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for today's Christian doctor

triple helix

at what cost?

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The blessings of marriage

Why marriage continues to matter

Marriage leads to better family relationships, less economic dependence, better physical health and longevity, improved mental health and emotional well-being and reduced crime and domestic violence.

These are the (unsurprising) main conclusions of a new report[1] on the benefits of marriage from the Institute of American values.

Based on a survey of over 250 peer-reviewed journal articles on marriage and family life from around the world, a team of 18 leading American family scholars chaired by Professor Wilcox of the University of Virginia has drawn 30 conclusions about the positive benefits associated with marriage under five headings.

Each of the conclusions is substantiated in the report and 20 pages of supporting references can be downloaded from Institute of American Values' website.

Amongst these conclusions are:

- Marriage, and a normative commitment to marriage, foster high-quality relationships between adults, as well as between parents and children.
- Children who live with their own two married parents enjoy better physical health, on average, than do children in other family forms.
- Marriage is associated with reduced rates of alcohol and substance abuse for both adults and teens.
- Marriage is associated with better health and lower rates of injury, illness, and disability for both men and women.
- Children whose parents divorce have higher rates of psychological distress and mental illness.
- Married women appear to have a lower risk of experiencing domestic violence than do cohabiting or dating women.

The findings of the landmark 2006 report 'Breakdown Britain'[2] were similar. Based on an extensive evidence-based analysis by the Centre for Social Justice[3] it found that the breakdown of marriage and the family was the key driver of Britain's collapse.

The percentage of children born outside marriage went from 8% in 1970 to 41% in 2003 to 46% in 2009[4]; lone parent families have increased by 40,000 per year since 1980.

Many of the mental and physical health problems that daily fill our GP surgeries, hospital wards and outpatient departments are symptoms of this. The main drivers, the five 'pathways to poverty', are all correlated with the collapse of marriage: family breakdown, educational failure, economic dependence, indebtedness, and addiction.

Furthermore the five 'pathways' are all interrelated. Children from a broken home are twice as likely to have behavioural problems, perform worse at school, become sexually active at a younger age, suffer depression, and turn to drugs, smoking and heavy drinking. A parent who has a serious drug problem or is addicted to alcohol can exhibit destructive behaviour patterns which can destroy the quality of life for the other parent and for children, leading in turn to family breakdown.

Solutions must be multi-layered. We need sound legislation to strengthen and protect the vulnerable, a welfare system that helps those in genuine need and encourages independence, active corporate philanthropy and flourishing voluntary organisations. All levels of society including government, the corporate and charitable sectors, communities, and families have a role to play in reversing the decline. But government, charities and business are increasing failing to deliver in Britain's increasingly indebted and fragmented society.

That is because the breakdown of Britain and its five 'drivers' are themselves symptoms of a more general spiritual malaise – a loss of Christian faith and values leading to a breakdown of marriage and family. The church has a huge role to play; not just in what it does directly to support families in the community, but through the actions of individual Christians in positions of influence in health, education, local councils and government.

But more than this the church has at this time an amazing opportunity to model marriage and family to a society where alternative models have failed.

Marriage is a virtually universal human institution because it was originally God's idea. It was God who first said that it was not good for man to be alone and who created the unique complementarity of the marriage relationship for companionship, pleasure, procreation and the raising of children – one man, one woman, united for life[5] – illustrative of Christ's own self-giving abandonment to his bride the church[6] and pointing to a greater richness of human relationships beyond the grave of which the very best on earth are but a pale shadow.[7]

Let's celebrate, demonstrate, promote and protect marriage as the vehicle of blessing that it is for husbands, wives, children, parents, extended family, community and ultimately the world.

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

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Organ donation after death

Presumed consent controversies

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

The issue of organ donation after death has sparked a number of media news stories recently. There is a real shortage of organs available for transplant which has led to several proposals intended to increase the supply of organs.

The Welsh Assembly plans to introduce 'presumed consent' to organ donation within five years.[1] A public consultation on this begins soon. If Wales introduce it, then the rest of the UK is more likely to follow suit. The Northern Ireland Health Minister has said he would like to introduce presumed consent in Northern Ireland.[2] The BMA debated organ donation at their Annual Conference this year, voting to support presumed consent.[3]

Currently, individuals in the UK can only donate their organs after death if they have registered as a donor. Under a 'presumed consent'[4] law every person would automatically become an organ donor on death, unless he/she has specifically registered to 'opt out'. The Welsh Assembly is advocating a 'soft' system of presumed consent, in which relatives would be able to veto organ donation even if no formal objection to it had been made by the deceased person.

Adding to the debate, and offering another possible solution to the organ shortage, the Nuffield Council on Bioethics has suggested that the NHS could pay the funeral expenses for those who sign the Organ Donor Register and subsequently become organ donors on their death.[5]

CMF submitted a response to the initial Welsh Assembly consultation, setting out in more detail our thoughts on this issue.[6] In essence, while we fully support organ donation and welcome the increase of registered organ donors in the UK (30% are now registered, 18 million in total[7]) we are concerned that a system of presumed consent effectively equals no consent, unless there were to be an extensive public information programme, capturing the entire adult population, including those on the margins of society. Without this, it would be impossible to ensure that those who do not opt out have made a positive choice, rather than doing so by default, by ignorance, or by a lack of knowledge or understanding. Without consent, donation becomes 'taking' organs rather than 'giving' them.

There are further issues around the ascertaining and timing of a diagnosis of death, about bodily integrity, about trust in professionals and about the role of donation as an altruistic gift. It is also questionable whether legislative changes are necessary, or whether structural changes that make it easier to donate are effective.

As the pressure to increase donation rates grows, we need to ensure that organ donation after death remains a genuinely altruistic gift. If there is any undermining of this gift, either through a hint of financial incentives and/or an element of felt duty, the gift principle will be undermined fundamentally changing the nature of the exercise.

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Judge rules in favour of life in M case

Encouraging but not surprising

Review by **Peter Saunders**
CMF Chief Executive

On 28 September the Court of Protection ruled in favour of life in the case of M, a 53 year old woman who suffered severe brain damage as a result of viral encephalitis in 2003.

M's sister and partner wanted artificial nutrition and hydration (ANH) given via a gastrostomy tube to be stopped with the explicit intention of ending her life. But the PCT caring for M and the Official Solicitor opposed them.

Since the 1993 Tony Bland decision,[1] 43 patients with permanent vegetative state (PVS) have died following court rulings to remove ANH but M was the first case with minimally conscious state (MCS), the next step up from PVS, to come before the courts.

In his judgment[2] Justice Baker found that M had some awareness of herself and her environment, and some understanding of language. She occasionally spoke, appeared to be able to appreciate some things that were said to her, and responded to music. She regularly experienced pain, but this was not constant or extreme, and her condition was stable. The prospect of any significant improvement in the level of consciousness was remote.[3] In reaching these findings he found, not surprisingly, that the carers who had daily contact with M had the greatest insight into her condition. It was their observations that squared most accurately with the more objective results from the 'Sensory Modality Assessment and Rehabilitation Technique' (SMART) and 'Wessex Head Injury Matrix' (WHIM) assessment tools.

The judge applied principles established by previous cases and affirmed by the Mental Capacity Act 2005 (MCA). ANH can only be removed if it is in the best interests of the patient[4] and the burden of establishing this rests on those who want it withdrawn.[5] In determining best interests a balance sheet approach is used,[6] but the assessment is holistic, including not just medical considerations, but also the patient's wishes, feelings, beliefs and values.

M had not given any indication before her injury about how she might like to be treated should she lose capacity. This meant that the deciding legal principle was the right to life. Justice Baker concluded: 'the principle of the right to life is simply stated but of the most profound importance. It needs no further elucidation. It carries very great weight in any balancing exercise.'

The decision was not surprising. The key problem enshrined in the MCA remains – it already allows legally binding advance refusals of ANH placing some vulnerable patients at risk – but this case has not taken us further down the slippery slope.

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GMC consultation on 'Good Medical Practice'

Christian doctors should study the draft guidance and respond

Review by **Peter Saunders**
CMF Chief Executive

The General Medical Council in October launched a consultation[1] on the new draft of 'Good Medical Practice', its core guidance for doctors. The guidance, which was last published in November 2006, is reviewed every five years.

Anyone can respond and questionnaires are available on line. The consultation closes on 10 February 2012 and a new edition will be published later next year.

The draft guidance runs to 22 pages, quotes 18 other GMC documents and includes 83 numbered paragraphs. These outline doctors' responsibilities under four main headings: 'Knowledge, skills and performance', 'Safety and quality', 'Communication, partnership and teamwork' and 'Maintaining trust'.

Doctors have a duty to be familiar with the guidance and to follow it (p3) and are warned that 'serious or persistent failure' to do so 'will put your registration at risk' (p5).

Most of the content is reproduced from the previous edition, although there is some rearrangement of material meaning that direct comparisons are not straight forward.

Christian doctors will be encouraged to see a cursory nod (p13) to the importance of 'spiritual, religious, social and cultural factors' in history taking but will be wary, in an environment of growing hostility to biblical faith and values, to potential booby traps around the old chestnuts of sharing faith and referring patients for unethical procedures like abortion. Few will take issue with the requirement to 'treat patients fairly and with respect whatever their life choices and beliefs' (p49) but I wondered why 'advising patients on the effects of their life choices on their health' (p51) was presented as an option rather than a duty. The now familiar prohibition on expressing personal beliefs (including political, religious and moral beliefs) to patients 'in ways that exploit their vulnerability or that are likely to cause them distress' is repeated but the real question will be how patient complaints are to be handled.

There is a duty not to 'unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange' (p60) along with a duty to report colleagues to employers and regulatory bodies if they are felt to be denying patients their rights (p22). There is also a duty to 'give patients the information they want….' (p31)

The paragraph on conscientious objection (52) attempts to strike a balance between the right for a doctor not to participate in procedures he or she believes to be immoral and the duty to inform patients of their right to see another doctor and to 'ensure that arrangements are made for another suitably qualified colleague to take over'.

I encourage all CMF members to study the wording of the guidance carefully and to respond. Once set in stone it will be the standard we are all judged against.

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Crisis in care?

The way of the Cross is the answer

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

The last few months have seen a series of reports from the Care Quality Commission (CQC)[1] and the Equalities and Human Rights Commission[2] showing that care for the elderly in our hospitals, care homes and even in people's own homes is falling far short of even the most basic acceptable standards.

This lack of care takes many forms, from call bells being deliberately placed out of reach, to curtains not being closed properly when patients were on bed pans or having bed baths. Elders being cared for at home were given the option of either getting dressed, washed or having a meal, but not all three!

We have also seen examples of blatant abuse, such as that at Winterbourne View where people with learning disabilities were physically and psychologically abused by staff on a systematic basis.[3]

While the negative aspects of these reports get the public's attention, often overlooking the majority of examples of good care, there is little doubt that there are real problems. Some are systemic (shortage of staff, a proliferation of providers, increased demand and funding that cannot keep pace). Others are more cultural; a society that does not value the elderly and disabled; a targets driven NHS more concerned with ticked boxes than people, etc. The CQC have also highlighted the failure of leadership at every level from NHS Trust Boards to clinical leadership at the ward level.

While action by government, regulatory and professional bodies is essential to improve these standards, there is also an individual professional responsibility. As CMF member Sarah Howles wrote in a recent piece for the CMF blog:[4]

'...as I lead that ward round, what am I teaching everyone with me? I'm telling my juniors that we as doctors shouldn't bother with people once we've "fixed" the list of medical problems. I'm showing them that if someone's a bit confused then there's no point in listening to them. I'm saying that if something's not "our job" we shouldn't engage with the problem. And it's not just the doctors who will be watching me; I'm showing the nurses and other ward staff what I think is an acceptable way to look after people. I'm modelling how to protect my own time and not work as a team.'

In the NHS's target driven culture and limited resources it is easier to follow the path of least resistance rather than modelling a more difficult, Christ-like approach to caring. This is the leadership we need in the NHS. As Paul puts it:

'In humility consider others better than yourselves. Each of you should look not only to your own interests but also to the interests of others.'[5]

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Helen Barratt explores the ethical dilemmas facing Clinician-Commissioners

AT WHAT COST?

STEWARDSHIP AND COMMISSIONING

key points

A key element of the NHS reforms will be the transfer of commissioning from Primary Care Trusts to the new Clinical Commissioning Groups (CCGs).

The author explores the ethical dilemmas that clinician commissioners will inevitably face due to the conflict of interest between commissioning for a local population and seeking the best treatment possible for an individual.

A reminder that good palliative care provides an alternative approach to high-cost drugs (with limited effects) raises the question over which is preferable in the light of the biblical mandate for good stewardship. Many complexities remain and discernment will be required when making decisions that impact individuals and whole communities.

Brian comes to see you in your Monday morning surgery. His wife Carol has colorectal cancer with hepatic metastases. All other treatments have failed, but her oncologist has recommended a monoclonal antibody therapy that costs over £10,000. Although the National Institute of Health and Clinical Excellence (NICE) is unable to recommend the use of this medication in these circumstances,[1] *the oncologist feels it might extend Carol's life by two or three months. The application for funding is currently being considered by your local Primary Care Trust (PCT) and Brian asks you to chase up the request. They have read about a patient in another part of the country for whom the drug was funded, and Brian argues that surely Carol therefore also 'has a right' to receive it.*

One of the key goals of the coalition government's NHS reforms is to shift the power for healthcare decision-making to frontline clinicians. Following the listening exercise and recommendations from the NHS Future Forum, clinical commissioning groups (CCGs) will take on the current responsibility of PCTs to purchase care on behalf of their local populations. CCGs will be composed largely of representatives from groups of GP practices, working alongside patient representatives and other healthcare professionals.

The future of commissioning

Although greater clinical involvement in commissioning has been welcomed by many, the new arrangements pose novel questions for the doctor-patient relationship, as the hypothetical case study about Carol and Brian illustrates. In the past, hospitals have received payment from the PCT for most of the care they provide, according to a national tariff that sets prices for services rendered by the NHS. Requests for treatments which are excluded from the tariff were submitted for consideration to the PCT. Examples include high cost drugs - specialist therapies whose use is often concentrated in a relatively small number of centres. If the use of a treatment was approved by NICE, PCTs would typically approve the request automatically. If, however, the drug did not have the approval of NICE, the request would be considered by a panel of PCT staff including, for example, representatives from commissioning, primary care, public health and pharmacy. The panel would consider evidence relating to the efficacy, safety and cost-effectiveness of the drug as well as the 'exceptionality' of the patient – are they significantly different from the average patient? Are they likely to gain significantly more benefit than the average patient?

Alongside the proposed changes to the way care is commissioned, a Cancer Drugs Fund was intro-

duced in April 2011 'to help cancer patients get greater access to cancer drugs that their doctors recommend.'[2] £200 million will be available annually for cancer patients in England from April 2011 to the end of 2013, following a pre-election pledge from the Conservatives that patients would be able to gain access to treatments that had been denied to them by NICE. Concern has been raised that such a system could lead to 'postcode lotteries', or geographical variations in care.[3] The fund only applies to cancer drugs, but it is questionable whether or not it represents a good use of NHS funding, if the data about the clinical and cost-effectiveness of the drugs is limited.

At the same time, the government has also stripped NICE of its powers to decide whether or not patients should be given high cost treatments. It seems likely that, in the absence of NICE, CCGs will have to decide for themselves whether other drugs represent good value for money for their patients. The change in NICE's role was welcomed by the *Daily Mail*, with the headline '"penny-pinching" NICE stripped of power to ban life-saving drugs.'[4] In contrast, Polly Toynbee noted in *The Guardian* that 'GPs struggling with the new tensions of distributing a shrinking budget between all patients and conditions will now find it impossible to refuse monumentally expensive drugs that preserve one person's painful last few weeks at the cost of many other lives that could be greatly improved... Will GPs take the flak in their local press if they spend where it works – or cave in to public pressure?'[5]

Future challenges

High cost treatments represent only a small part of NHS care, but they raise particular difficulties. As in the case of Carol, many are therapies for cancer which offer sufferers the possibility of prolonging life. The circumstances are therefore often highly emotive. However, many of the conditions are rare and consequently it is difficult to perform large scale trials, so the evidence base is limited. At the heart of this also lies the tension that Toynbee describes. Commissioners are tasked with doing the best they can for their community as a whole, with a limited pot of money. In contrast, for clinicians, the patient in front of them is paramount. Going forward, clinician commissioners will have to seek to resolve this and communicate the decision to patients and their families, like Carol and Brian.

The ethicists Beauchamp and Childress propose that ethical challenges should be considered in light of their impact on autonomy, justice, beneficence ('doing good') and non-maleficence ('not doing harm').[6] Prescribing a high cost drug for Carol may be respecting her autonomy and right to choose, but at what price to the local healthcare economy? The prescription may also be considered to be just for her and her family, doing them good. However, is spending the money this way equally just and good for the community as a whole, particularly when resources are stretched? Finally, is prescribing a drug for which there's limited evidence really in the patient's best interests? Or is it creating false expectations, when a pragmatic discussion about palliative care options may be more appropriate?

Biblical stewardship

The Bible is clear about our role as stewards of God's creation.[7] With this comes a responsibility to be good stewards of the resources we have been given, and – by extension – a responsibility for those commissioning healthcare to use the funds entrusted to them wisely. We are also charged with a particular responsibility to support disadvantaged groups.[8] Paul's teaching in 1 Timothy 5 offers a guide for allocating scarce resources. In this passage the apostle discusses the distribution of resources to widows. Paul urges the church to 'give proper recognition to those widows who are really in need.'[9] He goes on to argue that the church should give priority to those widows with no other means of support available to them[10] and those with a past record of responsible behaviour and service to others.[11] However, how should CCGs define need? Would Carol be more 'in need' if she cared for an elderly relative? If she were a former intravenous drug user with hepatocellular carcinoma secondary to Hepatitis C, would there be grounds for not funding her treatment? Restricting treatments only to those who have no other means of support risks further marginalising those in society who are already disadvantaged, unless careful thought is given to the definition of 'no support'.

Decisions about whether to fund high cost drugs will form only part of the work of commissioning groups. However, they provide a useful illustration of the tensions that may be involved in making difficult decisions about which forms of care to fund. Many questions remain unanswered, but being good stewards of the resources God has entrusted to us will involve hard choices about how to simultaneously do the best for individual patients on the one hand and the whole community on the other.

Helen Barratt *is a specialist registrar in public health in London currently completing a PhD at University College London*

Clinical Commissioning Groups will have to decide for themselves whether drugs represent good value for money

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Philippa Taylor examines controversial research linking abortion with mental health

ABORTION & MENTAL HEALTH – THE EVIDENCE BUILDS

key points

The link between induced abortion and mental health problems has often been dismissed on the basis of lack of any compelling academic evidence however the author suggests this dominant view may be challenged by new research.

Coleman's review asserts that as many as 10 per cent of all mental health problems are directly attributable to abortion. Despite some questions regarding the methodology of the review the clear conclusion is that women should be better informed about all the potential risks involved.

Acknowledging that there are mental health risks for post-abortive women will be a major hurdle when the pretext for most abortions in the UK is the reduction of mental health problems for the woman.

The standard rhetoric that well designed studies have failed to show any adverse effects of abortion on women is being increasingly undermined by solid new evidence showing that there are indeed increased rates of mental health problems for women post-abortion, even where the pregnancy is unwanted and/or unplanned.

The question of whether abortion is linked to mental health problems has long been a topic of debate. The majority (98 per cent) of abortions carried out in the UK under the Abortion Act 1967 in 2010 were carried out on the premise that it is better for a woman's mental health to have an abortion than to continue with an unwanted pregnancy.[1] Any challenge to this premise would effectively suggest that most abortions are not justified under the Act.

Not surprisingly therefore, despite consistent anecdotal evidence to the contrary from counselling centres and testimonies of women[2] and research findings,[3] many academics and health professionals (not least the Royal College of Obstetricians and Gynaecologists) have refused seriously to countenance any challenges to the long-held belief that no well-designed studies show adverse effects of abortion on mental health. At most it is ceded that perhaps a few women might experience problems, but only if they manifest mental health problems *before* the abortion.

The recent, and important, draft review of this topic by the Royal College of Psychiatrists (RCPsych) did include a few studies that showed some negative effects however, in our view, their conclusions failed fairly to represent these studies and undermined their findings. CMF sent in detailed comments on this draft, which are available on our website.[4] The draft conclusion of the RCPsych is that there are negligible adverse effects on women post-abortion compared to post-pregnancy, except when women have prior mental health problems. Their final report, funded by the NHS, will be highly influential and is expected to be published in the autumn.[5]

However one academic, Priscilla Coleman, who has published extensively in academic journals on this topic for many years, and who was referenced in the RCPsych draft, has for many years produced findings suggesting a clear link between abortion and adverse mental health effects. Her latest paper, a systematic review of 22 studies[6] has, in part through our efforts at CMF, received considerable attention in sections of the media.

Coleman's latest findings are striking. She claims that nearly 10 per cent of all mental health problems are directly attributable to abortion. Her findings show that women with an abortion history experience nearly double the risk of mental health problems when compared with women who had not had an abortion. Even compared to women delivering an unintended pregnancy, post-abortion women still have a 55 per cent increased risk of mental health problems.

The study reports increased risks that abortion has for specific outcomes. For example, Coleman found that there is a 220 per cent increased risk

of marijuana use post-abortion, 155 per cent risk of suicide behaviours, 110 per cent risk of alcohol abuse, 37 per cent risk of depression and 34 per cent increased risk of anxiety disorders.

Coleman's work has a number of strengths. It has been published in the prestigious *British Journal of Psychiatry*, hence has passed extensive scrutiny by three peer reviewers prior to publication. It undertakes a meta-analysis of 22 published studies, it analyses 36 effects and brings together data on nearly 900,000 participants, 164,000 of whom experienced an abortion. It uses clear selection criteria and a good range of controls, including prior history of mental health problems.

Coleman's research also has a number of methodological weaknesses that have been criticised by researchers who have come to different conclusions.[7] Coleman herself acknowledges that research on abortion is unable to demonstrate causality because: '*when the independent variable cannot be ethically manipulated, as is the case with abortion history, definitive causal conclusions are precluded*'. She does however add that: '*as more prospective studies with numerous controls are being published, indirect evidence for a causal connection is beginning to emerge*.'

Prof David Fergusson, of the University of Otago, New Zealand, who has published some of the most robust research on abortion and whose work is cited in the RCPsych report (and who does not consider himself to be at all 'pro-life') counterbalances some of the criticisms against Coleman. He suggests, interestingly, that her critics '*…follow a well-trodden strategy which has been used in a number of reviews to dismiss any evidence suggesting that abortion may have adverse effects on mental health*' namely, by undermining the methodology used and playing down the strength of findings. Fergusson says Coleman has done the field a service in her research and concurs with her overall finding: '*There is a clear statistical footprint suggesting elevated risks of mental health problems amongst women having abortions*.' Fergusson even re-analysed the data because of the criticisms against Coleman, concluding that: '*It is our view that the scientifically appropriate and cautious assessment is that: there is currently suggestive evidence indicating that abortion is associated with modest increases in risks of common mental disorders*.'[8]

While it appears that there may be some methodological questions over Coleman's findings, it also serves to demonstrate that at present there is no evidence to suggest the counter argument, that abortion has no mental health consequences. Policies and strategies need to be put in place to ensure women are better informed about the potential risks of abortion. Coleman's modest recommendation is simply that clinicians should: '*… convey the current state of uncertainty related to benefits of abortion in addition to sharing the most accurate information pertaining to statistically validated risks*.'

Women have been told that abortion is an emotion-free, quick and simple lunch-time op. They have the right to be told that it is much more significant than this. They need to be informed that research shows that some will experience painful emotions, that some will develop alcohol and drug problems and that some will encounter relationship problems as a direct consequence. At the very least they should be told that there is a real lack of academic studies showing any *benefits* from abortion – despite the fact that so many are carried out on the presumption that abortion reduces mental health risks!

At the very least, the uncertainty in the evidence, and the possibility that abortion may carry significant potential adverse effects to women's mental health, needs to be conveyed to the public, otherwise women are being inadequately informed. While these statistically validated findings are not disseminated to the public, or are undermined for ideological reasons, then women are not in a position to give fully informed consent or make an informed choice about what pathway to take with an unexpected pregnancy. It is not simply a matter of different ideologies at stake here but the lives and emotional health of many women.

Coleman's research raises separate questions around counselling and its content, as well as the legitimacy of most abortions in the UK. Some of these questions have been the centre of heated Parliamentary debates recently which has served to raise the public profile and nature of counselling before abortion.[9]

A further interesting development is the campaign by *The Times* newspaper on adoption, which has recently gained the public backing of the Prime Minister. *The Times* recommends a number of measures to overhaul adoption, including the following: '*Adoption should be presented as an option by local authorities, pregnancy advisory services and charities to women who choose to continue with unwanted pregnancies, alongside the option of keeping the child with the support of social services*'.[10] Presenting adoption as a positive option and a genuine alternative pathway for woman presenting with an unplanned pregnancy, or properly supporting a woman in keeping her child, would give a woman in a crisis pregnancy genuine choices about the pathway to take, rather than feeling that her only real option is to climb onto the conveyor belt towards abortion. This is surely what being 'pro-choice' should be about.

While there is no doubt that abortion continues to be a major political, cultural and spiritual battleground, these small but significant developments which are helping to expose the real truth about the effects of abortion for some women, while offering genuine alternatives, should encourage us that change is possible. It is often the small acts and changes (in this case, through research, counselling, caring and prayer) that, when multiplied, will transform our world.

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

The possibility that abortion may carry significant potential adverse effects to women's mental health, needs to be conveyed to the public

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Richard Hain comments on 'Choosing to Die' Terry Pratchett's physician assisted suicide documentary for the BBC

Photo: PA

IS IT REALLY CHOOSING TO DIE?

key points

Responding to the BBC Documentary 'Choosing to Die' the author argues that assisted suicide is not an expression of autonomy but rather a capitulation to death.

The programme's biased editorial line did not allow serious and considered exploration of alternatives such as hospice care.

Media bias towards assisted suicide is now commonplace but offers nothing to soften the horror of death outside of Christ. When it comes to dignity in dying – the author argues that true dignity does not come from assisted suicide but rather from good palliative care.

To my frustration, I missed the original broadcast of Terry Pratchett's well advertised documentary 'Choosing to die'. Terry Pratchett's books line my shelves in serried ranks, despite the fact that I find both the narrative line and the literary quality of the stories inconsistent. Perhaps what makes them attractive – and leads so many, like me, to buy book after book – is what they reveal about Pratchett's own character. The stories are full of warmth and humour. They are shot through with a love for mankind in general, and most of the individuals in it in particular. Whatever one feels about them as literature, it is impossible to read any of the Discworld novels without developing an affection for their author.

This same compassion and warmth shone through in Pratchett's documentary, as he accompanied two individuals with life-limiting conditions on their final journey to Switzerland for assisted suicide. From the moment he met them at their homes in England, to the moment he said farewell to one of them and sat and accompanied the other while he died, it was clear that Pratchett cared deeply for them, despite having met them for the first time in the making of the documentary.

It is a matter of public knowledge that Pratchett himself suffers from a form of dementia that he expects to progress relentlessly until it causes his own death. Pratchett's own 'journey', as he considered whether he felt physician assisted suicide was right for him, was a sub-theme of the documentary that was handled sensitively and well.

I am a palliative care physician working exclusively with children. I have a strong academic and practical interest in ethics and recognise the validity of a distinction between euthanasia and physician assisted suicide. So I did not begin to watch the programme with any firm prior moral conviction about the latter. But by the end, I found my views had resolved into a clear feeling that, whatever other ethical arguments there may be, any claim that assisted suicide is an expression of autonomy is a false claim.

The editorial line was clear and unabashed; that physician assisted suicide is a good thing towards which the United Kingdom should strive to move.

For me, however, this clear narrative contrasted markedly throughout with the feelings of those taking part in the documentary. Pratchett referred to the death of one of the individuals as a 'happy event' - but to me as a viewer it didn't feel happy.

The death took place in a soulless generic living room housed within a unit on an industrial estate. His wife, who was physically present in the room at the time, seemed curiously excluded from the proceedings; much more so, indeed, than the doctor who was assisting the suicide. While the doctor sat close and comforting, the patient's wife appeared profoundly ill at ease, almost poised to flee, caught perhaps between her love for her husband and an instinctive urge to run away. Pratchett himself stood awkwardly on the edge of the tableau, demonstrating an endearingly English discomfort at being present at what should have been a private and emotional scene. Afterwards, Pratchett dubbed the suicidee 'a brave man', an imputation of heroism which seemed at odds with his scripted assertion that the death had been a happy event.

To be fair, much of what made it seem cold and clinical was beyond the control of those facilitating the suicide, dictated by controls put into place by the Swiss government. For Swiss natives, the procedure would have been carried out at home; it is only foreigners who are condemned to this sort of motel-room death. The Swiss authorities, explained Pratchett, wanted to make sure uncontrolled deaths were not being conducted in secret isolation.

For me, what was disappointing about the documentary was that alternatives to physician assisted suicide were not seriously considered. A nod was given to good quality hospice and palliative care, in the form of Pratchett's interview with a retired cab driver in the advanced stages of motor neurone disease. The cabbie's insistence that his life was still fun was self evidently true. It shone from his face and sounded in his laughter. Death was conspicuous in the cabbie's conversations by its absence. Instead, he seemed effortlessly to illustrate a triumph of life over illness, and freedom over physical frailty. He radiated the joy of his physically constrained life. Combined with Pratchett's own gift for putting people at their ease, this *joie de vivre* resulted at one point in a dialogue in which Pratchett encouraged the patient to describe the route he would take on a cab journey given to him by Pratchett. The cabbie unerringly described the route, then paused and grinned before asking Pratchett for the fare!

Despite Pratchett's attempts to find it, triumph and freedom and humour were conspicuously absent from conversations with the other patients. One of the patients admitted 'I feel I have no choice'. He seemed to see assisted suicide as an unavoidable solution to a problem; what emerged for me was a sense of his feeling utterly beaten by his disease, made worthless by incurable illness. Furthermore, despite Pratchett's assertion that this was 'an heroic act', both patients showed a curious lack of interest in the feelings of those around them. Each admitted that his family was unhappy about the decision they had made, but seemed to dismiss those feelings as irrelevant. Again, Pratchett's use of the term 'heroic' to describe it perhaps owed more to his own generosity than to any merit in the act of assisted suicide.

Pratchett himself made the only allusion to another of the alternatives when he said: 'My wife says that she wants to care for me. But I'm not sure she knows much about assisted dying'. Perhaps not, Terry, I wanted to yell, but she does know about love and caring, and probably quite a lot about dementia by now. And she is certainly an expert in Terry Pratchett. She knows what it will mean, and she knows she wants to do it – as do many, many people caring for family members who are terminally ill.

So, to me there was a contrast between the editorial line taken by the documentary and what came over intuitively as the real feelings of the people involved. It's always a risky business second-guessing other people's feelings, of course. But to me, this documentary did not leave me with any sense that physician assisted suicide was an expression of autonomy. To me, it seemed simply what was left for people who felt there were no longer any choices they could make. And one choice is, in fact, no choice at all. I was left with an overwhelming sense of greyness, sadness, loss and failure.

There was a moment of light when one of the two patients said he thought Switzerland was beautiful and rather wished he could spend some time looking around. But no, he said wistfully, I have an appointment. They did not seem to me the voice, or the words, of a man who felt himself to be free.

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Photo: Katherine Hain

This documentary did not leave me with any sense that physician assisted suicide was an expression of autonomy

UK media – choosing their words carefully

Since 2008 the BBC has screened five programmes portraying assisted suicide in a positive light. The BBC and others such as Dignity in Dying seek to manipulate the emotions of their viewers/readers through carefully chosen language.

Taking the M case as an example – the BBC reported that the judgment was a 'refusal to allow M to die' as though it was against the will of M; as though M desires to be allowed to die and is frustrated by the decision to maintain and support life. Perhaps more accurate reporting might state the judgment was a refusal to allow M's life to be ended.

In this reporting issues of autonomy are glossed over and there is a conflation of the concepts of actively killing a relative and allowing that relative to die. These are of course quite different ethical concepts.

Andrew Miller describes a typical night on duty as a Street Pastor

A NIGHT ON THE TOWN

key points

Street Pastors is an initiative set-up by Ascension Trust in 2003 as an inter-denominational Christian response to gang culture, alcohol misuse and anti-social behaviour on the streets of London.

The movement has grown to over 220 groups in the UK and abroad. Each local group is made up of Christian volunteers who provide weekend night patrols offering support and help to people who endanger themselves through drunkenness.

Many of the young people who receive help from the patrols are deeply affected by the simple acts of kindness and compassion; leading the author to compare his experiences on patrol with the parable of the Good Samaritan.

Alcohol misuse is a national public health priority. Alongside the significant health problems that can result from heavy drinking, alcohol misuse also results in a variety of other negative outcomes, including social disorder and crime. It is estimated that alcohol misuse costs the NHS £2.7 billion in 2006-07. Emergency services, including ambulance services, together bear almost a third of these estimated costs.[1] 70% of Emergency Department (ED) attendances between 12 and 5am on weekend nights are alcohol-related.[2]

Street Pastors is an inter-denominational initiative aimed at tackling the effects of anti-social behaviour, including alcohol misuse, by engaging with people on the streets and in night-time venues. Volunteers from local churches patrol town centres in over 150 locations in the UK helping those who are lost, disorientated or unwell, calming potential conflict situations, and even handing out flip-flops to girls struggling in high heels.

Although it is difficult to attribute complex outcomes to single interventions, there has reportedly been a reduction in street crime in areas where the Street Pastors operate, as well as reductions in ambulance callouts, reducing the burden on EDs. The initiative has won a number of awards, and received praise from a range of sources including Boris Johnson, Mayor of London.[3]

The Street Pastors initiative is supported by Ascension Trust and each local group is co-ordinated by churches in the area. Street Pastors come from all walks of life and are supported during each patrol by a team of local prayer partners.

Diary of a Street Pastor

01.20: Back on the streets again after our half-time debrief and prayer time. We reprimanded our team leader for only providing biscuits; one of our two 83-year old women (known on the streets as 'The Legend') does do a wonderful lemon drizzle cake, but this was not one of her nights – pity. With it being the first night of a bank holiday, it is much busier than usual. Last week there had been a big confrontation outside Revs night club, with a lot of police and dogs, so we prayed for a peaceful evening. It is exceptionally rare for any SP to be assaulted, and we get good training on conflict-avoidance.

01.25: My partner for this half is 'H', who is very experienced. She decides to go off the normal beaten track (explains that she feels we should) and sure enough we spot a group of black young men who are easy to engage with. As with so many, they are curious and baffled as to why we do this, what do we get out of it and so on. H asks me to answer this; I explain that we are volunteers from local churches and that we do it for nothing; this is completely outside their experience. One bizarrely mentions Paul and Ephesus, so H uses the

opportunity to say that we do what Jesus would have done.

01.40: Back on our standard beat and I am preparing to walk past a young mixed-race man on his own but H senses we should stop and it turns out that he has had a bad evening. He has been visiting his brother with mental health problems, his mother has recently died of lung cancer, he is losing weight so is worried that he also has cancer, he only moved here recently, hasn't got a GP, he himself has mental health problems... I explain my medical background so that we can offer him practical suggestions. It seems opportune to offer him prayer, and he gladly accepts this. So I ask Father God to pour peace into his mind, into his body, into his heart; I do love praying with people, although it is only appropriate occasionally. We explain that our team is around every Friday and Saturday night if he wishes to chat to us on another occasion; we often get very positive feedback about previous encounters.

01.50: As we carry on up the High Street, I check with H whether it was OK to mention my work - she was very positive about it. It's really useful to bounce things off each other so that we can sharpen up and keep learning. One of the great things about this work is those you partner, 43 of us from 23 churches of widely different traditions; lots to discuss in-between contact with the 'customers'. We also often chat to club security staff, plus workers in the taxi firms and food outlets.

01.55: Standing at the bus stop where people congregate for the night bus. It's the night before a big Man United – Barcelona match, so three rather drunk men start quizzing us about football. Amazingly, I somehow knew that Barcelona had recently crushed Real Madrid 3-1, and we also talked about the Wembley Stadium. Rather winging it, but a good chat. Here I am, three times their age, a foreigner to their culture, never done anything before beyond the Church, never striking up conversations with people on the Underground; but I love it, and it isn't difficult to initiate conversations with these young people after all. Mind you, the twelve Saturdays of required training was very valuable, even though a major commitment, and made me realise that perhaps I could do it after all.

02.00: Twice now we have given out flip-flops to girls who have been partying so hard in their high heels that they are having to go home in bare feet. I personally kneel down to place the flip-flops (a revolting pink colour) on the ground for them, so that they don't need to bend down. A simple act of compassion, but the recipients often are profoundly affected. One of our team has told us that what motivates him is the opportunity to get in the dirt with Jesus.

02.15: H has just finished a long conversation initiated by a woman who is interested in what we do and clearly is happy to chat. Nothing particularly 'spiritual' comes up; which sometimes is the case for the whole evening. Still, even when we have not specifically shared the words of Christ, we are pervading his aroma, and people notice, much more than we usually recognise.

02.20: We have gone past Revs and start chatting with a group of black men who have just come out. They explain that the club does garage music on the first floor and junk music on the second. We admit ignorance to these (apparently my son's hip-hop is now so yesterday) so one of them plays us some from his mobile phone. So there we are, almost opposite the police station bopping around. Maybe the next time they encounter Street Pastors they will want to talk further...

02.30: As we walk up the High Street again there are two girls chatting to each other, and we are about to walk on when I sense that one has been crying, so we approach them. H discovers that she is feeling very ashamed for vomiting over her friend. I hand her a tissue from my pocket, and H gets out a plastic cup and bottled water from our rucksack which she appreciates for removing the taste of vomit. She now starts shivering, being scantily dressed like many of the clubbers, so its back to the rucksack for a space blanket, which H wraps round her. These Good Samaritan acts deeply affect these two women; like our biblical model we haven't said anything religious or prayed with them. Indeed, our motto is 'caring, listening, helping'.

02.50: A lot of people leaving the clubs now, men drunk and loud, women drunk and silly; very easy to judge the outside and miss connecting with the real person. Several police standing by; we have an excellent relationship with them (and the local council), and in spite of their cutbacks they still provide most of our funding. We have two-way radio contact with them and the bouncers at the clubs if needed.

03.20: We are now finishing, and relieved there wasn't any trouble outside Revs. The other group use their mobile to let us know that they need to escort a very drunk and vulnerable lady home, so we can't have our usual final debrief.

03.30: On my way home; in the kitchen there will be a lovely note from my wife plus a few nibbles. Although she says that there is no way that she could turn out until early morning, she is extremely supportive. I always get a roast before I go out because she is concerned about how I will survive the night; I tell her she is weak on physiology but excellent on psychology. Some time tomorrow I'll email this report to the friends who pray each time I go out – I couldn't do it without them either. Next session is in a fortnight, so I'll pray for lemon drizzle cake!

Andrew Miller is a retired physician who has been a Street Pastor in South London for a year.

For more information about Street Pastors projects in your area, including how to volunteer, visit www.streetpastors.co.uk

Photos: Ascension Trust

Even when we have not specifically shared the words of Christ, we are pervading his aroma, and people notice, much more than we usually recognise

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Catriona Waitt discusses reverse culture shock for those returning from service overseas

Returning home

key points

Having personally experienced reverse culture shock, upon returning to the UK after four years in Malawi, the author realised that many others were struggling to re-adjust when returning from overseas.

A short survey captured the views of over fifty returnees on the positive and negative aspects of returning home. By far the most negative experience was that of feeling misunderstood; in contrast renewing relationships with family and friends was a positive element of returning.

The survey shows there is a need for returnees to have the support of friends who will make themselves available to listen, ask questions and show genuine interest: other practical suggestions and resources are proposed for returnees and supporters.

In July 2010, my husband and I returned from four years working in Malawi. I had undertaken a Wellcome Trust Fellowship, and Peter worked in the government hospital and medical school. After extending our contracts three times, eventually it was time to return to the UK. Although we had made several visits to the UK during those four years for conferences and the births of two of our children, we were surprised at how difficult we found this final transition. There seemed to be an expectation that we would simply slot back into our old lives of four years ago, whereas in reality both we, and our friends and families, had undergone many significant life events in that time. Now that we were 'back', there often seemed disinterest regarding our time in Malawi and the on-going work there. We often felt misunderstood.

Culture shock and reverse culture shock

Talking to others who had returned from overseas work, I came to realise that our experience was not uncommon, and the challenges and frustrations we experienced were shared by many. On several occasions I was reminded that, 'returning home can be more difficult than the initial transition to overseas life'. The term 'culture shock' was coined by Kalervo Oberg in 1954, [1] describing psychological strain as a consequence of adaptation to a new environment, typically including an overwhelming sense of loss regarding friends, status, profession and possessions; confusion in role expectations, values, and self-identity; and surprise, anxiety, even disgust and indignation towards the new culture. [2]

Whilst those who choose to spend time overseas are often prepared in advance for this initial process, individuals are often less well prepared for 'reverse culture shock' on returning to their primary culture. [3] Similarly, those who have a role in supporting the returner may expect them to be delighted at having returned home, not recognising that they may be undergoing a grieving process resembling the aftermath of a bereavement.

> they may be undergoing a grieving process resembling the aftermath of a bereavement

Survey of returners

As I considered writing about reverse culture shock, I decided to research the experiences of a range of Christians who had recently returned from overseas work, rather than relying simply on anecdote. Fifty six respondents who had worked in 22 different countries took part in a survey, three quarters of whom had been involved in medical work. The results provide a spectrum of individual experience, and point to recommendations for the future.

The full methodology and results of this survey are available via *bit.ly/ruPJ3t*

The ten most positive and most negative aspects of the return home are summarised in the Table.

The most negative experiences for two thirds of respondents were in the realm of inter-personal relationships; feeling misunderstood, having diffi-

Positive Aspects of Return (% of Respondents)	Negative Aspects of Return (% of Respondents)
Family and friends (85)	Feeling misunderstood (59)
Job factors (37)	Practicalities regarding transition (41)
Infrastructure (14)	Leaving friends/ work/ country (36)
Opportunities for children (14)	Culture adjustment (32)
Familiar culture (12)	Materialism and consumer society (27)
Continued mission involvement (12)	Job practicalities (25)
Church (12)	Job experience (18)
Freedom (11)	Secularity (9)
Security (11)	Children adapting (9)
Language (9)	Loss of community (7)

culty in re-establishing relationships, feeling 'different' and isolated and that others were not interested in the work undertaken overseas. In addition to missing friends and work they had left behind, they also missed other aspects of the overseas community, including a more holistic and spiritual worldview, the incorporation of prayer and worship into daily hospital life and the sense of community. Almost a third struggled with the materialism and consumerism of the society to which they returned.

Work factors

Almost half reported positive work-related factors, such as ease of communication, improved computer facilities, access to training, a clear career structure and improved team-working opportunities.

42 per cent cited negative experiences, including getting reinstated on registers, having work undertaken overseas accredited and becoming accustomed to changes within the NHS. Factors relating to the experience of work included lack of confidence and up-to-date skills, a feeling that work was no longer as satisfying and frustrations at the high expectations of patients with minor medical complaints.

Support for returners

There was no association between the difficulty experienced on return and the length of time overseas, nor with different support structures (independent/ mission organisation/ church support). Those who went overseas via a mission organisation were more likely to undergo debriefing; however these individuals did not experience significantly less difficulty and provided similar comments to those who went overseas as independent professionals.

From informal conversations, I was not surprised to discover that almost half the respondents said that they had no support from their church or sending organisation during the transition home. However, as one individual commented, there is a need to '*give people the benefit of the doubt. They don't ask the right questions because they don't know the right questions to ask. It's not that they don't care*'. Friends, family and church members may feel ill-equipped to support the returner, but this survey suggests that simply being available to listen, ask questions and show an interest in the overseas work would help considerably. One respondent suggested a church could '*interview the returners so everyone understands where they came from and what their previous life was like; support the country or place they came from; pray for friends left behind and contacts made*'.

Forty per cent of respondents suggested that mentorship, either formal or informal, possibly involving the creation of networks of returners, would be of benefit; '*link people up with a "buddy" – someone who has trodden the path before – to give hints and ideas, but mostly just to listen and be able to understand where the person is at*'. Survey respondents gave examples of advice they might give to future returners:

'*Take the lead in talking about time away – if you don't, you might never be asked! Likewise, you have to remember a lot has gone on for your friends in the time you have been away*'.

'*Know that it's going to be difficult. Pray. Talk to people about how you feel. Get involved in new things. Realise that God will use you everywhere.*'

'*Try to see it as a move from one mission field to another rather than a return home; a Christian should never feel truly at home in this world*'.

Conclusions

The results of this survey reveal some of the main challenges encountered by returning overseas workers in addition to providing helpful suggestions as to how the process can be improved.

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Catriona would like to thank all those who took part in the research project and provided helpful information for this article.

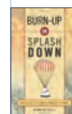
Vicky Lavy writes:

This survey highlights several ways in which CMF could support those returning from abroad, and we are in the process of putting together some useful information and resources. Connecting returners with others who have been through the process is worthwhile – please contact me if you could help with this.

Photos: Catriona Waitt

other resouces

Re-entry: Making the Transition from Missions /to Life at Home
Peter Jordan YWAM Publishing, U.S.; (Dec 2001)
Available from Amazon
amzn.to/quy6FN



Burn-Up or Splash Down: Surviving the Culture Shock of Re-Entry
Marion Knell Authentic Media (16 Mar 2007)
Available from Amazon
amzn.to/q5YbQG

for supporters

- Show an interest in the returner and their time overseas
- Offer hospitality and give some of your time
- Give opportunities to share experiences (formal and informal)
- Consider immediate practical needs (food, accommodation, transport etc.)
- Ask for prayer items
- Remain interested in the on-going work overseas
- Don't see the returner as 'super-spiritual', and watch for signs of discouragement

for the returner

- Communication with 'home' while abroad
- Planning return well in advance
- Continued professional development and paperwork
- Don't expect others to be able to 'read your mind'
- Show interest in the lives of others during your time overseas

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Anika Lillicrap shares her experiences of past mistakes, medical training, marriage, miscarriage and motherhood

FROM MEDICINE TO MOTHERHOOD

key points

Looking back on key moments in her life the author testifies to God's gentle leading helping her to adapt as circumstances changed.

After a night of teenage rebellion a profound sense of guilt brought about a genuine and deep repentance that was the start of a life lived to please God.

Through the pain of sub-fertility and miscarriage God was refining her faith and encouraging a deeper trust in him. Now as a mother the author gives thanks to God for her 'ordinary' but fulfilling role.

Standing on the edge of my dreams, about to enter medical school, what did I expect? I expected to become a successful doctor, perhaps a Paediatrician. I wondered about becoming a medical missionary. There was something noble, almost glamorous about that idea. What a great asset to God I could be! I hoped I'd get married and have children too. Somehow it would all work out perfectly and I would make a significant difference to the world, build a name for myself, achieve things for God and enjoy family life. I never thought I'd be where I am now.

I was a young Christian when I started at university and had already seen God bring unexpected changes to my life. I grew up in a non-Christian family and started boarding school aged eleven. From the clever, popular, self-assured child I was, God brought me to a place of doubt and insecurity in my early teens. This culminated in me accompanying an older girl to the off-license one Saturday afternoon and sharing a large quantity of alcohol with her. I can't remember much of what followed but know that the next morning I woke, filthy, smelly and rather confused, in the school sanatorium. I was told to wash, dress, have some breakfast then go to chapel (normal school routine on a Sunday) after which I would see the Headmaster.

For the first time in my life I was in big trouble. I felt sick with anxiety and as I sat in chapel, in the same pew I'd sat in almost every day for the past three years, I felt ashamed. Crushed under a burden I'd never seen or acknowledged before; guilt. I knew I'd let people down: myself, my friends, my teachers, my parents, but I now also had a sense that their forgiveness wouldn't be enough. All of a sudden I understood that I had let God down too.

I know now that this was God's Spirit at work in me convicting me of my sin. I knew I had to say sorry to God, for this act of rebellion along with all the others in my past. For the first time ever I sincerely prayed 'God, if you're there, please forgive me.' And what followed was another new experience; my burden lifted and I felt overwhelming and liberating peace. 'The peace of God which transcends all understanding' [1] had replaced my guilt, and instead of anxiety I now had courage to face the Headmaster and accept whatever punishment he would choose to give me. He chose to suspend me from school for a week.

God used this unexpected low point in my school career to teach me of my need for him, and his love for me. I didn't yet fully understand how the work of Jesus on the cross had bought my forgiveness; that would come in the years ahead, but I did now have a new desire to try and live for God.

But how insidious is the influence of our culture which along with our sinful hearts teaches us to worship and serve ourselves. The appeal of worldly

success nestled closely amongst my desires to help people, please my parents and serve God, and soon became the driving force behind my application to medical school.

Thankfully, as the years have unfolded, God has graciously been refining me. I married Matt at the end of my third year at university and as we began married life God challenged me to view my role as a wife above my role as a (future) doctor. I continued my studies alongside Matt, qualified as a doctor and began working – eager to do a good job and be well thought of. Then, during my Foundation Programme along came two unexpected things. The first was a growing realisation that my work was consuming me, preventing me from supporting and encouraging Matt as his wife, and the second was subfertility.

God has done some major surgery to my sense of identity, which had been bound up in being a successful doctor, respected and esteemed by society

The latter of these was the more difficult to bear. For two years we struggled with failure and frustration, both of which I, like most medics, was unused to. There was failure to have a successful pregnancy and frustration at not being in control. We grieved over two miscarriages and questioned God's purpose, but in the end learnt to 'find refuge in the shadow of his wings'.[2] God does not promise that all couples will have children, but he does promise to work through all things for our good, to make us like Christ.[3] I was not in control, but he was. God gently taught me to relinquish my desire to control our circumstances and instead trust in his goodness and sovereignty. And how liberating this was! God had already given me the most precious gift of his son – I needed nothing more. How could we do anything else but trust him and obey?

During this time Matt was becoming more and more involved with church ministry, and feeling a growing desire to do this full-time. An opportunity to work for CMF as a part-time staffworker arose, and our pastor and previous CMF staff encouraged Matt to do this. Our deanery took over a year to respond to his application to train flexibly, when we were again met by two unexpected events – I became pregnant, and Matt's part-time training was approved! Nine months later Charis Joy was born, and soon after Matt began working for CMF.

Now I was not only a doctor, and a wife, but also a mother. It was time once again to consider how I could best serve God with my life and career. God asks young women to 'love their husbands and children, to be self-controlled and pure, to be busy at home, to be kind, and to be subject to their husbands'.[4] Would I make this my ambition? Would I let go, once and for all, of my own dreams and adopt God's ambition for my life? As Matt and I considered this we concluded that I could best do this by staying at home full-time, at least for now. So, despite pressure from well-meaning colleagues that I would be wasting my talents, I handed in my resignation. God has done some major surgery to my sense of identity, which had been bound up in being a successful doctor, respected and esteemed by society. Now I do the 'ordinary' work of a mum, often seen by no one except the three little ones God has blessed me with, but this is glorifying to God, and what I was made for. It's an important job – more important than the job I did as a doctor. Another mother's response to the question 'what do you do for a living' was this:

'I'm socialising two *homo sapiens* in the dominant values of the Judeo-Christian tradition that they may be instruments for the transformation of the social order.'[5]

I might try that next time I'm asked!

As I work to support my husband, and raise Charis, her sister Thea who was born just over a year after her and her brother Toby who arrived 15 months after that, I'm investing my gifts and training. Rather than pursuing my own professional development, I'm now working for the personal and spiritual development of the children God has entrusted to me. God has given me opportunity to use my medical training in other ways too: I partnered Matt in his CMF role and now support him back in full-time hospital medicine. I've been able to get alongside female medical students and encourage them in a way Matt obviously couldn't and have had opportunity to use the inter-personal skills I gained at medical school to assist Matt in leading our Bible study group. My medical background has also enabled me to volunteer at Tyneside Pregnancy Advice Centre, advising and scanning pregnant women. Nothing is wasted.

So here I am, far from my girlish dreams of being a high-flying doctor or even a medical missionary. But I'm where God wants me. He has given me a new dream, and I'm living it. I never thought I'd step out of medicine so soon after entering it; I never thought I'd be fulfilled by being an 'ordinary' wife and mum, but by God's grace I am.

Anika Lillicrap *is a full time mother of three young children*

Photos: Anika Lillicrap

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Andrew Flatt
on money matters

MANAGING RESOURCES

– KINGDOM RESOURCES IN AN UNCERTAIN WORLD

Billy Graham once said: 'A chequebook is a theology document – it shows us what we worship.' As doctors many of us are privileged to be financially secure but wealth comes with responsibility. Money holds extreme power; so what does the Bible have to say about how we should handle it?

The biblical character most famous for his wealth is Solomon. As David's successor and the constructor of the temple, many would have hailed him as infallible. But fail he did. His major downfall was taking many wives from neighbouring nations, and worshipping their deities in defiance of the law. [1] He levied burdensome taxation on his people and over-spent (perhaps as a result of taking so many wives and concubines!) so that his son Rehoboam inherited serious budget shortfalls.

The Bible offers many principles to guide our money management decisions; however it is not a financial handbook. We will look briefly at what the Bible says about earning, borrowing, giving, spending and saving.

Earning

Ecclesiastes reminds us that: '*Whoever loves money never has enough; whoever loves wealth is never satisfied with their income.*' [3] We need to be careful as wealth can displace God [4] and can be a barrier to faith. [5] There are numerous examples of greed and its consequences recorded in the Bible: Gehazi, [6] Balaam, [7] Judas Iscariot, [8] and Ananias & Sapphira, [9] to name a few. However working to earn money is legitimate, [10, 11] as long as we do so fairly. [12] We are also required to ensure we pay the tax required of us. [13]

Borrowing

Most of us will have to borrow money at some point, whether to buy a house or buy into partnership as a GP. The Bible does not forbid the borrowing of money [14] but advises us to repay it as soon as possible. [15]

Giving

Instead of greed the Bible teaches us to recognise God as the great provider; we are to trust him to give us 'our daily bread' [16] but more than that we are to use the money he gives us as part of our worship. The story of the widow's mite is one of the most challenging; giving out of her poverty the widow showed her total trust in God's ability to provide for her needs. [17]

St Paul has much to teach us both as encourager and example. He encouraged the early Christians to participate in the joy of giving, so they might receive the spiritual blessings involved. [18] He worked as a tentmaker so that he need not depend on the churches' financial support. [19] His letter to the Philippians abounds with joy, and Paul rejoices that he has learnt to be content in all material situations. [20]

Giving, as with any discipline, matures through practice, diligence and prayer. It is best to make specific gifts, and regularly review the amount so as to increase it in proportion to the growth of our resources. It can be helpful to also set aside an amount each month for spontaneous giving. We are called to be generous [21] with our giving and to plan our giving in advance. [22] If all that you gave away was returned at the end of the year would it make a clear difference to you? If not maybe we need to consider whether we are giving enough.

Spending

When we view money as a precious resource that God has given we will aim to use it more efficiently. The call to be 'as clever as vipers and as innocent as doves' [23] applies well to financial management. It is remarkable what can be saved through initiative; home-made sandwiches generate significant saving over most bought food, but can be impractical, especially if you're not a morning person!

It is important to live within our means. For some it may be wise to use money (which we have) to buy time (which many of us lack), eg by employing cleaners or decorators. Carefully consider purchases before making them but do allow yourself rest, relaxation and holiday.

Saving

We should consider repaying debt, giving and spending before we think about saving. I am sure we are all aware of the Old Testament story of Joseph, who saved Egypt from famine, through saving up grain in response to a dream God gave Pharaoh. Similarly it is important that we prepare financially for unexpected crises and future needs. However, as Christians, we need to consider how we balance giving, spending, saving and providing for our families. [24]

Our finances reveal a lot about whether Jesus is really Lord of our lives. If things are wrong with how we use our money, we need first to turn our attention to our relationship with him rather than going straight to sorting out our accounts.

***Andrew Flatt** is an ST4 in Microbiology*

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Steve Fouch comments on the West's promotion of sex-selective abortion

WESTERN COMPLICITY
IN GLOBAL GENDER IMBALANCE

Over twenty years ago, the Indian writer Amartya Sen wrote about the 'missing millions' of girls in India, speculating that a deeply entrenched bias towards boys rather than girls would lead to neglect of girl children that would compound the gender imbalance. [1] Twenty years later, there are regions of India where there are as many as 120-130 men for every 100 women. [2] China's 'One Child Policy' has led to a similar imbalance in the number of boys to girls in that nation. [3]

Although sex-selective abortion has been outlawed in India, China and many other nations, the reality is that these laws are flouted and broken widely. The trend towards sex-selection is strongest amongst the urban middle and upper classes – where poverty is not the driving force. [4] Poor villagers have less access to antenatal screening and medical abortion, but tend to take less care of their female children (stopping breast feeding earlier, giving smaller portions at meal times, less access to good clothing or education), and have more children to ensure a male child is born. [5] The rich can circumvent this and go directly to a medical solution.

However, a recent UN report on the issue sidesteps an even more troubling matter. [6] The science writer, Mara Hvistendahl, in her new book, 'Unnatural Selection' [7] has unearthed evidence that these gender imbalances, far from simply being due to cultural preferences and modern medical technology, are also the result of a deliberate population control strategy of UNFPA, IPPF, World Bank and other Western agencies during the sixties and seventies. In an article published in *Foreign Policy Magazine*, she explains how the Malthusian fears of thinkers in the UN and other Western agencies led them to promote male gender preference, and to fund sex screening and selective abortion of girls as a way of securing long term population reduction amongst the poor populations of Asia. [8]

One proposed solution to rising birth rates was to use the emerging technologies of ante-natal screening to identify foetal gender and allow for terminations of girls – ensuring that boys would be born to families without the need for 'excess' girls. In South Korea in the sixties and seventies this led to the US Army and USAID sending mobile clinics around the countryside offering antenatal sex screening, abortion and tubal ligation to every pregnant woman, driving up abortion rates so that by the seventies as many as 2.75 abortions were performed for every live birth.

In India the World Bank and Rockefeller Foundation pumped millions of dollars into research on antenatal sex screening during the sixties, and in the seventies rolled out mobile clinics offering amniocentesis and abortion free to poor women in rural areas. Early pilots were so 'successful' that they led to a nationwide programme, specifically targeted at reducing the number of girls being born.

Hvistendahl also relates how in China the UNFPA and IPPF pumped tens of millions into new screening technologies and training ultra-sonographers just as the One Child Policy came into effect. In China the screening was less consensual, with cases of forced abortions, and immense pressure to produce a male child. UNFPA and IPPF's complicity in this has permanently wounded their reputation in many parts of the developing world, and led many governments (notably the US) to cut off large portions of their funding.

Demographers suggest that by 2020, in some parts of India, as many as 10-15% of men will have no female counterpart. The consequence of this is already being seen in trafficking and bride abductions in some countries, as families desperate to secure wives for their sons resort to kidnapping young women and girls from surrounding communities and nations. The social and health impact on living women of this gender imbalance is a grave cause for concern. [9]

The prophets urged believers to stand up for the poor and voiceless in the face of oppression and injustice, [10] and to refrain from taking life. [11] These missing girls certainly deserve justice and a voice, for as Ross Doutha of *The New York Times* puts it '*the tragedy of the world's 160 million missing girls isn't that they're "missing". The tragedy is that they're dead.*' [12]

***Steve Fouch** is CMF Head of Allied Professions Ministries*

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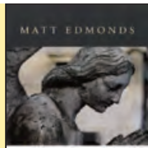


A Theological Diagnosis

A new direction on genetic therapy, 'disability' and the ethics of healing

Matt Edmonds

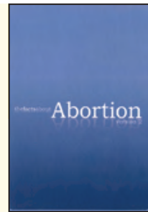
- Jessica Kingsley Publishers, 2011
- £25 Pb 208pp
- ISBN 978 1 84310 998 3

This unusual book includes chapters on theology, genetic techniques and faith healing. The surprising link is the author's experience with the L'Arche community. He reviews the literature on the theology of disability and explains his personal theology of grace and concern for each individual known by name. An unnecessarily detailed description of the new genetic technologies is followed by a good discussion of the theology of genetics. Of far more concern to the author is the 'prosperity gospel' and three chapters review the rise of this form of Christianity, highlighting its limitations and disasters. Its emphasis on healing as a 'right' of true believers denigrates and distresses those with disability, implying that it is their faith, or that of their carers that is lacking.

The final chapter outlines the work of the L'Arche communities with their attitude of grace and acceptance for each individual however severe their inability.

Well referenced and indexed this is a complex book, difficult to summarise briefly but well worth reading.

***Caroline Berry** is a retired Consultant Geneticist who worked at Guy's Hospital in London*



The Facts about Abortion v.2

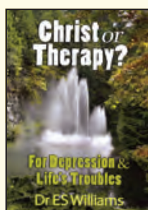
- Lovewise 2011
- £12 Running time: 45-60 minutes
- Available from www.lovewise.org.uk/abortion.html

Talk about Abortion and God in schools? Surely not! Yet it is possible and necessary amid the fallacies and fallout from this procedure. This excellent teaching package on Abortion, by Newcastle paediatrician Dr Chris Richards, provides a good quality pro-life resource for use in PSHE, RE and science lessons as well as for youth groups.

We professionals are well placed to teach "in season and out" on abortion to church or youth. But where does one begin? Here are 50 slides and three videos ready to use. Pitched at the general level for ages 14 up to adult, the material can be split into two lessons starting with the facts about the wonders of our own beginnings. The resources cover biological, medical and ethical issues including the damaging consequences and the hard cases like rape.

Video ultrasound of a lively foetus backs up interviews with two women over their agonising choices. A running script offers questions and discussion starters to get people talking. Yes God appears by slide 5, but naturally and sensitively as a delighted Creator not a threatening judge. Here is a useful tool for teaching.

***Mark Houghton** is a GP and Chairman of* Love2Last



Christ or Therapy?

For depression & life's troubles

Dr ES Williams

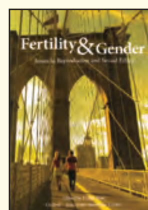
- Belmont House Publishing, 2010
- £6.95 Pb 156pp
- ISBN 978 1 87085 571 6

Life in a fallen world can be profoundly challenging, driving us to seek relief wherever it can be found. In this book Dr Williams poses a basic dichotomy – do Christians need secular psychotherapies, or can they find all that they need in Christ and His word? He critiques the rise of pop psychology in the contemporary church, and the secular assumptions underlying this. He then challenges some commonly held doctrines, in particular questioning the biblical basis for thinking that God's love and forgiveness are unconditional, and rejecting marriage education and cognitive-behavioural therapy as unbiblical. He concludes that Christian counselling is modern-day gnosticism and has 'perverted the Gospel of Christ'.

Dr Williams rightly questions the appropriate scope and applications of extra-biblical strategies for psychological difficulties, while accepting that some problems can be severe enough to require medical treatment. However, several of his conclusions do not provide a sufficiently nuanced biblical response to core issues, coming across as somewhat naively dismissive and overstated pietistic reactions to false dichotomies.

This book is worth reading critically for the questions posed, but not all conclusions should be taken as biblically comprehensive nor universally applicable.

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



Fertility & Gender

Issues in reproductive and sexual ethics

Edited by Helen Watt

- Oxford - Anscombe Bioethics Centre 2011-08-27
- £15.95 Pb 220pp
- ISBN : 978-0-906561-12-6

This book contains the proceedings of an international conference 'Fertility, Infertility and Gender' held in Maynooth, Ireland in 2010 by the Linacre Centre for Healthcare Ethics (now the Anscombe Bioethics Centre). Its thirteen chapters cover contributions which will be of interest to Christian doctors such as: Fertility, Celibacy and the Biblical Vindication of Marriage, Psychological Issues in Gender Identity and Same-Sex Attraction, Teenage Pregnancy, STIs and Abstinence Strategies, Population Growth and Population Control, Contraception, Moral Virtue and Technology, Condoms and HIV Transmission, Motherhood, IVF and Sexual Ethics. Authors include philosophers, psychologists theologians and priests.

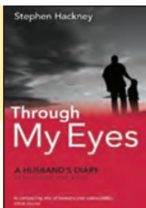
Although Scripture is quoted, the underlying authorities are Papal Encyclicals especially Humanae Vitae (1968). This makes it of especial value to Roman Catholic Doctors. As an evangelical I find it difficult to accept its teaching that contraception within marriage is always wrong and sinful and that 'faithful compliance with natural law is necessary for eternal salvation' (Pope Paul VI). I think *Fertility & Faith* by Brendan McCarthy (IVP 1997) has a more biblical foundation and will be more helpful to CMF members.

***Stephen Browne** is a GP in Birmingham*

Through My Eyes

A husband's diary

Steve Hackney



- Authentic Media Limited, 2011
- £8.99 Pb 100pp
- ISBN 185078955X

Through My Eyes is a man's story of his wife's illness and death from cancer, written by a Pentecostal minister in Nottingham. Stephen's wife Lesley was diagnosed with a rare nasopharyngeal tumour in her early thirties and died four years later leaving him with a young daughter. The book is written in the form of a diary with the first two chapters focussing on some of his prayers. These are inevitably somewhat repetitive, but they do illustrate some of the frustration and anguish of unanswered prayer.

Later the diary takes on a narrative form and becomes more reflective. The entries are not daily, so sometimes parts of the story are re-capped at a later date. As time goes on there is a sense of resignation to the natural course of the illness, yet a dilemma is posed every time somebody suggests prayer for healing. Stephen writes honestly about the strain put on their relationship by the illness, and the strain on himself as carer. There is a very good epilogue where he brings together some of the themes of the book, including the roles of suffering and prayer in the Christian life.

I would recommend this book as an honest and insightful look into the realities of living with progressive cancer.

Roxanna Walker *is a GP in Nottingham*

Resistance Fighter

God's heart for the broken

Susie Howe

- IVP (2011)
- £7.99 Pb 176pp
- ISBN 9781844745173

This book is part autobiography and part an exploration of one of the great global issues of our time.

The story outlines how Susie came to faith, and as a consequence gave up the promise of a career in dancing to become a nurse. That opened the doorway for her to become involved in caring for people living with HIV and AIDS.

When she and her husband went to work for a couple of years at a small Zimbabwean hospital, she encountered one of the most dreadful consequences of HIV – the children forced to live on their own or with elderly grandparents because they have lost their parents to AIDS related illnesses. Susie set up an NGO that has gone round the world equipping, training, supporting and learning from local communities and churches seeking to help the vulnerable children in their communities.

Susie is a bit of a one-off – dynamic, energetic, full of God's love and as a result, a burning drive for compassion and justice. But when you read the stories of tragic young lives turned round by the care and compassion of God's people around the globe, you cannot fail to be inspired, and encouraged. This is a book to challenge complacency and give hope and inspiration.

Steve Fouch *is CMF Head of Allied Professions Ministries*

The House of Hope

God's love for the abandoned orphans of China

Elisabeth Gifford

- Monarch Books, 2011
- £8.99 Pb 223pp
- ISBN 978 0 85721 059 3

In 1998 expatriates Robin Hill and his doctor wife Joyce heard God's call to give up their comfortable Beijing life to care for abandoned Chinese infants, released to them from the official Children's Welfare Institutions (CWIs). Deemed hopeless, some had life-threatening but operable conditions. Sympathisers worldwide helped the Hills to build and supervise several scattered 'Houses of Hope'. One-to-one care then saved hundreds of lives, sometimes after urgent or repeated surgery by international experts, responsive to Joyce's emailed assessments. Many of these children have gone on to be adopted, usually by families overseas but often after lengthy fostering in China. A novel and welcome development has been the supervision of palliative care units, requested by some CWIs for their moribund infants. As the Hills aimed to treat each child like one of their own they have trained equally caring managers for the different centres.

Despite sometimes disruptive backtracking, moving stories are told of God's loving care for 'the least of these'. Supposedly hopeless infants thrive, others find new families or are loved until they die, and experiences of God's perfect timing strengthen faith. Readers hesitating about saying 'yes' to one of God's surprising, if costly, invitations will find much in these pages to inspire and encourage.

Janet Goodall *is a retired paediatrician in Stoke-on-Trent*

Keziah

A little piece of God's heart

Lizzie Grayson

- Sovereign World Ltd, 2011
- £7.99 Pb 144pp
- ISBN 978 1 85240 540 3

This is one of a small but growing number of books on the market telling the story of how people cope with the news that their unborn child has a potentially fatal diagnosis. 20 weeks into pregnancy, a short, 'impersonal' phone call, informed Lizzie Grayson that her daughter had Trisomy 18 (also known as Edwards syndrome). She relates her journey from that point to, and beyond, the further grief of stillbirth at 41 weeks.

Able to be read in a couple of hours, it's told with an infectious enthusiasm for God's word. An appendix on 'Salvation' is for those who want to know how to follow Christ. This reviewer's only concern is that, in a second appendix, 'For those who may have terminated a pregnancy', she writes 'your unborn child is safe in heaven'. Does Scripture allow us that certainty?

Lizzie's account is a hugely inspiring testimony of how repeated, deliberate decisions to praise God, no matter what the circumstances, lead to peace and joy. Every Christian should read it, and it could be given to those curious to know what (who!) can give us such astonishing strength.

Karen Palmer *is a specialty psychiatrist in Glasgow*

The spiritual dimension

A recent article in the *Journal of the Norwegian Medical Association* set out the benefits of taking a spiritual case history. The authors recognise this will not be relevant for all but in certain circumstances it can be of special relevance to patients including those who have serious illnesses, a limited life expectancy, or chronic illness with major loss of function or high symptom intensity. Taking a spiritual case history can also strengthen the doctor-patient relationship through the patient's perception of being cared for as a complete human being.
(*J Norwegian Med Assoc* 2011. *bit.ly/v2iRuk*)

Gay blood-donor ban lifted

The UK's lifetime ban on blood donations from homosexual and bisexual men has been lifted. Under new rules men will be able to donate if they have not had anal or oral sex (with or without a comdom) in the preceding twelve months. Sir Nick Partridge, of the Terence Higgins Trust, commented that it is impossible to say how many men will be able to start donating blood as 'the vast majority of gay men are still [sexually] active'.
(*BBC* 8 September 2011. *bbc.in/raGAoB*)

Wish you were here

The death of Steve Jobs, late CEO of Apple Inc, resulted in world-wide mourning. Apple's statement read: 'Steve's brilliance, passion and energy were the source of countless innovations that enrich and improve all of our lives. The world is immeasurably better because of Steve.' Although such eulogies sound messianic Jobs' creativity was highly valued by millions of happy consumers. What is less well known is that Jobs was adopted at birth, so for those struggling to come to terms with a 'Jobs-less' world the real question is 'What if he had never been?' His passing serves as a reminder of adoption as an alternative in crisis pregnancies.
(*Apple Inc*. 5 October 2011. *bit.ly/nxRqYW*)

Praying for patients

The Medical Defence Union's guidance on praying for patients strikes a balanced response to a sensitive issue 'which arouses strong feelings in those who see religious belief as a potential comfort for patients and those who see such discussions with patients as inappropriate in a clinical consultation.' The guidance allows doctors to offer prayer for their patients so long as discussion has established that the patient might be receptive and the offer of prayer is made 'tactfully' to enable the patient to decline without embarrassment.
(*Medical Defence Union* 12 July 2011 *bit.ly/tfmlCi*)

Stem-cell research

An editorial in the *New Scientist* on advances in ethical stem-cell research pointed to some fascinating findings such as the fact that humans have '*accessible stem cells*' in the nose or that 'human fetuses shed stem cells into the fluid around them'. In terms of application these findings could lead to 'personalised stem-cell treatments that, ...are simpler than what has gone before.'
(*New Scientist* 17 October 2011. *bit.ly/vjCaVO*)

Cholera epidemic spreads

In October the UN reported that a cholera epidemic which is rapidly spreading throughout West and Central Africa is one of the biggest in the region's history. Some 85,000 people are said to have been infected and 2,466 deaths recorded. In Haiti the country is still wrestling with a cholera epidemic more than a year after the disease broke out although international funds and aid efforts have so far helped to curb its spread. The challenge to come will be the impact of the tightening world economy on international aid efforts.
(*Reuters* 11 Oct 2011. *reut.rs/nRa2zk*)

Wise use of resources

Staying with money, the World Health Organisation published a plan to tackle non-communicable diseases such as heart disease, which it says now pose a greater global burden than infectious diseases. According to the WHO the total cost of adopting these strategies in all low-and middle-income countries would be $11.4bn (£7.2bn) per year. That's a large figure but a drop in the ocean compared to the £117 billion of UK taxpayers' money used to bail out the banks in 2008-2009. (*CMF Blog* 22 September 2011. *bit.ly/qYAJhw*)

Abortion stats: in the public interest

Healthcare confidentiality is integral to professional ethical standards but should confidential personal information be made available for research? This question is explored in the *Journal of Medical Ethics* especially in relation to the DoH decision to withhold data from the publication of its annual abortion statistics; a decision which was overturned by the High Court earlier this year after a Freedom of Information request was made by the ProLife Alliance. Complexities regarding the legal regulation of confidentiality and privacy are considered.
(*J Med Ethics* 2011. *bit.ly/tlY81q*)

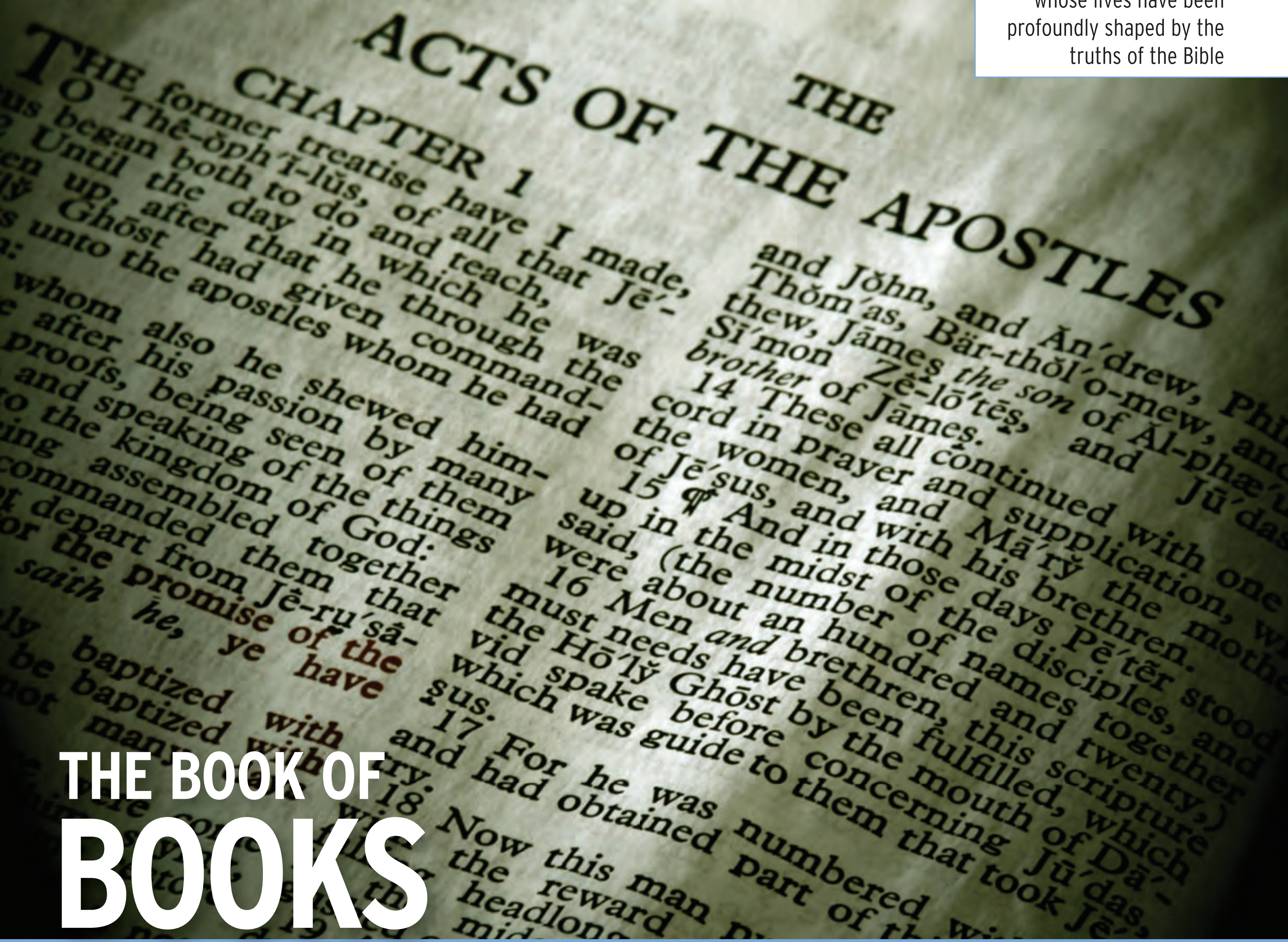
The seven billionth baby

The UN reported that world population figures passed 7 billion on 31 October 2011 although there was some disagreement over the exact timing of the milestone with the US Census Bureau suggesting it will come between March and April next year and the Vienna Institute of Demography, opting for the first half of 2012. Whilst some used the announcement as a pre-text to argue for tighter population controls and wider availability of contraceptives and abortion, the BBC took a more balanced line exposing the failure of Western policymakers to deal with underlying issues of poverty and injustice.
(*BBC* 28 October 2011. *bbc.in/tePbyp*)

'Do Not Resuscitate' tattoo

And finally, an 81-year-old grandmother has gone to considerable lengths to ensure her 'living will' or 'advance directive' doesn't go un-noticed, by having the words 'Do Not Resuscitate' tattooed across her chest. The message extends to her back where a further tattoo gives the instruction 'PTO' with a picture of an arrow. Somewhat ironically, it seems that such instructions would not, by themselves, be legally binding.
(*BBC* 6 September, 2011. *bbc.in/pcoTL4*)

Jason Roach on doctors whose lives have been profoundly shaped by the truths of the Bible



THE BOOK OF BOOKS

It has been called the most influential translation of the most influential book in the world. Over the last 400 years the King James Version of the Bible has stirred social movements such as the abolition of slavery, the suffragettes, the building of hospitals and the end of child labour so it's no surprise to find that this incredible book continues to inspire many doctors today.

The King James Bible provided the foundation of our nation's legislation

John Wyatt, Professor of Ethics and Perinatology at University College London articulated this wonderfully in a speech to the House of Lords saying: 'If I was to intentionally kill one of these babies struggling for life, in English law I would be guilty of the same crime as though I had marched down here to try to kill one of the peers who rule the land.'

The Bible inspires us to lead an integrated life

Some find it easy to separate life in the clinic or at a desk from life in a church building or home group. But the puritans, perhaps some of the first to comb the King James Version afresh rejected such distinctions. Tracey Foy, a GP in North London, has found great solace in God's interest in every area of life: 'I find being a GP quite draining at times and it can be difficult to motivate myself especially when faced with a long list of patients with varying problems. The verse that always spring to mind for me in these times is Colossians 3:23 as it reminds me that when we do things for other people we are doing them for Christ, which I think helps me have a better mind-set when faced with patients whom I may see as difficult.'

The Bible encourages us to see with the right perspective

Hebrews 3:13 urges us to 'encourage one another daily'. For Catherine Brown, a medical registrar in London, this is often how God's word has come to her most powerfully. Speaking of her long struggle with depression she said: 'I remember some really low days, days when I would just burst into tears with a friend. Sometimes I wondered how I would make it through the day. But time and again, those who cared for me were able to lovingly and gently put an arm around me, let me know they were there, and share something of the comfort Christ promises us. To know that there is a day when Jesus himself will wipe away my tears, and remake my body without the burdens of illness is a day I cling onto tightly.'

I have spoken to only a handful of doctors, and yet even this brief sample gives a glimpse of the breadth and depth of the Bible's impact on our lives. By God's grace, may it continue.

***Rev Dr Jason Roach** former Editor of* BMJ Clinical Evidence *and Minister, Westminster at One*

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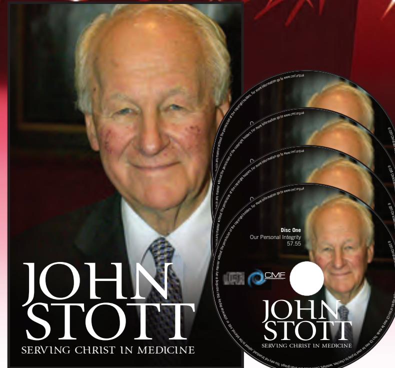

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