, from education to healthcare, foodbanks to debt counselling, befriending and housing. Yet, the reality is that the church in the UK is still not able to be as significant a part of the 'Big Society' as it could, and should, be.

Interestingly, Theos did an analysis of some of the data from Oasis Trust's research that showed that the general public do not believe that the church has the capability to do this.³ This is mostly because they see churches and Christian charities as lacking the skills and capacity. Moreover they are

suspicious of any organisation taking over what is still perceived as government work. Very little of the suspicion is around concerns that Christian organisations would be discriminatory or proselytising.

These reports all suggest that the scale of what the church is doing is underestimated, but also that we have a lot of work to do. While we are good at education (the Church of England alone runs over 5,000 schools), we are less experienced in healthcare, with huge gaps appearing in the ability of state-run services to provide in certain areas (such as adolescent mental health or care for the elderly and disabled). The challenge for the church is to think about what needs we are uniquely placed to address and for the government and wider civil society to actually work with us, and we with them. The reality is that the so-called 'Big Society' never really got the attention and

investment needed to make it happen. With austerity biting into vulnerable communities, the need for strong church engagement is greater than it has been in decades.

This is not to take the church away from its primary role in sharing the good news. Rather, it is reclaiming a role we always had, as the major source of care and social support, given in the name of Jesus to a hurting world. In showing his love in deed, as well as proclaiming his truth in word, we will be fulfilling our calling to be his witnesses.⁴

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BMA retains opposition to assisted suicide

Neutrality is worst of all positions

Review by **Peter Saunders**
CMF Chief Executive

On 21 June the Annual Representative Meeting (ARM) of the British Medical Association (BMA) in Belfast voted against going neutral on assisted suicide by a two to one majority.¹

Delegates rejected motion 80, 'that this meeting believes that the BMA should adopt a neutral stance on assisted dying', by 198 to 115 (63% to 37%). The debate took place after a previous motion affirming that 'it is not appropriate at this time to debate whether or not to change existing BMA policy' was defeated by 164 to 160.

Fifteen doctors spoke during an impassioned debate on the two motions but the final vote was decisive, and reflected the 65% opposition to legalising assisted suicide shown in most opinion polls.

The Royal College of Physicians, Royal College of General Practitioners and British Geriatrics Society are all officially opposed to a change in the law along with 82% of Association for Palliative Medicine members.² Amongst all doctors, this latter group carries the greatest weight in this debate due to their understanding of the vulnerability of dying patients and their knowledge of treatments to alleviate their

symptoms. Assisted suicide and euthanasia are contrary to all historic codes of medical ethics, including the Hippocratic Oath, the Declaration of Geneva, the International Code of Medical Ethics and the Statement of Marbella.³

Neutrality on this particular issue would have given assisted suicide a status that no other issue enjoys. Furthermore, to drop medical opposition to the legalisation of assisted suicide and euthanasia at a time of economic austerity would have been highly dangerous. Many families, and the NHS itself, are under huge financial strain and the pressure vulnerable people might face to end their lives so as not to be a financial (or emotional) burden on others is potentially immense.

In rejecting a previous attempt to move to neutral at its ARM in 2012, the BMA said that neutrality was the worst of all positions.⁴ This was based on bitter experience. When the BMA took a neutral position for a year in 2005-2006 we saw huge pressure to change the law by way of the Joffe Bill. Throughout that crucial debate, which had the potential of changing the shape of medicine in this country, the BMA was forced to remain silent and took no part in

the discussions. Were it to go neutral again it would be similarly gagged and doctors would have no collective voice.

Going neutral would instead have played into the hands of a longstanding campaign led by a small pressure group with a strong political agenda.⁵ Healthcare Professionals for Assisted Dying (HPAD), which is affiliated to the pressure group 'Dignity in Dying' (formerly the Voluntary Euthanasia Society), at last count had just over 500 supporters, representing fewer than 0.25% of Britain's 240,000 doctors.⁶

Instead the BMA ARM wisely gave short shrift to this latest neutrality proposal and signalled by the margin of defeat that this matter should now be settled for the foreseeable future.

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Pippa Peppiatt assesses issues in teamwork within the NHS



THE NURSE-PHYSICIAN RELATIONSHIP

key points

- The nurse-doctor relationship is changing. But there is still too much conflict and lack of collaboration; and much potential for quality improvement.
- Nurses are not alone in suffering from negative relationships at work. Female doctors, especially juniors, are given less assistance and respect by female nurses.
- We need to be intentional about working in a patient and loving way with one another. Here lies another potential area of witness for Christian nurses.

In a recent issue of the *Nursing Times*, chief nurses were called to help tackle 'shameful' bullying statistics.¹ One in four NHS staff is bullied. This especially affects nurses.²

Retention of nurses is further hampered by nurses reporting they feel frustrated and dissatisfied with working relationships that devalue their professional worth, especially that of the nurse-doctor relationship.³

The disciplines of nursing and medicine are expected to work in unusually close proximity to one another, not just practising side by side but interacting with one another to achieve a common good – the health and well-being of patients. Collaboration, a relationship of interdependence, requires the recognition of complementary roles. Moreover, in a climate constantly demanding efficiency, cost-effectiveness, and quality improvement, nurse-physician collaboration holds promise for improving patient care and creating satisfying work roles.⁴ Yet all too often, there is conflict and lack of collaboration between staff.

Historically, the doctor-nurse relationship has been characterised as essentially a dominant-subservient relationship

Historically, the doctor-nurse relationship has been characterised as an essentially a dominant-subservient relationship.⁵ Some doctors, especially older ones, still view nursing through this hierarchical lens and sadly treat nurses in a dismissive, belittling or intimidating manner. Unhelpfully, the entertainment media is a leading source of this handmaiden imagery.⁶

Nursing is an autonomous profession and a distinct scientific discipline. It overlaps with medicine and one element of nursing is carrying out care plans crafted by medics. But nurses train, manage, and regulate themselves, with a unique focus and scope of practice, including special

expertise. So when doctors show disrespect to nurses and don't listen to them, it is one of the major factors in nurses' dissatisfaction in their work.

Nurse-physician relationships have improved in certain healthcare situations, such as the operating room and intensive care settings. However, many nurses report that the same negative issues between nurses and physicians⁷ that have existed for years still persist. A 2013 survey⁸ found that the state of nurse-doctor relationships is still in need of improvement. In light of this, educators need to address how medical and nursing training can better equip doctors and nurses to work compatibly.

It isn't just nurses who suffer from negative relationships at work. Recent studies⁹ show that female doctors, especially juniors, are given less assistance and respect by female nurses. Here lies another potential area of witness for Christian nurses – to model good interdisciplinary collaboration with female doctors, without prejudice.

For many years – until the 1960s – fewer than 10% of British doctors were female. Then things changed. For the past four decades about 60% of students selected for training in UK medical schools have been female. Now 43% doctors in UK are women.¹⁰ By 2017, for the first time, there will be more female than male doctors in the United Kingdom. One positive effect of this is that it will further challenge the historical social trope which upholds the subordination of women in the caring environment and which has hindered the professionalisation of nursing.

In this climate, what an opportunity we have as Christian nurses and doctors (and indeed all healthcare professionals) to model good, respectful and loving teamwork.

Every given interaction may leave lasting positive or negative impressions on those involved, or on those who witness a particular nurse-physician interaction. We need to use the best knowledge and abilities of all health team members and, furthermore, to model kingdom values and cohesive team relationships.

We need to be intentional about working in a patient and loving way with one another, remembering Paul's instructions, to 'set an example...in speech, in conduct, in love, in faith and in purity.'¹¹

It's important to outwork this in practice by avoiding gossip and speaking well of one another. Doctors could strive to be servant-hearted, especially in those less demarcated areas at work, like cleaning up after a medical examination, fetching case records or equipment, not presuming on nurses to do so. In God's wonderful, upside-down kingdom, the first shall be last and the last first.

We lead by serving. Treat nurses as fellow professionals and respect their informed input on ward rounds and care planning. Please respect them when they say they can't perform a task – at times, even when they are competent, nurses may be constrained by legislation and restrictions on what

they can and cannot do. This can be frustrating for them too.

Christian nurses primarily receive their self-worth from the Lord and know the value in what they do. This will enable them to nurse without approval-seeking or competitiveness with other nurses and doctors. They can especially aim to be more supportive and positive in the way they deal with (and talk about) doctors. I know first-hand the difference it made to medical students and junior doctors when I and other staff nurses actively sought to help, orient, advise and assist them as they came fresh to work on our ward.

One doctor recently told me how she had experienced particularly good support and Christian encouragement from nurse colleagues on a geriatric ward she'd worked on as an F2 (SHO) in London. She writes:

SHOs looked after the ward day and night so we got to know our patients and the regular staff pretty well. It was a lonely job and quite tiring being on over the weekend, and especially sad at night on the darkened ward when a patient died. Going to certify an expected death behind drawn curtains with a couple of the nurses, the charge nurse and I stood very quietly and shared some prayers for the dead man. It felt right for us all. We were recognising and sharing our own sadness, giving support to each other, giving thanks for a life and putting him in God's hands. I was so grateful to the charge nurse for his initiative. Even on a ward where faith was recognised, it takes some confidence and courage to do this. I was grateful.¹²

Christian witness in the workplace is not just speaking the good news. We need reminding of Jesus' exhortations to us, 'Love each other. Just as I have loved you, you should love each other. Your love for one another will prove to the world that you are my disciples.'¹³ And 'Since God so loved us, we also ought to love one another. No one has ever seen God; but if we love one another, God lives in us and his love is made complete in us.'¹⁴

My nursing colleagues used to be amazed at the love and trust that was immediately evident among Christians on the wards, whatever their professional title. They couldn't believe that sometimes we had only just met and hadn't known each other for years. This sort of relating, as loving brothers and sisters, is such a witness, and truly does reflect Father God in a powerful way.

So, as Christian doctors and nurses, let's try and model working in a climate of loving care, mutual respect and interdisciplinary collaboration, for his glory. I leave you with a challenge from a friend of mine: 'As Christians, can you relate to each other so qualitatively differently that it brings the world running?'¹⁵

Pippa Peppiatt is CMF Nurses Student Staffworker.



By 2017, for the first time, there will be more female than male doctors in the UK. One positive effect is that it will further challenge the historical social trope which upholds the subordination of women

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EXPORTING BRITISH HEALTHCARE EXPERTISE

key points

- From close-up, British people are well aware of the short-comings of the NHS; from a global perspective it is highly regarded and governments the world over are keen to benefit from 68 years of operating a healthcare system that is free at point of delivery.
- There is scope for making British knowhow available to a wide range of other countries.
- Income from it can be regarded as a legitimate return on what this country has invested in the NHS.

For many years now, successive British governments have been accused of trying to sell off or privatise the National Health Service. The Lansley Reforms introduced by the Coalition Government in 2012 were felt by some to be preparing the way for greater involvement of the private sector in both the commissioning and the delivery of healthcare services. But the *Five Year Forward View for NHS England*, published in October 2014,¹ put more emphasis on partnership and innovation in raising standards and transforming the provision of healthcare to meet the needs of the 21st century. The role of the private sector was noticeable by its absence.

Nevertheless, there is considerable scope for selling NHS services to an international clientele which has long been eager to access the knowledge and expertise acquired over the past 68 years of operating the world's largest universal healthcare system. Showcasing the NHS and Great Ormond

Showcasing the NHS and Great Ormond Street Hospital in the opening ceremony of the London Olympic Games reminded the world how highly we British regard our tax-funded health system, free at the point of need

Street Hospital in the opening ceremony of the London Olympic Games reminded the world how highly we British regard our tax-funded health system, free at the point of need, and how integral it is to our social identity as a nation. It also elicited a barrage of requests for help in improving their health systems from a wide range of countries, most

notably those emerging nations with increasing economic success, such as India, China, Brazil and the Middle East.

Many shortcomings

As citizens of the UK – and even more so for those of us who work inside the NHS – we are uncomfortably aware of its shortcomings, whether they be the mounting pressures on GP services, the heavy reliance on agency nursing staff, the deficiencies in mental health provision, overcrowding in Accident and Emergency Departments, and the lack of integration between health and social care, to name just a few. The *Forward View* seeks to address the perceived widening gaps in *health and wellbeing, care and quality, and funding and efficiency* through the creation of new partnerships and ‘the right investments’; so there is no complacency about the challenges we are facing. But in an international context, we have much to be proud of – and grateful for – compared with most other countries. Perhaps Jesus’ summing up of the parable of the talents is relevant here: ‘From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked.’² What is certain is that as part of a global community we cannot simply live to ourselves.

An ageing population

The oft-quoted report by researchers at the New York-based Commonwealth Fund published in 2014 bears testimony to the high regard in which our health system is held when compared with countries like France, Switzerland, Germany, Sweden, the Netherlands, Australia, Canada and the United States (see chart on next page). The UK comes out top on access, quality of care and efficiency, and second on equity. But of greatest interest to emerging nations, struggling to know how best to provide acceptable standards of healthcare to their burgeoning populations, is the *expenditure per capita figure* where the UK is lower than all the other countries, apart from New Zealand, and less than half the cost per head of the United States.³

However, the latest OECD Report⁴ demonstrated that the UK, at 8.5% of GDP, is still below the OECD average of 8.9% and is also below the UK level for 2009 when figures are adjusted for inflation. Understandably, most people would agree with the OECD’s conclusion (and the Economist Intelligence Unit’s analysis of the same figures) that the UK needs to spend more of its GDP on healthcare if we are to cope with the rising demands of an ageing population.⁵ But since 2009, Britain has been trying to tackle unprecedented levels of national debt and a growing budget deficit. So where is the much-needed extra money going to come from?

Sharing expertise

One contribution could come from income generated by sharing expertise with the interna-

tional community, especially in emerging markets where growth in expenditure on healthcare in countries like China is expected to double in the decade up to 2020. And so, following the Olympic Games in 2012, the Department of Health, NHS England, and UK Trade & Investment jointly agreed to establish a new organisation to facilitate the export of British healthcare knowledge and experience to generate revenues for the UK economy.

This new organisation, called Healthcare UK, was launched at Arab Health in Dubai in January 2013 with a mandate to encourage suitably-qualified public and private sector healthcare organisations to maximise their export potential. Targeting the high growth countries in Asia, the Middle East and Latin America, Healthcare UK⁶ was tasked with identifying the biggest opportunities for British organisations to work with overseas governments to help them improve their healthcare delivery through major infrastructure projects, training and education partnerships, application of digital technology, advice on health systems development and sharing expertise in genomics, clinical services and personalised medicine.

Partnerships












In each of these areas, Healthcare UK has facilitated engagement for NHS Trusts, arms-length bodies like Public Health England, Royal Colleges and Universities. Many of these already had international experience but often lacked the commercial knowledge to take best advantage of the opportunities that were being identified. Overseas governments were keen to engage with the most well-known institutions such as Great Ormond Street Hospital but, above all, they wanted access to the knowledge and expertise which they associated with the NHS brand. By creating consortia of NHS, private and educational institutions to respond to specific needs, Healthcare UK has been able to provide tailored solutions where risks are mitigated for the public not-for-profit organisations and revenues are maximised for all parties.

Not only does this generate much-needed revenues for NHS Trusts but often it will expose NHS staff to other health delivery systems and offer invaluable learning opportunities through working on international projects. Examples include one North London Trust sharing their world-class research and experience in community-based mental health delivery with the Mongolian Centre for Mental Health. NHS Tayside has customised their model for delivering improved outcomes for diabetes patients with the Kuwait Health Network. Leeds University Teaching Hospitals has developed a partnership with the King Hussein Cancer Centre in Jordan for research and clinical services support. Portsmouth has franchised a programme used in more than eight countries teaching staff to anticipate, recognise and prevent critical illness at an early stage. King’s College Hospital has agreed to



‘From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked’

The NHS is named the best healthcare system

											
	UK	CHE	SWE	AUS	GER	NED	NOR	NZ	FRA	CAN	US
Overall ranking (2013)	1	2	3	4	5	5	7	7	9	10	11
Quality care	1	3	10	2	7	5	11	4	8	9	5
Effective care	1	8	10	4	6	5	11	2	9	7	3
Safe care	1	4	5	3	6	7	11	9	2	10	7
Coordinated care	1	3	11	4	10	5	7	2	9	8	6
Patient-centered care	1	2	9	5	7	3	11	6	10	8	4
Access	1	2	4	8	2	4	6	7	11	9	9
Cost-related problem	1	7	1	9	4	8	3	6	10	5	11
Timeliness of care	3	1	9	6	4	2	8	7	10	11	5
Efficiency	1	6	2	4	9	7	4	3	8	10	11
Equity	2	2	1	5	4	8	6	10	7	9	11
Healthy lives	10	3	2	4	7	5	6	9	1	8	11
Health expenditures/capital 2011*	\$3,405	\$5,643	\$3,925	\$3,800	\$4,495	\$5,099	\$5,669	\$3,182	\$4,118	\$4,522	\$8,508

* Expenditure shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010. Adapted from *Mirror, Mirror on the Wall, 2014: Update How the US Health Care System Compares Internationally*. Davis, Stremikis, Squires and Schoen, The Commonwealth Fund 2014

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help establish a teaching hospital and medical school in Punjab. And this selection of projects is just the tip of the iceberg. Many UK-based clinicians have developed associations and partnerships with clinicians working in other countries which have significant revenue-generating potential if properly addressed. The key is to develop the right business model to minimise risk and any potential impact on home services, whilst maximising the returns for the NHS Trust.

Healthcare UK focuses on projects that will generate revenues for the UK economy, but it also helps organisations who want to share their expertise on a philanthropic basis. Many NHS Trusts have set up partnerships to work with overseas hospitals that are less well-resourced.

Income generation

The Tropical Health & Education Trust (THET) has been a facilitator of such partnerships for the past 25 years.⁷ THET has been appointed by the Department for International Development to administer the Health Partnership Scheme, which helps UK health institutions and professionals to establish partnerships with counterparts in developing countries to strengthen health systems in some of the poorest countries through skills transfer and capacity development. A typical example is the partnership between Northumbria NHS Trust and Kilimanjaro Christian Medical Centre in Tanzania to support the launch of a National Burns Unit.

Given that nearly half of all hospitals in Africa are operated by Christian charities, links and exchanges between NHS Trusts and African hospitals can be a fruitful way of sharing knowledge gained in our resource-rich NHS with those who have learned to make do with much less – and being a blessing to each other!

Back in the 1980s, there was an outcry when hospitals started to generate income from on-site

banks, shopping malls and Starbucks coffee shops (replacing the tea-stands run on a shoe-string by the Red Cross or League of Friends). Now income generation of many different kinds is an acceptable feature of NHS Trusts, and a vital contribution to balancing the books.

In its first three years of operation, Healthcare UK has succeeded in helping over 100 organisations in both the NHS and private sector to win contracts valued at just under £5billion as well as introducing more than 750 organisations to export opportunities in the target markets. Compared with the projected deficit of £30billion, this is still a relatively small amount. But if every NHS Trust maximises its potential for international work – without compromising the focus on delivering high-quality services to the local population – the chances of safeguarding a sustainable, publicly-funded NHS, free at the point of need, will increase significantly.

Howard Lyons was managing director of Healthcare UK 2013–16, an enterprise helping UK healthcare providers to do more business overseas. He was CMF Treasurer 2010–14. Howard was awarded the CBE in the 2016 Queen's Birthday Honours.

NEW TEMPLATE FOR THE UK LAW OF CONSENT

Last year a landmark case changed how the UK law of consent is to be interpreted and applied.¹ The emphasis in decision making must be on partnership and shared decisions, not paternalism. Doctors who ignore or withhold information from their patients, even about a very small risk, may now be breaking the law.

The case has introduced a patient-focused test to the UK law on informed consent. It concerned a patient named Mrs Montgomery, who was expecting her first child. As the mother, being both small and having diabetes mellitus, the risk of shoulder dystocia during labour was 9–10%. She expressed concern to her doctor about the size of the baby and whether she would be able to deliver vaginally. She did not, however, ask 'specifically about the exact risks'. Nor did her doctor discuss the potential risks of shoulder dystocia. In her estimation, the risk of a grave problem resulting from a shoulder dystocia was very small. The risk of a brachial plexus injury in such a case is 0.2% and the risk of cerebral palsy or death from complications is 0.1%. The doctor contended that if shoulder dystocia were mentioned to every diabetic patient, most women would ask for a caesarean section. In her opinion it was not in the interests of women to have caesarean sections.

However the birth *was* complicated by shoulder dystocia. Mrs Montgomery's son was deprived of oxygen and subsequently diagnosed with cerebral palsy as well as Erb's palsy. The court reasoned that the doctor ought to have advised the patient of the substantial risk of shoulder dystocia and that if she had, the patient would have opted for a caesarean section. The judgement makes it clear that patients in the UK now have a legal right to be informed of material risks before making a decision. These material risks are determined by the circumstances of the particular case, and whether a reasonable person in the patient's position would be likely to attach significance to it.

GMC guidelines on consent produced in 2008 influenced the judgment. They emphasised the need for a dialogue to ascertain the beliefs and values of the patient, enabling doctors to learn what risks and complications of each option would be considered to be material to the patient. In that sense, it is a move away from medical paternalism.² So what are the implications for doctors now? Most doctors will already understand informed consent within the parameters of the GMC guidelines.³ A risk to one patient may not be seen as such to another. Thus, it is vital to ascertain the views, hopes and wishes of every patient considering a procedure.

Most doctors will be reasonably familiar with the Bolam Test regarding medical negligence.⁴ This test asks whether a doctor's conduct or action is supported by a responsible body of medical opinion. Up until this case, the Bolam Test put the responsibility on the clinician to decide how and what information to impart.

Now the law makes it clear that the key questions to be asked are: 'Would a reasonable patient want to know this information? Would this particular patient consider it to be important and relevant information?' This change is in keeping with developments in Australian and Canadian law.

This new model of dialogue fits in well with what John Wyatt calls the 'expert-expert relationship'⁵ or what Per Fugelli called 'shared power'.⁶ This new case law, together with the joint GMC and NMC guidelines on the duty of candour,⁷ seem to have brought back the notion of professional judgement. As Soko commented in the *BMJ*, 'A pro forma approach to consent is common but is ethically and legally dubious'.⁸ Pro forma approaches tend to signify a technician-client relationships that is based on a contract. Shared power between the patient and the doctor, however, should be a collaborative relationship based on mutual respect and trust. Both parties bring their expertise, doctors their knowledge of treatment options and ethical frameworks, patients their knowledge of their history and way of life. Together, they reach a consensus, always keeping respect central.⁹ This is how doctors can show that they care deeply for their patients as individuals.

In light of this new ruling, the process of consent for abortion procedures may justify more scrutiny. There is no legal requirement for the doctor to have seen a patient requesting an abortion, to have a one-to-one conversation about personal values and beliefs or the risks and complications of the various options available. The new ruling has now made it clear that in the consent process we should explore options with that specific patient in mind. Those who ignore or withhold information due to bias are breaking the law.

It is also possible that doctors who withhold information, such as the link between abortions and subsequent prematurity, may also be at risk.¹⁰ The case for independent abortion counselling and accurate information giving has just got stronger.

Informed consent is about established trust and a deep respect for a patient's autonomy. In the process of informed consent, patients need to know that they can rely on their doctor to be truthful and unbiased, caring and acting in their best interest. Just as God bestowed on us free will and bore the burden of the possibility that we might turn away from him, just as the rich young ruler did,¹¹ we are asked to bear the burden of informing our patients as best as we possibly can, bearing the burden of sorrow that they may choose wrongly or unwisely.

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Andrew Tomkins examines the forces behind exclusion and explores solutions

TACKLING GLOBAL HEALTH INEQUALITIES



key points

- Millions are excluded from adequate healthcare. The 'supply side' is often affected by distances from services and shortages of resources and trained healthcare workers. The 'demand' side is often affected by societal attitudes.
- The UN Universal Declaration of Human Rights (1948) and the Declaration of the Rights of the Child (1958) contain important globally-agreed benchmarks for the care and protection of vulnerable people.
- There are many opportunities for Christian healthcare professionals to become involved: as advocates, trainers and working internationally as they develop and implement a personal Global Healthcare Action Plan (GHAP).

Why are so many people excluded from healthcare?

Being poor and disadvantaged is generally recognised as being 'bad for your health.'¹ The WHO Global Health Observatory² website displays striking differences in healthcare coverage according to country, education and poverty. But there are many other important reasons for exclusion from healthcare.

Factors on the 'supply side' include a lack of skilled and equipped staff, despite increased numbers trained in recent years. There are changing global health challenges such as the 'Double Burden of Malnutrition'. Many millions of children are severely malnourished. Severe Acute Malnutrition now kills more children than malaria. Conversely, many millions of obese adults have diabetes, hypertension and vascular disease.

Protocols, skills and supplies are often inadequate. Many millions still live far from healthcare services. There are varying viewpoints and scriptural interpretations about when life starts – at fertilisation, at implantation, or even later. This affects the type of family planning technologies that staff will discuss or provide. Differing viewpoints also affect the provision of harm reduction methods for HIV prevention, including condoms and clean needles.³

Factors on the 'demand side' include the stigma

Remarkable Christian healthcare professionals have provided outstanding care for the excluded for centuries

that often excludes people with mental illness, HIV, leprosy, albinism, epilepsy, and stillbirth. These are often deemed to be 'caused by bad spirits' and considered as needing treatment by traditional healers rather than healthcare professionals. Disabled people face particular stigma and difficulty in accessing healthcare.

With regard to sexuality, LGBT persons are judged by many Christian leaders, preventing access to diagnosis, treatment and care. The Archbishop of Canterbury, Justin Welby, apologised strongly for this judgment, but it persists. Power relations are critical. Many girls have their genitals cut and have no say about when they should marry or have babies. Mothers are often denied permission to visit clinics or deliver in a health facility. Women subject to domestic abuse are often too frightened to attend clinics. Conflict creates refugees, internally displaced people, migrants and prisoners, many of whom often face major problems in accessing healthcare.

How do people feel when they are excluded?

The Bible uses the word 'forsaken' (literally – giving up something that is valued highly). David cried out, 'Why have you forsaken me?'⁴ Jesus used these words on the cross.⁵ All humans are made *in God's own image* and are deeply loved by him.⁶ By excluding or forsaking other humans, we turn our back on part of God's creation.

Responding to inequity

The Bible portrays covenants that support an individual's rights and protects them: by God for Noah,⁷ Abraham⁸ and Moses.⁹ God, through Isaiah, warns, 'Woe to those who deprive the poor of their rights and withhold justice from the oppressed'¹⁰ and exhorts people to 'seek justice, encourage the oppressed, defend the cause of the orphan and plead the cause of the widow'.¹¹

Should these biblical values be implemented by a few inspired individuals, or by laws which aim to protect individuals and communities who are 'excluded'? For centuries, remarkable Christian healthcare professionals have provided outstanding care for the excluded. Christians are also exhorted to be 'salt and light', inferring the need to promote rights-based improved healthcare for the excluded.

During the Second World War millions of people were exterminated because of race and disability. Afterwards there was a desperate desire to create a culture of 'never again', enforced by law. The UN Universal Declaration of Human Rights (1948) was drafted and accepted by nearly every country. The statement by Hernán Santa Cruz, a senior Chilean politician involved in the drafting, is profound. *'I perceived clearly that I was participating in a truly significant historic event in which a consensus had been reached as to the supreme value of the human person, a value that did not originate in the decision of a worldly power, but rather in the fact of existing – which gave rise to the inalienable right to live free from want and oppression and to fully develop one's personality'.* The 'supreme value of the human person' is strongly supported by scripture.

A decade later (1959) the Declaration of the Rights of the Child was widely adopted. Principle two stated that *'The child shall enjoy special protection ... by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner'*. Interestingly, 'spirituality' was dropped by the WHO in its definition of health but has been reintroduced recently in WHO policies on palliative care. Such decisions have been influenced by articulate and powerful, often secular, lobby groups who seek to promote their viewpoints within law.

CMF supports 'a rights-based approach to life', building on biblical principles and being supported by the UN Declaration of Human Rights. At present, the legal basis for providing healthcare for the excluded is less strongly championed. There is important work to do on rights-based support for 'healthcare for the excluded', but is that all?

Compassion is crucial. It is a key attribute of God

and believers are encouraged to be compassionate. In practice some healthcare professionals are deeply compassionate while others are not. Why? Strong influences from family and community members are important, but the Bible also emphasises more than 'trying to be compassionate'. It describes how believers are 'anointed with the Holy Spirit' and describes the 'fruit of the Spirit' as vital in building compassion – 'kindness, goodness, faithfulness, gentleness and self-control'.¹² Perhaps a key question that Christian healthcare professionals need to ask is *'How compassionate am I towards the excluded?' and 'How might God nurture compassion for the excluded within me?'* We spend a lot of time on career planning, training and appraisals but how often do we, possibly with a trusted friend, review how we are progressing in our 'compassion score'? Words of Dietrich Bonhoeffer – written before his execution by the Nazis – are deeply challenging. *'God chooses people as his instruments and performs his wonders where one would least expect them. God is near to lowliness; he loves the lost, the neglected, the unseemly, the excluded, the weak and the broken.'*¹³

How can healthcare professionals respond?

Becoming informed and being an advocate.

We can support organisations that campaign for the excluded such as Amnesty International, Tearfund, CAFOD, and World Vision. The Joint Learning Initiative on Faith and Local Communities is increasingly influential at the policy level.¹⁴ In 2015, they organised the launch of the Lancet series on Faith and Healthcare at the World Bank. It documented the high coverage rates by faith-based healthcare groups for the poorest in Africa and the impact of some faith leaders who challenge prejudice, health-damaging behaviour and exclusion.¹⁵ The International Development Departments of the UK, Germany and the USA also acknowledge the effectiveness of faith-based healthcare organisations in reaching the excluded. Several UN agencies, including UNAIDS and UNFPA, now have policy units focusing on faith based healthcare. There are full-time career and short-term contracts for healthcare professionals within such organisations. National faith-based healthcare organisations are also now more effective in their advocacy; provision of healthcare for slum dwellers in India for years has enabled ASHA to campaign effectively for improved social services, including healthcare, from national government.¹⁶

Working overseas as a healthcare professional.

There are inspirational accounts of Christian healthcare professionals who have worked in church-based healthcare programmes – 'medical missionaries'. Reviews by Schram¹⁷ of those in Africa and Philip¹⁸ of those in Asia make challenging reading. There are increasing opportunities for clinical and public health work, working alongside national colleagues – either short-term or

The Rendle Short Lecture

The Rendle Short Lecture is given annually, usually at the CMF National Conference. It commemorates the work and ministry of Professor Arthur Rendle Short (1880 – 1953). He was a professor of surgery at Bristol University and devoted his great gifts in whole-hearted service to God, particularly in apologetics and as a speaker and teacher in the student world.



There are increasing opportunities for clinical and public health work by expatriate healthcare professionals, working alongside national colleagues – either short term or long term



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long-term as reviewed in iSERVe (Global Connections) and through CMF.¹⁹ The Royal College of Paediatrics and Child Health (RCPCH) organises mentored training programmes in developing countries.²⁰ There are many unfilled jobs in international NGOs working in acute humanitarian relief. Local community groups, including many Christian communities, are mentored by UK trained healthcare professionals as they identify some of the root causes of health problems and do something about it themselves.²¹

The term 'tropical medicine' describes clinical and public health programmes for malaria, HIV, TB, leprosy, helminthiasis, filariasis, schistosomiasis, malnutrition and appropriate technologies for surgery, obstetrics and ophthalmology – 'in the tropics'. With fast-developing antimicrobial drug resistance and outbreaks of unexpected infections such as the Ebola and Zika viruses, research is critical and international journals are now filled with research papers on 'tropical medicine'. Short and long-term research contracts are available for those with aptitude.

Insights from sociology, health economics and behavioural science are also crucial if adequate healthcare is to be accessed by the 'excluded'. The term 'global health' is now used to describe multidisciplinary ways of tackling disease and disability, especially among vulnerable people. There are strong research programmes and fellowships, especially for those prepared to maintain their core clinical discipline but work with others.²² 'Implementation research' is increasingly recognised as being crucial, requiring rigorous methodology and the development of novel approaches.

Providing training

Many UK healthcare professionals now provide training through link programmes between NHS trusts and healthcare programmes overseas. The best provide a long-term link, making repeated short-term visits over a number of years. Tropical Health Education Trust (THET)²³ and Prime run excellent programmes; there are many others. CMF publications give invaluable guidance on these opportunities.²⁴ Internet and mobile phone-based support for healthcare such as HIFA2015 and CHILD 2015 and modern communications technology in radiology, histology and case conferences are increasingly used.

There are many jobs with Christian, multi-faith or secular organisations overseas. It is nearly always possible to join and contribute to a local Christian fellowship wherever you work. The term 'Christians in global health' best describes the remarkable range of ways in which Christian healthcare professionals can make a difference.

How to prepare

As with any decision in life, Christians are encouraged to be informed, examine scripture, pray and obtain wise, experienced advice. There are some general principles:

- **Develop a professional, vocational career** but be prepared to work outside that area – a UK trained clinical paediatrician might work overseas and treat severely malnourished children using home-based regimes.
- **Develop relationships that last;** keep communications going once you return to the UK. Work with some good mentors and meet people who are making a difference.
- **Build capacity in your overseas colleagues.** Much professional building in the UK is about 'self', whereas in global health it is about 'others'.
- **Put more emphasis on planning for logistics, communications and sustainability** than you do in the UK – become more socially and politically aware.
- **Network as much as you can.** Look at websites which are not of direct interest to your professional career. Read the *Lancet* and *BMJ*, both have global health editions.
- **Understand your leadership and communication style** and how that might need to change to optimally support overseas colleagues.
- **Link with an active, multidisciplinary research and teaching department** of global health in the UK.
- **Review job lists** – CMF, iSERVE, SCF, Medair.
- **Be prepared to take some risks** – to your career and your pride. Negotiate hard with your career development supervisors and trusts. They may need convincing of the benefits to you of working overseas. There are many positive examples you can quote.
- **Marry the right partner.** If you have children do not be too protective. Recognise that they may benefit enormously by living and learning overseas.
- **Make a personal GHAP** (Global Healthcare Action Plan) – discuss it with colleagues, your family and church as you plan it, put it into practice and nurture it.

In times past, work by Christian healthcare professionals in poor countries was for the 'chosen few'. Most remained in the UK, publicising, praying and supporting this outstanding work 'by those overseas' in many ways. However, the world has changed. Communications, careers, regulatory bodies, travel and technology are all different now. Developing a personal GHAP is no longer 'an option for some'. It is an 'opportunity for all'. Putting a personal GHAP into action will stretch you and your family more than you might imagine, but it will also stretch and grow your faith and professional life in ways that you might never envisage. At the very least, it can be a way of following the example of Jesus who came 'to proclaim good news to the poor...to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free, to proclaim the year of the Lord's favour.'²⁵

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ROBOTS AND HEALTHCARE

Sitting in a comfortable armchair, Maureen is smiling. In her late 70s and with hair a silvery grey, Maureen's hand gently strokes what looks like a furry white seal beside her.

'You're a good boy aren't you?' she croons in a BBC video.¹ As the 'seal' makes a cooing reply, Maureen chuckles with delight. The seal is Paro,² a therapeutic robot designed to help people, some with dementia and other cognitive health issues, who cannot look after a pet. Paro is being used in a handful of NHS trusts such as the Sussex Partnership NHS Foundation Trust, which is partnering with the University of Brighton to trial use of the robot. 'For some people he might provoke memories of giving, caring, loving,' Dr Penny Dodds, a qualified nurse and lecturer at the University of Brighton, told the BBC.³ 'For other people it might be that he helps soothe and relax and reduce anxiety and distress. We might use him as an alternative to medication to reduce anxiety.'⁴

This is just the beginning. Once considered the subject of our imagination, best left in the realm of science fiction, robots are now a growing technology. 'In the US, robots are already being used in hospitals to deliver medicines to patients and to ask if they are OK,' says Dr John Murray⁵ from the University of Lincolnshire, where robots intended for areas such as healthcare are already walking the corridors. 'And they act as guides in museums... I think we will see them here soon in museums, hospitals, and in care homes elderly people might want them around the home.'⁶

Countries such as Japan are already making full use of these robots or 'carebots' which now help care for its ageing population.⁷ The UK is also facing similar issues,⁸ so other trusts such as NHS Western Isles and NHS Shetland⁹ are also trialling the use of robots such as Giraff¹⁰ in patients' homes. Robotics can also be applied in diagnostic systems, robot-assisted surgery and rehabilitation systems for patient groups such as amputees. But with a global market of US\$17billion for service robots,¹¹ what are some ethical issues we should consider?

Loss of personalised care

As the Sharkeys have warned, 'Robots designed as replacement nurses or carers... may make their charges feel like objects... [and] that they had even less control over their lives than when they are dependent on human nursing care'.¹²

Loss of human contact

Can a machine ever meet the emotional and spiritual needs of elderly citizens and patients? We are not just another animal¹³ in the forest or another robot in the laboratory, and promoting the idea that we are is a very dangerous one. The Bible is clear: people are built for relationships.¹⁴ As ample evidence suggests, conditions such as Alzheimer's are more likely to develop in people deprived of social interaction.

Autonomy, control and accountability

Who will, or should, control the robot, and can a robot assess the mental capacity of patients? As Sharkey¹⁵ asks: 'If a senior were to request that a robot throws them off the balcony, should the robot carry out that command? ... In a system in which a robot is responding to the commands of an elderly person, who or what should be held... accountable if something goes wrong?'¹⁶

Patient safety

The right balance¹⁷ needs to be found between empowering an elderly person by making them mobile and protecting them from the dangerous situations they might encounter.

Possible exacerbation of healthcare inequalities.

John Wyatt and Philippa Taylor have warned, 'the technological divide between wealthy and impoverished nations could result in unequal access [and] reinforce, perhaps exacerbate, existing social inequalities¹⁸ and exploitation, leading to worsening¹⁹ of the situation for those already vulnerable.'²⁰

Christians are aware that God has blessed us with technology for our benefit²¹ and not to exploit others or replace him as creator.²² We need to use these resources wisely and justly. But as Wyatt and Taylor comment, 'Technology can be used for good or evil [so] the challenge we are faced with is to assess each technological advance with the questions: "What will these advances do to our sense of being human and to the equal value of all humans?"'²³

Trudy Simpson is CMF Junior Public Policy Researcher.

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Frank Wells shares experience of a career in research ethics

INTEGRITY IN RESEARCH

key points

- Truth telling is foundational for doctors, although at times they will need to judge whether patients can bear hearing completely 'unvarnished' truth about their illness.
- In medical research, there is no room whatsoever for untruthfulness, but this doesn't always happen so checks are needed.
- As well as being accountable to their peers, doctors and medical researchers are accountable to God and his standards of truthfulness.

Doctors don't tell lies, do they? Well, maybe a white one just occasionally. After all, not every patient wants to know they have inoperable cancer – at least, not straightaway. But in a research context, which is where I have spent much of my professional life, recording what really happens is a must: there really is no point in doing anything different.

When I was a small boy – decades ago – my parents firmly drilled into me a mantra that I have never forgotten: be polite, do your best and tell the truth. These three principles have stuck with me all my life, but it's the third one I am concentrating on in this article. A lot has happened to me since I was a small boy, of which by far the most important was becoming a born-again Christian in my mid-teens. I qualified as a doctor in 1960 and practised for nearly 20 years as a GP. But, as I now look back and firmly believe, it was God who guided me through seven years working for the BMA (but mainly on ethics and the BNF) and ten years as a pharmaceutical physician, before eventually leading me to a role in research ethics and the maintenance of research integrity.

My advisory role on research integrity means that

I'm frequently talking about the importance of telling the truth, especially in the context of clinical research where the accurate reporting of findings and results is essential, including the accurate reporting of negative results.

The practice of integrity is the quality of being honest, and the Bible says a lot about integrity, though sometimes it is not specific. In the Old Testament, for example, integrity can be translated from the Hebrew as 'sincerity, soundness, uprightness or wholeness'. The ninth commandment states, 'You shall not give false testimony against your neighbour'¹ which means always be truthful as far as other people are concerned. More straightforwardly, the psalmist says, referring to the Lord, 'Because of my integrity you uphold me and set me in your presence for ever.'² Then in Proverbs, 'The upright will inhabit the land and those with integrity will remain in it'.³ 'The Lord detests lying lips, but he delights in people who are trustworthy.'⁴

Turning to the New Testament 'integrity' means 'honesty and adherence to a pattern of good works'. For example Paul, writing to Titus, says 'In everything set them an example by doing what is good,

In your teaching show integrity and seriousness'.⁵ Jesus is the perfect example of a man of integrity: tempted by Satan but never giving in, without blemish and completely truthful. His own statement of his integrity is a fundamental principle of our Christian faith: 'I am the way and the truth and the life. No one comes to the Father except through me'.⁶ And, in a colloquial interpretation of the sermon on the mount, Jesus said, 'Don't do anything you don't mean' – and he went on to say a lot more: *'This counsel is embedded deep in our traditions. You only make things worse when you lay down a smoke screen of pious talk saying "I'll pray for you" and never doing it, or saying "God be with you" and not meaning it. You don't make your words true by embellishing them with religious lace. In making your speech sound more religious, it becomes less true. Just say "yes" or "no". When you manipulate words to get your own way, you go wrong'*.⁷ These are hugely important messages: don't do anything you don't mean; and, yes, always tell the truth.

I have investigated many cases where the researcher has clearly reported material that wasn't true, and not all of my cases involved patients. Indeed, one of my most interesting cases related to a pre-clinical research project for a new treatment of stress-related anxiety.⁸ The protocol required treating rats that had been stressed, according to a well-documented model for stressing rats.

The PhD student delegated to do the study could not make the model work – but was told to continue as if it had, so that at the end of the study the rats could be said no longer to be stressed (which they never had been anyway). The student tried to alert the authorities at the university about her concerns, but at first they were not interested. Eventually, however, the university authorities agreed that the model to stress rats did not work, but only after the case had been fully investigated. The implications of not telling the truth about the uselessness of the model for stressing rats could have been far reaching. This was a classic case of a university sweeping the evidence of misconduct under the carpet: lies are told and no action is taken.

What was the first lie ever told? Well, we cannot be absolutely certain, but the first recorded one was in the garden of Eden: 'The serpent said to the woman "You shall not die. For God knows that in the day that you eat [the fruit of the tree in the midst of the garden], then your eyes shall be opened and you shall be as gods, knowing good and evil"'.⁹ Satan focused on a restriction and used it to blind Eve to all of God's blessings. There was only one tree in the garden that Eve could not enjoy, but there were numerous good trees from which she could enjoy the fruit without restriction. Satan focused only on one perceived negative restriction, and Eve subsequently forgot about God's generosity and grace. Integrity counted for nothing! But it is still so easy for us to forget God's generosity and grace – Satan is still around!

Perhaps Satan got into the mind of the psychiatrist who featured in my first case of fraudbusting.¹⁰ The research project was a clinical trial on a new anti-depressant, which, amongst other things, required biochemistry tests. The clinical trial monitor could not trace any source documents for some of the biochemistry reported results. When challenged, the psychiatrist stated that he had delegated complete responsibility for the study to one of his junior colleagues (whose name he had forgotten!). The junior colleague concerned, once traced, denied any knowledge of the study whatsoever. The psychiatrist was found guilty of serious professional misconduct, for inventing significant data and even including a patient who did not exist. Again the implications of making licensing decisions based on fabricated data are very serious.

Andrew Wakefield is a doctor whose lack of integrity has probably caused dozens of children to die unnecessarily.¹¹ In 1998 he published a fraudulent research paper claiming a connection between administration of the mumps, measles and rubella vaccine (MMR) and the development of autism and bowel disease. No subsequent researcher was ever able to reproduce these findings and in 2010 he was struck off the Medical Register by the General Medical Council on account of scientific dishonesty and serious professional misconduct. The disease implications of his dishonesty have been enormous.

Paul wrote what has become a very well-known passage of scripture, offering spiritual guidance on integrity: 'whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable – if anything is excellent or praiseworthy – think about such things.'¹²

So why is integrity valuable? As Christians, we have a responsibility to develop and maintain a reputation for telling the truth. We have a promise from God that he will help us to maintain the trust of others by telling the truth. But he knows we may sometimes fall short and tell lies, and forgives us if we confess that we have done so.

Let's go one stage further and ask why integrity is really valuable. We know that Jesus is coming again.¹³ Everyone will have to give account of 'every empty word they have spoken.'¹⁴ Hopefully, we have done our best, been polite and, most of the time, told the truth; for when he comes, that is when we will really appreciate the value of integrity.

Frank Wells was a GP for 20 years and later Under Secretary of the BMA. He founded the Ethical Issues Committee of the Faculty of Pharmaceutical Medicine and is currently Vice Chair of Cambridge South Research Ethics Committee and the Lead Advisor to the Health Research Authority on Integrity, Fraud and Misconduct.



As Christians, we have a responsibility to develop and maintain a reputation for telling the truth. We have a promise from God that he will help us to maintain the trust of others by telling the truth

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Richard Scott shares experiences of evangelistic medical missions



GOSPEL MISSION AND MEDICINE

key points

- There is huge need for medical help in isolated and poor areas.
- Evangelistic medical team members often find the experience transforming.
- It's essential to work with local partners; one-offs are to be avoided.
- Opportunities are almost unlimited.

It all started when a Maasai pastor requested a medical team to come to Kenya to build on evangelistic work done by Cambridge-based charity Through Faith Missions (TFM). I agreed to go on one condition: that the focus must be split equally between mission and medicine. So Evangelistic Medical Missions Abroad (EMMA) came into being.

Pastor David Kereto immediately prophesied that this work would go worldwide. I demurred, seeing plenty of work in his far-ranging community. Nevertheless, over the past six years, team visits have ranged from India, through Kenya to West Africa.

Over the past six years, team visits have ranged from India, through Kenya to West Africa

Six years ago, in the Winter 2010 issue of *Triple Helix*, I reported on the first ultra-short medical mission undertaken by EMMA. The article questioned whether two to three week medical missions were worthwhile. In particular, were we working in isolation or part of a bigger picture? How were our teams of mixed health professionals made up, what funds were needed, and would our

'medics' cope with leading Bible studies, giving testimony and even preaching? And ultimately, how many patients were treated and made commitments to Christ?

Supervision and scrutiny

To counteract potential bias, CMF asked three medical experts to comment. Their enthusiasm varied but locals were less ambivalent. A chief ventured that they'd been late in receiving the gospel and had never had medical aid. Clearly the combination attracted the Maasai who responded to the bush telegraph and radio in droves. Some 3,500 were treated, with hundreds of teeth extracted and spectacles dispensed. Plus 737 made commitments to Christ, mainly from among those attending the evening Jesus film. Unsurprisingly, future medical mission teams were requested.

The impact on EMMA members was scarcely less spectacular. Being tested physically, by working in poorly-lit schools and clinics; spiritually, as they opened their mouths for God; and financially, in funding projects seen first-hand. We concluded that EMMA had been blessed and that Maasailand 2010 shouldn't be a one-off.

Our second medical mission, in April 2011, had similar beginnings. Tony Males, a Cambridge GP, had worked with Pastor Prem Babu in Hyderabad, India, since 1993, teaching in his small Bible College. Prem wanted a diagnostic centre to supplement his team's evangelistic work amongst the poor. The centre was inaugurated during this first mission and our smaller Indian teams (averaging six members) have brought primary healthcare to these rural and slum communities in Andhra Pradesh.

The lighter side

As ever on mission, there are unexpected spin-offs. Many teams have been bolstered by local doctors, dentists and nurses. Dr Sravani Reddy joined us in 2011. Glamorous and ambitious, her career path was 'undone' by what she encountered; she now co-pastors a church with her husband as well as medically treating the poor in Hyderabad.

Medical mission is fun. I'll always remember Tony rather playfully testing the eyesight of Muslim ladies in a church by asking how well they could see the cross. And during an evening meeting, the stage rocked so much as we sang that it collapsed, perfectly capturing the audience's attention for my preach.

Our West African locations have resulted from existing connections. Kwasi Appiah had long wanted to ease the burden on doctors working at the King's Village, near Tamale, Ghana – his homeland. Taking an EMMA team in Autumn 2012 enabled this to take place. Four days were allocated to medical outreach to villages where traditional religion and Islam were predominant. These were followed by nightly open-air meeting using the *Jesus film*.

Life-changing

Pastor Daada Luogon had escaped the Liberian civil war in which his father died. Deeming the situation stable by 2013, he contacted EMMA through our partners from All Souls, Langham Place, London. Eight hours inland from Monrovia, far away from the usual charity networks, we served under the United Liberian Inland Church in three sub-locations.

The second Saturday was seminar day. Topics ranged from hand-washing to teenage sex, polygamy to alcoholism, ending memorably with 500 children worshipping the Lord. Preaching on Easter Sunday Tony Males used three life-sized crosses, reminding locals that God forgives. This message was so relevant in communities where pews contained killers as well as the bereaved. Approximately 3,000 patients were treated and 200 gave their lives to the Lord, with funds distributed between needy patients, staff and pastors.

Loraine, an Irish ophthalmic nurse, was so touched by the needs of war-torn Liberia that she has returned full-time to Saclepea. She began her work by organising midwifery, aided intermittently by our bio-medical scientist, Amanda, and supported by churches from Ireland, Devon and Cambridge.

Continuing to emphasise medicine and mission, we experimented with split medical and evangelistic teams this January in Kenya. The medics concentrated on treating 1,500 patients (at a cost of £1 per patient), allowing the evangelists to reach patients (and their motorcycle taxi drivers) on the road to clinic. Grateful for our powerful medicines, 645 responded to the far greater 'dawa ya Jesu' (medicine provided by Jesus).

So what of the future? Six years on, we continue to receive many requests, but can only fulfil a handful due to lack of medics. We'd love to continue in this vein, but to fulfil requests in existing locations, as well as in Sumatra, South Sudan and Tanzania, we need more staff.

Medical mission is life-changing.

For more information see www.uk-emma.org

Richard Scott is an evangelist and GP based in Margate.



The message that God forgives was so relevant in communities where pews contained killers as well as the bereaved



A yak in the fridge

Life and work in Nepal

John Dickinson and family

- Xulon Press, 2016, £13.15 Pb 228pp, ISBN 9781498461221
- Reviewed by **John Martin**, CMF Head of Communications

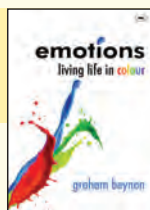
The title alludes to the author's research into altitude sickness, involving storing yak hearts in the kitchen refrigerator. It's one episode in a compelling account of a medical career devoted to Nepal. The author and his family went there in 1969 with BMMF (now Interserve) to work with the United Mission to Nepal (UMN).

It's a lively, often humorous, account of expatriate life among the poor, spiced with comments. Lots of quirky incidents as West meets East: stresses and lifestyle plusses. The story continues after UMN with work as an army doctor and consultancy.

Dickinson insists it's not a 'missionary' book; no accounts of church life, missiology or cross-

cultural issues. Nevertheless there's a profound underlying mission narrative. In 1969 there were just 500 Nepali Christians, with conversion and evangelism punishable by imprisonment. Today Nepali Christians number 800,000. As in China, a persecuted minority learned to share the faith and grow the church with little outside help. UMN did no visible missionary work; its contribution will only be known in the annals of eternity.

A case study for the western health professional considering service long-term in a resource-poor context: learn the language, be flexible, do research and get it published, acquire networking skills and, most importantly, love the country and its people.



Emotions

Living life in colour

Graham Beynon

- Hart Publishing, 2011, £8.99 Pb 176pp, ISBN 9781844745890
- Reviewed by **Everett Julian**, Consultant Psychiatrist based in Ayrshire

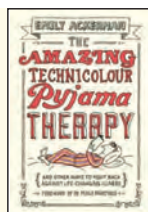
'Emotions are unimportant' or so I once famously remarked as a somewhat naive medical student, probably in reaction to what I perceived as excesses in the opposite direction. God soon disabused me of this notion through a variety of interesting circumstances, but this book would have been really helpful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

Graham Beynon's easy and accessible writing style is matched by biblically-balanced content to help us think through the important issue of our feelings. Through ten chapters he establishes some basics about

emotions, leading on to a consideration of various practical issues. In addition to focusing our attention on Jesus as the perfect man, with feelings as God intended, he also addresses areas such as depression, and emotions in worship.

He seeks to help us liberate and celebrate the God-given emotional aspect of our lives, that we might become redeemed, whole people with integrated thoughts, feelings and actions, and that we might respond to God with all that we are.

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



The amazing technicolour pyjama therapy

Emily Ackerman

- Muddy Pearl Books, 2014, £9.99, Pb 224pp ISBN 9781910012123
- Reviewed by **Lizzie Croton**, GP based at Selly Oak, Birmingham

Emily Ackerman was working as a doctor when she developed ME and switched from physician to patient. Her story is humorously told through prose and cartoons (which are very funny, by the way). This book aims to help those facing life-changing illness to fight back and draw close to God through their suffering. It uses biblical truth (the stories of Joseph, Daniel and Jesus) combined with reflective questions and helpful quotes from both secular and Christian sources.

By the end I felt greatly inspired by her warmth and humour. Emily tackles challenging topics often glossed

over in books of a similar ilk, including grief, social rejection, chronic pain and how faith has helped her cope. The section on grief was particularly helpful, as many myths and social expectations still exist.

Although written from a Christian perspective, it will appeal to readers from all backgrounds without compromising on Christian truth. There's also a small evangelistic section in the first chapter. Even if you are lucky enough to be healthy, Emily's story will help you understand and walk with those experiencing chronic illness. It's a fantastic book to recommend to patients and friends in our wider social circles.



The worry book

Finding a path to freedom

Will van der Hart and Rob Waller

- IVP, 2011, £9.99 Pb 188pp, ISBN 978184474543
- Reviewed by **Alex Bunn**, CMF Student Staffworker

Jesus told us not to worry. But many Christians do, and then feel guilty as well. This excellent book offers practical tips for sufferers. Written by a sympathetic pastor and psychiatrist, it's full of helpful illustrations and biblical application. For instance, do you recognise the rocking chair of worry, which goes nowhere, but seems preferable to an unpalatable task?

They distinguish two types of worry from Matthew 6:34; the solvable problems of today, and the free floating 'what ifs' of tomorrow. Helpfully, they warn against guilt-inducing inner policing, 'taking captive' every thought (2 Corinthians 10:5). Instead they question the 'worry

themes' that sustain anxiety, such as the false belief that excessive worry about family must be a sign of care.

Much worry arises from discomfort in uncertainty. Faith trusts in what God has provided and does not put God to the test. They emphasise retraining rather than instant healing, as we learn to trust a God who wants our spiritual muscles to grow.

Contemplation has been suspect in some Christian circles, but they give a helpful description of a practice to detach from negative thoughts, and 'give your entire attention to what God is doing right now' (Matt 6:34, The Message). A very readable and therapeutic book.



Rediscovering a ministry of health

Parish nursing as a mission of the local church
Helen Wordsworth

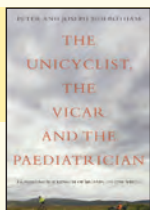
- Wipf & Stock, 2015, £16.00 Pb 208pp ISBN 9781498205955
- Reviewed by **Steve Fouch**, CMF Head of Nursing

The role of nurses as part of the ministry of the local church is not a new idea. It has been practised in the UK in one form or other since the start of the church and later by 'Bible Nurses'. However, with the advent of the NHS, the UK church has largely neglected its ministry in the health arena.

This book, adapted from the author's PhD thesis, is by the founding director of Parish Nursing Ministries in the UK. It explores whether parish nursing (as it is now most commonly called) actually has any impact on the mission of the local church.

Her research shows that while parish nursing itself may not be evangelistic, it does open the doorway for sharing the gospel, greater engagement in social action by the whole church and an integration of all areas of mission. It is one of a number of ministries of the local church, and one that needs to be rediscovered.

While some aspects of the book are quite academic, the historical context and key findings make interesting reading for anyone concerned to see the local church become more effective in its outreach.



The unicyclist, the vicar and the paediatrician

Peter and Joe Sidebotham

- Troubador, 2013, £8.95 Pb 144pp, ISBN 9781780885155
- Reviewed by **Sarah Maidment**, Trainee GP based in Oxfordshire

As a Christian doctor, a keen cyclist and having previously ridden the 1,000 miles from Land's End to John O'Groats, I felt adequately qualified to do this review. The book is written by a Christian Paediatrician, Peter Sidebotham, who tells the story of his 16-year-old son, Joe, as they ride together from Land's End to John O'Groats on a unicycle.

The opening chapters recount their less-than-perfect training and preparation for this epic adventure. Joe and his dad are by no means 'seasoned cyclists'. Joe would probably describe himself more as a 'stunt man', having found his way into unicycling via circus skills workshops.

Spurred on by pledges of sponsorship (for charity), an exciting challenge and Joe's enthusiasm, the unicyclist [Joe,

on one wheel], the Paediatrician [Peter, on two wheels] and the Vicar [60-year-old David, on a three-wheeled recumbent tricycle] begin their journey from Land's End.

Even the best travel authors and most highly-acclaimed cycle-tourists at times struggle to captivate their audience, as they write about what can become a fairly mundane trip from A to B, ticking off the miles. Peter's account is interspersed with snippets from Joe's audio-blog, telling their story from different viewpoints. Their journey is interspersed with mishaps and unfortunate events, which make a compelling read. I was disappointed by the amateur style of writing but could not help feeling impressed by their efforts, with a real sense of 'good for them', for what they had achieved.



Openness unhindered: Further thoughts of an unlikely convert on sexual identity and union with Christ

Rosaria Champagne Butterfield

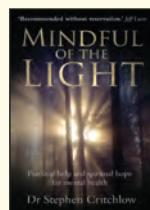
- Crown & Covenant Publications, 2015, £6.65 Pb 209pp, ISBN 9761884527999
- Reviewed by **Trevor Stammers**, Programme Director in Bioethics and Medical Law, St Mary's Twickenham

This book certainly lives up to its name as a former lesbian activist turned Christian author, homemaker, mother and wife shares her life experience and wisdom with a remarkable balance of openness and integrity.

She comes across as honest without being in any way sensationalist as she writes about issues relating to Christian and sexual identities, the meaning of repentance and conversion, the importance of our terminology and how it can unwittingly mislead more than we realise – she has some very interesting insights into the use of 'gay Christian', and she is

very sober in her appraisal of gay therapy.

This caution springs from her conviction that living in community as the body of Christ is the most important thing that transforms our lives as Christians, and hence should exert a more powerful demonstration of the gospel in our society. Her prayerful, practical and loving commitment to her own neighbourhood was one of the most challenging aspects of the book to me. If we all lived that way, how much emptier our surgeries and clinics would be of those whose sickness is basically that no one truly cares for them.



Mindful of the light

Practical help and spiritual hope for mental health
Stephen Critchlow

- Instant Apostle, 2016, £8.99 Pb 224pp, ISBN 1909728446
- Reviewed by **Ken Yeow**, Consultant Psychiatrist based in Belfast

I found this to be an extremely helpful book. It makes a vital contribution to the important area of mental health and spirituality. The material has developed out of a series of talks that the author presented in various settings and this helps make the writing very readable. There is systematic coverage of six important mental health issues (stress and anxiety, depression, suicidality, addictions, schizophrenia, dementia). For each topic Critchlow presents a chapter containing core, empirically-validated information followed by a chapter on the spiritual help potentially available.

There is a balance of clinical acumen honed from years of frontline psychiatric practice at

senior level as well as deep pastoral sensitivity arising from mature Christian discipleship and ministry. Chapters are brought to life by ample illustrations and case studies. Resources for further exploration are suggested.

I think this book can have wide application. Those who struggle will find good information and comfort. Those who care for them will be resourced to provide well-informed help. Every church leader would benefit from having a copy to refer to. Because of its practical utility and grace-filled essence, this is one of the books that I am able to heartily recommend to those with any interest at all in the interface between Christianity and mental health issues.

WHO seeks new Director General

Euty chus notes that the search is underway for a new Director General of the WHO. The appointee will be elected at the WHO Assembly in May 2017, succeeding Margaret Chan who's been in the job for ten years. Despite many commendable achievements, Chan's administration attracted sharp criticism for sluggishness in responding to the Ebola crisis and WHO was forced to re-shape emergency protocols. This is a huge role in a huge organisation and Christians in global healthcare are encouraged to take a prayerful interest in the search process and its outcome. *WHO news release*, 21 April 2016 bit.ly/1r3I5dG

Lack of beds affects mental health services

Freedom of information requests are proving something of a thorn in the side of the NHS. Apparently they are up 13% since 2014. Moreover data unearthed through these requests showed that nearly 5,500 mental health patients had to travel out of their area due to lack of hospital beds. Some had to travel more than 300 miles. While it can at times be appropriate to send a patient outside their area, especially for highly-specialised care, sending people a long way out of their local community means risks, including risk of suicide. *BBC Health*, 20 May 2016 bbc.in/1U40zRW

End of polio?

Some 150 countries are taking up a new polio vaccine which, according to healthcare campaigners, signals a key milestone toward eradication of this terrible disease. There were just 74 cases of polio in 2015 and ten so far this year. All of the cases were in Afghanistan and Pakistan. Africa has been free of polio for more than a year. The new vaccine is taken via drops in the mouth so requires minimal training for those administering it. Even so, switching to a new vaccine is a huge logistical exercise. *BBC Health*, 17 April 2016 bbc.in/1MB2SPE

Health of indigenous peoples

A landmark study from 23 well-off countries shows that the health of indigenous or first nation peoples is often little better than those living in resource-poor countries. Data on the health and wellbeing of almost half of the world's indigenous and tribal peoples is captured in this joint project by the *Lancet* and Australia's Lowitja Institute. Factors assessed were: life expectancy at birth, infant mortality, maternal mortality, nutritional status, educational attainment and poverty. 'Indigenous people should not just be brought to the table, but be co-designers in solutions,' the study said. *Guardian*, 21 April 2016 bit.ly/1qEVybg

Loneliness linked to stroke

Loneliness is a public health issue, raises the risk of stroke and should be treated as a public health problem like smoking or over-eating, a new study from York University says. The research reviewed 23 studies involving 181,000 people. Lonely people, it claims, are 30% more likely to suffer stroke or heart disease. It has been linked to a compromised immune system and high blood pressure. 'Addressing loneliness and social isolation may have an important role in the prevention of two of the leading causes of morbidity in high-income countries', claimed York's University's Dr Nicole Valtorta. *Telegraph*, 19 April 2016 bit.ly/1pfmoG1

Who cares for carers?

Numbers of people in their 80s and beyond who are relied on as carers has rocketed in the last seven years according to Age UK. It claims one in seven of 'oldest old' - nearly 420,000 people, provide some sort of unpaid care for family or friends, with half of them give more than 35 hours a week. Needless to say, many report being exhausted and worried about how long they can carry on. The findings come from an annual representative household survey of 15,000 people aged 60 and more. *BBC News*, 18 May 2016 bbc.in/23WDh68

Change of scene

China's population police used to be notorious. Stationed in every community, they hunted down families who defied the draconian one-child laws. They had powers to levy heavy fines and even order abortions without anaesthetic. Now, after 35 years, China has realised the folly of this policy; it created a lopsided male-female population balance and generations of hostile and dysfunctional males denied a marriage partner. Now, former officers are being redeployed, teaching families to develop the minds and social skills of their toddlers through talking, singing and reading to them. *BBC News*, 4 May 2016 bbc.in/23qWegQ

Alcohol, good for you?

Not so. Studies suggesting that moderate drinking of alcohol brings health benefits are flawed, new research claims. Earlier studies suggested a glass of wine a day reduced hazards such as risk of heart disease. A review of 87 past research papers concluded, however, that these studies were flawed - biased and poorly designed. One researcher in the Canadian team conducting the review said, 'There's a general idea out there that alcohol is good for us, because that's what you hear reported all the time, but there are many reasons to be sceptical.' *CBS News*, 22 March 2016 cbsn.ws/1Pox7nc

Probiotic ballyhoo

For many, a daily swig of a probiotic drink is a bit like a religious act. Makers of Yakult, Actimel and the like have built a £20billion global industry. Six in ten British households use them. Now scientists say there is 'no convincing evidence' of benefits for healthy people. Danish researchers reviewed seven trials. Their conclusion: they made little difference to the make-up of the gut's bacteria in most cases. In six of the seven trials there was no difference in the bacteria between adults given probiotics or placebos. *Daily Mail*, 10 May 2016 dailymail.com/1T7Ing8

'Wellness' scam unmasked

On the theme of ballyhoo, *Euty chus* notes that the Australian state of Victoria's consumer watchdog has initiated legal action against 'wellness' blogger Belle Gibson (see 'Wellness': a new gnosticism, *Euty chus*, *Triple Helix*, issue 65). Gibson initiated an elaborate scam, launching a book and lifestyle app, *The Whole Pantry*, where she claimed she beat brain cancer using natural remedies. 'None of it's true,' she finally admitted. She faces costs of up to £500,000 in fines and legal fees. Alarming, her publisher, *Penguin*, failed to properly investigate her claims. *Guardian*, 11 May 2016 bit.ly/1q2Qf4V

Treating children with muscle tone issues can mirror God's compassion says **Peter Sidebotham**

HELP WITH LEARNING TO WALK

As a paediatrician, I am often referred young children who are delayed in their development, including those who are slow in learning to walk. This may just be a mild developmental delay, the child taking time to acquire the skills and confidence or motivation to walk. Sometimes there is an underlying medical disorder preventing them from acquiring those skills. These children typically fall into one of two broad groups: those with low muscle tone (hypotonia) and those with high muscle tone (hypertonia).

Children with hypotonia have weak, floppy muscles which are unable to support their weight effectively. We find this, for example, in children with Down syndrome. Those with hypertonia, such as children with some forms of cerebral palsy, have stiff, inflexible muscles. They find it equally difficult to walk, but for different reasons: their muscles, though stiff, are still weak, and they cannot easily achieve the coordination and balance to stand upright.

When I am assessing a young child's ability to stand and walk, I need to provide support and a stable base so that the child feels secure. In order to do this, I typically sit or kneel on the floor, with the child sitting between my legs, back to me. When the children sit like that, they feel secure and safe. Hypotonic children are held stable and seem somehow to gain confidence and motivation; those with high muscle tone often relax, enabling me to move their legs and assess the muscle strength.

Once I have the child properly relaxed, I will gently lift it to a more upright position, the trunk still supported against me, my arms around the waist, to keep the child from falling. In that position, the child can feel secure and is able to take some weight on the legs, perhaps even taking some preliminary, supported steps.

I often think of God being like that with me. In my spiritual development, I may feel weak and hypotonic, unable to stand up in the face of difficult challenges. Or I may try too hard, my hypertonic spiritual muscles getting in the way of my attempts to go forward. I may feel insecure and afraid of falling or getting things wrong, or I may have already been hurt by life's events and be feeling a bit bruised and battered. In all these situations, I picture God as a heavenly paediatrician, holding me securely in his embrace, giving me the strength and courage to take those first, tentative steps.

That is the picture conveyed by Hosea's passionate words of God's love for the people of Israel: 'It was I who taught Ephraim to walk, taking them by the arms'.¹ God is someone we can trust, who will not let us fall. Secure in God's loving embrace, we can step out, even into the hardest of situations.

Peter Sidebotham is Associate Professor of Child Health, Warwick

references

1. Hosea 11:3

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