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easter 2010

a life - or death?

worldview | church choice | crash call

nucleus

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editorial...

How many choices will you make today? You might not think about them all. Some, like which colour socks to wear, probably don't matter too much. Others, like whether tonight's dinner comes from the kitchen cupboard, the local pizza takeaway or is shared with friends next door may well have consequences, but perhaps don't seem too significant. Choices may be made without realisation that a choice has been made – for example choosing to read for an hour also means choosing not to do something else in that time.

Other choices may be thought through in minute detail. How much time did you spend deciding where to go to medical school? Or whether you wanted to be a doctor in the first place? Or whether you would believe in Jesus?

Choosing which church to attend is often a hard decision. Giles Cattermole offers some hints (page 34), reminding us that the decision isn't just about ourselves. Deciding how we share God's word with our friends is often not easy with a wide variety of evangelistic methods being advocated. God-Man-God (page 36) suggests a gospel outline we could use, whilst Rachel Hubbard shares an example of a recent evangelistic endeavour in Newcastle (page 4), which fed those on the receiving end both spiritually and physically!

Future decisions also require choices. Where will we eventually work? There is health need everywhere, whether in the leafy London suburb or in Birmingham's inner city. Yet there are many fewer doctors for each patient in other parts of the world. Katie Dexter (page 31) considers what we can do to answer Jesus' call to care for the poor in its international context.

One day the story of our career may affect the choices of tomorrow's students. John Wyatt's story is set out in Abigail Brempah's interview (page 11). We hope it will inspire and enthuse. Another famous doctor is Luke, writer of the gospel and Acts. Alex Bunn compares him with the less inspiring Pontius Pilate (page 40), and helps us think through the way in which Luke and Pilate made their decisions.

How will we make *our* decisions? What ethics basis will we use (page 27)? How will we deal with a difficult case? Lizzie Groom explores some of the deeper issues raised by the sad case of Kerrie Wooltorton (page 18). If we use the Bible as the basis for our decisions, how will we know which version to use (page 38)? Not everyone will use the same basis as us, and we will need to ask why when someone makes an assertion that we may not agree with (page 24).

I very much hope this issue of *Nucleus* will help you know God's word, and be guided by it as you approach the choices that face you each day.

Laurence Crutchlow
is managing editor of Nucleus

have your cake... and eat it!

***Rachel Hubbard** suggests a creative form of evangelism*

At Newcastle CMF there are two things we love: God and cake. Incidentally, we also love Norwich City (but I get the feeling that one might be edited out!)

Cakes are a great way to reach people with the gospel; I mean can you think of somebody who does not like cake? No? Neither can I! At Newcastle Medical School, it's a rarity when you walk through the foyer not to see a cake stall, so preclinical CMF students decided to join in and set one up themselves. Not wishing to be outdone by others, they worked through the night, baking in the name of CMF.
As pictured, a wide variety of cakes were made (and of course tested!) The cake stall was set up at 8.30am and alongside selling cake we also gave out CMF literature. Cake stalls provide awesome opportunities to tell people about CMF and the values we stand for, as well as raising money. People love cake, so why not sell cake and make money for CMF? It's pretty simple.

But Newcastle's love for cake and the Gospel does not end there and neither should yours! For what better way to spread the word to your friends and course-mates than with cake... and Bible verses?

At Newcastle, the fourth years have a difficult end of first term, for when all other courses are enjoying the Christmas atmosphere, the medics end up living in the library and digesting more alpha haemoglobinopathies than mince pies. So are your friends too stressed to hear about Jesus? Yes... wrong again! When thinking about how to reach more fourth years we were struggling to think about what practically would work amidst the stress of exams. So at a CMF social at a breakfast parlour they came up with the idea of putting cakes in the library whilst medics were revising, so that when they had a break from work there would be a nice surprise waiting for them. An example of showing God's love for them practically, but is that enough on its own?

The answer is probably not. It's not that showing people our and God's love practically is a bad thing (after all James does say 'faith apart from works is useless' - ESV [1]). But when we're trying to tell people the Gospel, words are pretty crucial. If not, then sure - people would like the cakes and they may wonder who made them, but that would be it. It would just be a temporary thing. We're told of the necessity of explaining and telling people the Gospel in Romans:

How, then, can they call on the one they have not believed in? And how can they believe in the one of whom they have not heard? [2]

So we decided to put Bible verses and leave Gospel tracts with the cakes in the library café. This gives a relaxed environment for people to eat cakes and read and look over the verses and tracts in their own times.

The week was successful; cakes got eaten, Bible verses read and thank you notes were written. The results of it we don't know, but as Kevin Vaughan reminded us in his recent address at CMF National Student Conference 'a lot of what we do is cultivating; it's about sowing seeds, and the rest is all up to God'. We can rest in the promise that 'so is my word that goes out from my mouth: It will not return to me empty, but will accomplish what I desire and achieve the purpose for which I sent it'. [3] As one medic Zoe summarises: 'It was a great opportunity to simply share God's love in a time of need'.

You too can do this, it's not hard, so here is a step-by-step guide to evangelism and fundraising through cakes - Newcastle style!

1) Bake cakes.
2) Find a location and put cakes, Bible verses, tracts and CMF bookmarks there.
3) Put on a friendly face and if selling cakes or manning the stall, be ready to explain what CMF do, and discuss the gospel when prompted.
4) Have fun - remember cakes are amazing! It's a good change to have fellowship baking!

Newcastle CMF prides itself on poetic skills so we'll end with a poem!

Cakes are great and tasty too.
We should show God in all we do,
With Bible verses and Gospel cards,
Sharing God's love with his help
is not that hard!

Make cakes and share the Gospel!

Rachel Hubbard
is a 4th year medical student in Newcastle

REFERENCES

1. James 2.20
2. Romans 10:14
3. Isaiah 55.11

SPOTLIGHT ON...
proposed health reforms of the UK's three main political parties

With the UK's next general election fast approaching, the future of the NHS is being fiercely debated at every level. But what are Labour, the Conservatives and the Liberal Democrats actually proposing?

the main themes

The unifying ideal throughout the proposals seems to be a **patient-led NHS** with all three parties putting a great deal of emphasis on **patient preference** and the '**right to choose**'. In addition, the recent buzz around the issue of **health inequalities** has resulted in every party paying a great deal of attention to the topic. Other common themes include the Liberal Democrats' (LibDems) and Conservatives' (Tories) proposals to revive **NHS dentistry** and reform the NHS dentists' contract in order to do so. They also plan to scrap central Government targets. **Abolishing all mixed-sex wards** is on the agenda for both the Tories and Labour. In no particular order, here is some more detail:

the Conservative Party

The Tories plan to **give patients more control** through patient-held records, in the hope that patients would be able to make more informed choices about their care. **Payment-by-results** would be implemented in GP surgeries as well as hospitals. An '**information revolution**' would aid transparency of the system: the online publishing of detailed information on the performance of all areas of the NHS and its staff would ensure that the NHS is accountable to its patients.

An independent **NHS board** would be charged with allocating resources fairly across the country. The focus on tackling health inequalities continues with a **Health Premium**, ensuring extra resources for the poorest areas with the worst outcomes. The renaming of the Department of Health into the **Department of Public Health** hopes to bring a new focus onto disease prevention. Palliative care services would be boosted by **per-patient funding**, as opposed to a general budget, and a £10 million per year budget for **children's hospices** after 2011. The introduction of a one-off £8,000 payment, as an **Insurance Premium**, for people entering retirement will allow them to fund potential future residential care without being forced to sell their homes.

the Liberal Democrats

The LibDems propose to abolish the **Strategic Health Authorities** and create **Local Health Boards** run by elected local people, thus enabling local people to have some control over their local services (eg save hospitals which are threatened with closure). The introduction of a **Patient Contract**, which would explain in detail the services and treatments that a person is entitled to, as well as explaining their rights with regards to access to medical records, would be expected to **guarantee high standards**. Patients with chronic conditions would be given a **Personal Care Plan** explaining how, where and when they will be treated and any extra support they will receive (eg social care), the idea being that informed patients can then make more decisions about the management of their condition.

A **Universal Care Payment** would be made to those over 65 who need help with caring for themselves. This would be allocated based on needs rather than ability to pay, with the aim of ensuring a minimum standard of care country-wide. To control the 'superbug' infection threat, a **zero-tolerance** stance would be enforced in all areas and patients given **compensation** if they suffer as a result of negligence in relation to 'superbugs'.

To improve access to GPs, patients would be allowed to **register at more than one GP practice**. A **Warm Homes Package** would be rolled out to help increase energy efficiency of homes and a **Winter Fuel Payment** of £250 would be given to disabled people, similar to that which pensioners currently receive.

the Labour Party

Like the other parties, Labour are planning to offer patients guarantees on aspects of treatment, such as waiting lists, but Labour intend to make these **guarantees legally enforceable**. There are plans to create a **National Care Service** to look after the most at-need in society and the offer of free, home personal care for those with greatest need.

The creation of at least 100 **GP-led centres** in the poorest areas is aimed at addressing widening health inequalities. The recently published NHS constitution informs both staff and patients what they can expect from the NHS. There is £100million directed to increase privacy and dignity in the NHS, with the **abolition of mixed sex wards** being a high priority and **financial penalties** enforced for hospitals that fail to work towards this.

New vascular checks and **extended ages for screening** breast and bowel cancer are planned to address public health needs. More psychological therapists will be employed to help treat mental illness.

(*BMJ* 2010;340:c684 (10 February), *labour.org.uk*, *conservatives.com*, *libdems.org.uk*)

16 year-old to become Britain's youngest sex-change patient

Bradley Cooper from East Yorkshire has become the youngest person to be accepted for an NHS sex-change operation in Britain. 'People might think I'm too young to make such a huge decision but I know my own mind and this is what I want.'

The trainee hairdresser, who calls himself 'Ria', has reportedly known for years that he was a woman, dressing as one since the age of twelve. He said that the operation would reconcile what he feels on the inside with who he is on the outside, finally bringing him 'peace of mind', particularly after years of bullying at school for being 'gay'. After researching sex-change operations himself and seeing his GP, Bradley was referred to a psychologist, who put him on a waiting list for the operation, satisfied that he knew his own mind and was eligible.

The decision has provoked outcry, particularly from the TaxPayer's Alliance, who say the NHS should spend money more wisely in the current economic climate, since the operation costs £10,000, but also from other sex change patients, who feel that Bradley is too young and impressionable to have the irreversible procedure. (*dailymail.co.uk* 2010; 24 January, *telegraph.co.uk* 2010; 24 January, *newsoftheworld.co.uk* 2010; 24 January)

rickets resurgence in the UK

Hours spent inside by children playing computer games or watching television are thought to be contributing to the resurgence of rickets in the UK. Associated with poverty in Victorian Britain and malnutrition in developing countries, rickets is caused by chronic vitamin D deficiency, resulting in abnormal growth and 'bow legs'. Dr Tim Cheetham and Professor Simon Pearce, scientists from Newcastle writing in the *British Medical Journal* (*BMJ*), call for Vitamin D supplementation in milk and other food products in the UK. 'I am dismayed by the increasing numbers of children we are treating with this entirely preventable condition.' There are currently more than 20 new cases of rickets per year in Newcastle alone.

People normally receive their Vitamin D from a small number of foodstuffs such as egg yolks and oily fish, or by synthesising it in the skin when exposed to sunlight. It is thought, however, that half of all British adults experience Vitamin D deficiency in the winter and spring; prevalence is higher in Scotland and the north of England, and amongst the Asian population. A recent study also suggested that Vitamin D supplementation could cut rates of bowel cancer, although not necessarily more so than an adequate natural intake.

Vitamin D supplementation of food products has already been successfully implemented in other countries. Moves to introduce it in Britain are currently opposed by both the Scientific Advisory Committee on Nutrition and the Food Standards Agency. (*timesonline.co.uk* 2010; 22 January, *bbc.co.uk* 2010; 21 January)

patient photos on Facebook

A nurse in Glasgow has been suspended after claims that she uploaded photos of patients onto Facebook. The photos, reportedly of individuals being operated on in theatre, were thought to be taken using a camera phone without the knowledge of other staff; patients are said to be unidentifiable in the photos. The nurse has been removed from her post whilst investigations are

underway. The incident has raised debate about the use of mobile phone photography in hospitals. (*bbc.co.uk* 2010; 22 January, *telegraph.co.uk* 2010; 22 January)

mother kills son with heroin injection

A 57 year-old mother was given a life sentence in January after killing her son as an 'act of mercy'. Frances Inglis from Dagenham, Essex, was found guilty of murder after injecting heroin into the thighs and arms of her 22 year-old son, Thomas Inglis.

Mr Inglis had long-standing brain damage after falling from an ambulance in July 2007. His mother first attempted to kill him with heroin a month after the accident, but he was successfully resuscitated and moved to a rehabilitation centre in Hertfordshire. Mrs Inglis was placed on bail for attempted murder and subsequently denied access to visit her son. 14 months later, however, Mrs Inglis visited her son using her sister's name and killed him with an injection of heroin. When nurses tried to enter Mr Inglis' room, the door was barricaded shut using oxygen cylinders. Mrs Inglis denied the charge of murder, stating that ending her son's life was an act of mercy. She considered that Tom would have wanted to die rather than continue living in such a condition, and that injecting heroin was the best way to allow her son a painless and peaceful death.

Judge Brian Barker told the court that 'mercy killing' is not a concept recognised in law – 'it is still killing'. The jury ruled that Mrs Inglis was guilty of murder with a majority of ten to two. She will serve a minimum sentence of nine years. (*telegraph.co.uk* 2010; 20 January, *bbc.co.uk* 2010; 20 January)

child's fictitious illness created by his mother

A mother was recently sentenced to 39 months in prison after fabricating her son's lifelong illness.

Lisa Hayden-Johnson's son spent the first six and a half years of his life being investigated by specialists from Bristol to Great Ormond Street; his supposed illnesses included cerebral palsy, cystic fibrosis, an allergy to sunlight, and diabetes. His mother also claimed that he couldn't swallow so he was fed through a tube.

Mrs Hayden-Johnson misled doctors, family and friends by forcing her son to sit in a wheelchair, making him breathe with the aid of an oxygen cylinder and spiking his urine with glucose. At the age of four he had a PEG tube fitted because he was seriously underweight. These fictions gained Mrs Hayden-Johnson and her son a large amount of attention and support, including meetings with Tony Blair and the Duchess of Cornwall.

Eventually it was uncovered that the problems Mrs Hayden-Johnson claimed her son suffered from were fictitious, the result of a form of child abuse called 'Munchausen Syndrome by proxy' where a parent (usually the mother) fabricates or induces illness in their child, seemingly simply to gain medical attention. In this case there were also considerable financial rewards with £130,000 claimed in benefits.

Mrs Hayden-Johnson's son is now eight and has been given a new identity. He is said to have been perfectly healthy since his removal from his mother. (*bbc.co.uk* 2010; 22 January, *timesonline.co.uk* 2010; 23 January, Abdulhamid I. Munchausen Syndrome by Proxy, *emedicine.medscape.com*)

mother cleared of attempted murder

Kay Gilderdale, a 55 year-old-woman, has been cleared of attempted murder after admitting to assisting the suicide of her daughter after a week-long trial. The jury of six men and six women took less than two hours to return their unanimous verdict.

Lynn Gilderdale, 31, was said to have suffered with ME for 17 years after contracting a virus aged 14. This left her severely ill and bedridden at her home in East Sussex, with her mother providing 24 hour care. She communicated using sign language, went through the menopause aged 20, and lost half her bone density from osteoporosis. She was fed through a naso-gastric tube and daily administered around 210mg morphine via a syringe driver to help manage her pain.

In December 2008 she persuaded her mother to help her die after saying that her 'body was broken': 'I want the pain to go – I don't want to go on'. Her mother provided Lynn with double her normal daily dose of morphine which her daughter administered herself. Lynn later awoke distressed at which point her mother administered a mixture of anti-depressants and sleeping tablets, as well as injecting three boluses of air to cause embolism.

Mrs Gilderdale was given a twelve month conditional discharge; the maximum sentence for assisted suicide is 14 years. The case sits against the backdrop of the newly published final guidelines on the situations in which someone would be prosecuted for assisting suicide. (*telegraph.co.uk* 2010; 26 January, *timesonline.co.uk* 2010; 25 January, *bbc.co.uk* 2010; 25 February)

child self-harm figures revealed

Figures released in January show that over 7,000 children in Scotland were admitted to hospital after self-harming in the last decade.

However, individual patients can trigger multiple episodes depending upon the different instances and aspects of health services they presented to. The Liberal Democrats health spokesman, Ross Finnie, who obtained the figures using Parliamentary Questions, described them as a 'desperate cry for help'. Finnie commented 'that there are long waits to access certain services, particularly services for younger and older people, and there is a lack of out of hours and crisis services in some areas'. He also said distribution of funding needed to change so that those at risk of self-harm were identified and helped in the community.

Shona Robison, Public Health minister, commented: 'we are aware of the extent of the issue of self-harming and are committed to tackling this'. She said a £5.5 million sum to boost mental health services will include funds for specialists to work with self-harm patients, leading to an increase in staff. This is planned to contribute to a reduction in the waiting time to see Child and Adolescent Mental Health Services (CAMHS) to no longer than 26 weeks by 2013.

Billy Watson, chief executive of Scottish Association of Mental Health, said self-harm should be taken seriously and is usually symptomatic of a deeper problem. He also commented on the need to promote a supportive culture in schools and to provide support for paid workers and parents. (*bbc.co.uk* 2010; 24 January, *scotlandonsunday.scotsman.com* 2010; 24 January)

know the man: John Wyatt

***Abigail Brempah** interviews John Wyatt, author of* Matters of Life and Death *and Professor of Ethics and Perinatology at University College London (UCL)*

Tell us how you became a Christian?

I grew up in a strong Christian family in Manchester and as a child you absorb all that you're taught. Then I went through a rather difficult period where I was questioning a lot, challenging what I'd been taught, and thought I'd been brainwashed by my parents. It wasn't until I left home at 18 to go to university that the crisis really came and it was really at that point that I decided I would devote my life to Christ. Suddenly something that had been theoretical became a reality in my life.

why did you decide to study medicine?

I went to university and read physics then I had a sort of spiritual crisis and realised that the God who had taken hold of my life was much more concerned about people than he was about neutrinos. Therefore I developed a very strong sense that God was calling me to change into

medicine as a vocation. That was actually very difficult to do because it wasn't possible for me to stay at the same university. I had studied no biology at school and I couldn't get into medical school until I had it so I did a crash course in Biology O-level for two weeks and then took the exam. I somehow scraped through and so left Oxford and came to London to study medicine.

how did you end up in neonatology?

Part of my spiritual crisis was also a realisation that I had been called not just to the UK but to somehow serve the God of the whole world. So my plan actually was to become a missionary doctor, and the reason I was interested in paediatrics is because it is one of the most useful things that can be done in many developing countries. So my first exposure to neonatology was just as part of my training in paediatrics but I loved it. I also saw for the first time a really positive model of doing academic research in a way that would really make a difference for people's lives and I saw that you didn't have to choose between being an academic and being a really caring physician - it was possible to do both.

when did you decide against being a missionary doctor?

Well, I still had it in the back of my mind that this was what I would do but I then stayed on at UCL doing research and after a number of years I was offered the possibility of staying on as a consultant at UCL, without having applied for the position. That really was another big crunch point because clearly that wasn't the plan at all. So there was quite a lot of heart-searching and I spoke to a number of people for advice and prayed about this decision and rather to my surprise, it seemed that God was actually pushing me to stay in this academic position, to try to be an influence for Christ in this academic work.

you are also a professor of ethics. how did you get into this?

It was entirely because of my experience in neonatology; I realised that I was in the middle of an ethical *maelstrom*. As the technologies were advancing very rapidly, there were all these ethical dilemmas and questions that were being raised about their use. We were seeing babies survive who previously would have died, but the question was 'Was it right to resuscitate every baby?' I was working on new ways of detecting brain damage using different forms of brain scanning but then the question was 'What do we do when we discover that this baby has terrible and irreversible brain damage? What now? What is our responsibility with this knowledge?'

You couldn't avoid the whole question about abortion, particularly when the law changed in the early 1990s so that late abortions started to be performed. This led to the situation where in the same hospital we were enabling younger and younger babies to survive and at the same time considerably more mature foetuses were being terminated. I was regularly being asked to go and counsel mothers who were considering having an abortion and wanted to speak to a paediatrician about the decision.

I felt a great responsibility as a Christian to think 'how could I think through these issues?' and 'how could I develop a Christian response?' So I felt I was being pushed into ethics really; it wasn't something that I naturally thought I should just do but I couldn't avoid the challenge.

you've just written a new book - the second edition

of* Matters of Life and Death,[1] *could you tell us more about that?

About eleven years ago, I was invited to give a series of lectures called 'The London Lectures in Contemporary Christianity', and part of the deal was that a book would be written out of the lectures. It really forced me to put down the ideas that I'd been developing over a period of 10-15 years and try to crystallise them in a book. I found it a real struggle to write, both the first edition and the second too. But I've been really moved and humbled by the way God has used this book, particularly (to my surprise) the way it has been used outside the UK.

When I wrote the first edition I felt it was important to really try to grapple with what was actually happening at the time. One of the things that I learnt from John Stott (who's been a big influence in my life) is that when we're trying to counteract the arguments of somebody with anti-Christian views, we shouldn't just try to grapple with their bad arguments but we should also try to grapple with their best arguments. So in the book, rather than caricature the secular arguments, I'm trying to take the best exponents and then show the faults of the arguments and how we can respond to these as Christians. I felt it was important to try to update it [in the second edition] and it was interesting to see how the arguments had moved on over ten years. I have tried to develop some new ideas in the new book.

you seem to think that it is important for us as Christians not to ignore ethical issues but to think about them, and to engage with and debate about them.

I do, and in fact I think it's not an optional extra; it's often put forward that you can just be an ordinary Christian and there are a few eggheads who will think about ethics but the rest of us can get on with living our lives. I really don't think that is biblical Christianity. I think the biblical perspective is that God has called each of us into existence in this particular time in world history so the challenge is 'How can I be obedient to Christ? How can I be the person that God has made me for, in this particular place that he has called me to be his witness?' Part of being an effective witness is understanding the world which God has put us in.

It's a little sad that often medical students and doctors develop their thinking in their studies to a high level, working at graduate or postgraduate level but when it comes to Christian thinking and ethical thinking they're quite happy to operate at GCSE level and are not prepared to develop their academic and intellectual skills to apply to these very complex and difficult issues. We're supposed to love the Lord our God with all our minds as well as with all our hearts, our souls and our strengths, and part of loving God with all our mind is to use the intellectual and academic gifts that God has given us in his service.

you are involved with the Christian Medics student group at UCL, how did this begin?

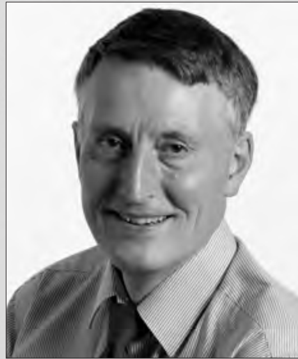
I've been involved since I was a junior doctor in the mid 1980s, and my wife Celia and I started inviting medical students to come for meals in our house. We've had the privilege of being linked with that group ever since. It's been a great joy; sharing our home and encouraging and supporting medical students. Many of the people who first came into our home as students are now established in their careers and we meet them from time to time. It's been one of the great joys of our lives.

what else do you do in CMF and how did this begin?

I got involved with CMF as a medical student and was then invited to become a member of the Medical Study Group, an ethical committee. I stayed as part of the group for a number of years and I'm now chair. What we try to do is horizon scanning - looking at the latest developments in technology, ethics and science and trying to develop Christian responses to new challenges as they arise. It's been a very exciting and challenging job, and we meet several times every year. I'm also a member of the CMF Board of Trustees - we have the privilege of helping in leadership and taking responsibility for the overall direction of the Fellowship.

you're a clinician, professor in perinatology and ethics, and involved with CMF, the UCL Christian Medics and with campaigning. I don't know if you have any spare time at all, but what do you like to do in your leisure time?

(Laughs) I've been a musician ever since I was a child and so one of the things we really enjoy as a family is playing



music - all my three sons are musicians and quite often we have family jams...

oh, nice! 'The Wyatts!'

(Laughs) Yes, that's right! Also, one of the things I learned from John Stott was to value the created world and so I became interested in natural history and just being able to spend time in God's world. It's very restorative to our sanity. The problem within a city and within a hospital is that everything you're surrounded by is man-made and therefore man's preoccupations become predominant but when we go and expose ourselves to the natural world, suddenly we're reminded about God's creation and God's priorities, and that's the way it's meant to be.

are there any special words you would like to say to the Christian medical students all around the country who would be reading this?

Gosh! Well, I just see the fantastic potential that is locked up in any one life, what God can do with any one life that is given over to him. My sadness is for so many people, for whatever reason, they fail to find God's best in their lives. I think in the parable of the sower,[2] the most ominous aspect is where it talks about the thorns - it's the thorns which choke the seed and prevent it from being fruitful. The biggest danger for medical students is that their fruitfulness for Christ will be choked by those thorns. The positive thing is that God loves to work with the weak and the pathetic and the people who feel that they have little to offer, and so if there are people reading this who feel that they come into that category, that they don't have any special skills, that they are full of weaknesses, then they are precisely the kind of people that God wants to use.

Abigail Brempah
is a clinical medical student at UCL

REFERENCES

1. Wyatt, J. *Matters of Life and Death*, Nottingham: IVP/CMF, 2010
2. Mark 3:3-20; Luke 8:4-15

crash call:

an urgent appointment with the living God

***Jo Lovell** reports on the 2010 National Student Conference*

What is our motivation for living differently amongst our friends and course-mates at medical school? What is the vision towards which we strive? Whom do we serve and why do we serve him? Amidst the busyness of any medical student's life, as we juggle study, placements, friends, church life and family, it's easy to forget the answers to these questions. And yet how wonderfully God provides for his children! The National Student Conference weekend gave us the opportunity to leave the commotion of every day life; to listen again to God's truth in all its fullness, and to see its impact on the whole of our lives.

The atmosphere of the first evening was brilliant. More than 300 students from the UK were joined by others from as far afield as Tajikistan, Russia and Georgia. Looking around the conference hall, I was thrilled to know that each of us had come wanting to know more about our great God, and how we can serve him in our lives as medics. Meeting other students over meals, in seminars and in review groups was a wonderful chance to chat and share experiences of what God was doing around the country both in our own lives, and in the lives of those around us. I also took the opportunity to chat to 'grown-ups' – real doctors with stories to tell, and wisdom to draw from!

For students like me who are largely ignorant of what goes on in the CMF world, I was glad of the chance to hear about who was who on the CMF staff, and what was what in the work they do. The 'Newsround' on Saturday morning was our opportunity to be both informed and encouraged by the work of CMF, for example the Christian values promoted by CMF in the public arena. We were also challenged to consider the positions we are each placed in, and how to use them to serve the living God. I was amused to learn that the Student Conference Committee reps considered their role of service to God and us to include leaving us each a Valentine's Day gift to find outside our doors on Sunday morning (14th February)!

We were blessed by having Terry Virgo (founder of the NewFrontiers church network)

with us and teaching us from God's word. He challenged us to look at the way God worked through the life of Moses, who 'By faith... regarded disgrace for the sake of Christ as of greater value than the treasures of Egypt because he was looking ahead to his reward'.[1] He showed us that living by faith, like Moses did, was to live for what we do not yet see; the unseen riches of heaven diminish the appeal of the seen riches of this world. To understand this is to be freed to live joyfully serving the real King, motivated by the knowledge that Christ is a better inheritance than the passing 'pleasures of sin'.[2]
On Sunday afternoon, we were shown from Exodus 15 that the natural reaction to seeing who God is and what he has done is a song of praise – with our lips and in our lives.

This faithful teaching formed an effective backdrop to the topics covered by the seminars. Ranging from 'Medical Mission' to 'Psychiatry' there was plenty of choice, and plenty to get one's teeth into! I for one took the opportunity to ask all the questions I had stored up on my clinical travels, and sought to understand the Christ-honouring response to the issues Christian medics face every day. I was so encouraged to be able to chat to older, wiser medics, who were well thought-through on issues the Christian doctor faces, and the way their faith impacts the way they practise.

plenty of choice, and plenty to get one's teeth into!

One particular issue I had been mulling over before arriving at the conference was that of the new wave of support for legalising 'assisted suicide', which has recently emerged in the British press. I hoped that the conference would provide me with the chance to quiz a Christian doctor on the right response to this controversial issue; I was not disappointed.

I had a wonderful chat with Kathy Myers, a consultant in palliative care in Hertfordshire, who ran a seminar entitled 'Caring for dying patients'. She helped me to learn again that whilst the argument for dignity in dying was a powerful one, we as Christians point to true human dignity; not derivative of what we can or cannot do, but rather that which is given to us being made in God's image. She gave me some wise advice in how to defend the Christian view that this kind of value deserves the best kind of treatment we as doctors

can offer. From her own experience, she offered both spiritual and utilitarian examples of what this care looks like.

All this was brought together beautifully by the Conference Address given by Kevin Vaughan on Saturday afternoon - 'Sharing Christ with Patients'. Kevin is CMF Head of Graduate Ministries and was previously a GP in Birmingham and missionary doctor in Africa. He carefully unpacked the biblical concept of sowing seeds, as described in parables like those in Mark 4.

Listening to Kevin made me realise how little I trust God to do his own work; I want to see results immediately! Kevin is clearly a man who has served the Lord over many years, and has seen him work in the lives of his patients in the most amazing ways. 'Sometimes', he told us, 'we have to do the work of clearing the ground of rocks and tree stumps, before it is ready to be ploughed and sown and harvested. Our job is to sow the seeds, whenever we can; God's job is to make them grow.'

On Saturday evening, various activities were provided for the delegates; the ever popular Ceilidh, a quiz, a film and discussion, and a praise concert led by Colin Brown who had led the music during the conference. Having spent some free time during the afternoon going for a jog with some students from Manchester, I was feeling a little more reflective than energetic by this time, so I opted to join the discussion around the film '*The Village*', directed by M. Night Shyamalam. The new Head of Student Ministries, Giles Cattermole, enthusiastically encouraged us to engage with the message, themes and ideas presented in the film, and we had a great discussion.

The result of four seminars, three Bible addresses, two evenings, and one conference address is zero energy left! A packed weekend indeed, but I left feeling refreshed by the truth of who God is, the plans he has for the world, and the ways he can and does work through people like me. I pray that God will continue to teach me during the busyness of my student days that my motivation, my vision and my service is all for his glory, and in the name of his Son.

Thanks to all who made it possible!

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REFERENCES

1. Hebrews 11:24a, 26
2. Hebrews 11:25

who cared for Kerrie?

__Lizzie Groom__ considers the consequences of a hard case

On 18 September 2007 Kerrie Wooltorton, a 26-year-old woman, was rushed into Norwich University Hospital A&E department having called an ambulance after drinking lethal antifreeze in an attempt to commit suicide. What happened next turned what is, tragically, a fairly common occurrence into headline news. Kerrie was well known to the department, as this was her ninth suicide attempt that year.

All other times she had agreed to dialysis treatment. This time she refused. She produced an advanced refusal, signed three days prior, stating she did not want any curative treatment and was '100 per cent aware' of the consequences of her refusal.[1] She said she had only called an ambulance because she didn't wish to die alone or in pain. Ms Wooltorton was described by staff as appearing 'calm'.

However her history revealed that she suffered from an emotionally unstable personality disorder, and was known to mental health services.[2] Picture the scene in a busy casualty department as staff were left trying to determine what to do. Eventually the staff with the support of hospital lawyers agreed not to start dialysis and Kerrie died four days later.

The story returned to the media spotlight in 2009 when the Coroner at the inquest exonerated the medical team from blame. Again the case provoked strong feelings in the public with widely conflicting opinions of what ought to have been done. Andy Burnham, the current Health Secretary, remarked on the case saying it was taking the law into 'new territory'.[3] While we can sympathise with the staff who undoubtedly had the best of intentions, Kerrie's case highlights some of the alarming consequences produced by current thinking in medical ethics. This tragic story also hits closer to home. I found Kerrie's story a real challenge. As future doctors how should we care for our patients? And how should we care for those around us?

capacity and consent

all about 'advance refusals'?

Unfortunately there was considerable confusion as to what the law allowed a doctor to do or not do in this situation. The 'living will' which Kerrie came in clutching was seized upon by the press in an unhelpful way. Advanced refusals, commonly known as 'living wills', were introduced with the intention that they could help to counter inappropriate and excessively burdensome treatment

that could often be imposed on the terminally ill by well meaning, but perhaps misguided doctors. The intention was certainly good, although critics argued that it could be misused, especially in the context of the euthanasia debate. The *CMF file* 'Advanced Directives' by James Paul is helpful and offers a full discussion of the issues involved.[4]

Mental Capacity Act 2005

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

A person is unable to make a decision for himself if he is unable:
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means)'[7]

However, Kerrie's 'advanced refusal' was a diversion from the central issues. It was not applicable, since Kerrie came in fully conscious and able to communicate with staff. Had Kerrie come into A&E unconscious with a *valid* advanced refusal then the legal position would be less clear, as many critics had forewarned before the legislation was introduced. But Kerrie was not unconscious. Additionally even if she had been unconscious, Kerrie's 'advance refusal' had not been witnessed, rendering it invalid.

assessing capacity

So what are the relevant legal issues in this case? As Sheila McLean, Professor in Medical Ethics and Law at Glasgow University clearly explains on her *BMJ* blog,[5] this case rests on whether Kerrie had capacity to refuse treatment. Capacity may be a familiar concept for some students, but others may be less sure about it. Don't worry - this won't get too technical - but it is important for us to be clear on our legal obligations. Capacity (or competence) is the legal term used to describe whether or not the patient is legally able to make treatment decisions. English law maintains that an adult of sound mind has the right to refuse treatment for rational or irrational reasons and this should be respected, even if the decision leads to death. If treatment is imposed on a competent adult it amounts to a 'battery' (assault) and this is a serious criminal offence. Clearly it is important to ascertain if a person has

capacity. The Mental Capacity Act 2005[6] lays out tests (see box on previous page).

Communication can be difficult for some patients (eg asylum seekers, patients suffering from strokes) and doctors and others involved in care should try to find ways around these obstacles so a patient can express their views.

Alcohol, drugs and the severity of an overdose can impair a person's capacity temporarily. In these cases the doctor is allowed to give essential life saving treatment in order to restore the patient to a state where they are competent to make decisions. If a patient is permanently incompetent then doctors are expected to make treatment decisions that are believed to be in the patient's best interest. It is wise to seek legal advice if unsure how to proceed.

mental illness and capacity

Did Kerrie have capacity to refuse treatment? Well none of us were there. We didn't meet Kerrie or assess her psychological state so can't speak with complete confidence. However the details of the case, as disclosed in the press, raise serious concerns as to her ability to make this decision. Can someone who has recently repeatedly attempted suicide be of sound mind? Kerrie was known to have been depressed since receiving news that she would struggle to become pregnant. Severe depression is likely to limit a person's ability to weigh information. Kerrie also suffered from a personality disorder; in itself this does not amount to a lack of capacity but combined with the other details it could throw doubt on her capacity. Two leading consultant psychiatrists, Bashir and Crawford, concluded after studying the case that 'depression and emotionally unstable personality disorder are mental disorders, which often impair a person's cognition and emotional health'.[8]

> we are wrong if we equate killing with caring

A psychiatric opinion is often essential. If acute mental illness or chronic impairment is believed to be affecting the patient's capacity then they can be detained under the Mental Health Act. Treatment may be commenced if it is believed that the overdose was the consequences of the mental illness.[9]

confused about care

We discussed this case in an ethics tutorial recently and I found the discussion troubling. We were distressed to hear that Kerrie had suffered such a painful end to her life and we all agreed that what happened didn't seem right. However, when discussing what could have been done, someone suggested that the caring thing would have been to help Kerrie end her life. Establishing a programme of assisted suicide was proposed, so that depressed individuals such as Kerrie would be helped to end their lives in a more 'dignified way'.

I'm sure that suggestion was motivated by a desire to care. However, we are wrong if we equate killing with caring. What has caused us to lose our way?

all about autonomy

In recent years there has been a dramatic increase in the importance given to the patient's autonomy when making healthcare decisions. Autonomy literally means 'self

rule' and in the healthcare context can be described as the 'freedom that a person has to order his or her life according to his or her own desires and values'.[10] Autonomy has been an important concept in healthcare decisions, but until recently had always been balanced against other values such as beneficence (doing good), non-maleficence (not doing harm to patients) and justice.

The desire for patient autonomy is now at the heart of many of the modern complex medical ethics challenges. Secular ethicist Professor John Harris, a firm supporter of autonomy, writes 'Since it is my life, its value to me consists precisely in doing with it what I choose'.[11]

Rights are the new language of ethics - the 'right to die', or more accurately the 'right to die when and how I choose' (which translates into a 'right to be killed by a doctor') is one of the key arguments in the euthanasia and physician assisted suicide debate. Many commentators, both religious and secular, are questioning whether we have lost our way.[12] Has our attempt to empower patients gone too far? Is too much emphasis placed on autonomy?

all about autonomy: what does the Bible say?

There is much that could be said and the 2005 *CMF File* on 'Autonomy - who chooses?'[13] goes into considerable more detail and has greatly influenced this article. It's well worth a read!

Autonomy can be broken down into three classifications - partial moral autonomy, civil autonomy and libertarian autonomy. Partial moral autonomy refers to the 'right of each person to choose his or her own course of action within boundaries of acceptable standards and norms'.[14] We are created beings, but we are created in God's own image and have been given a certain amount of freedom and responsibility to make decisions.[15] Christian teaching supports this concept of limited autonomy. Civil autonomy describes our right to make choices without pressure or coercion, and is supported in the Bible. God is just and calls us to promote justice for all in our world:

He defends the cause of the fatherless and the widow, and loves the alien, giving him food and clothing. And you are to love those who are aliens, for you yourselves were aliens in Egypt.[16]

Libertarian autonomy promotes freedom to do whatever you like. If there is no God to hold us to account then this view makes sense. The world is our playground and we are free to play by whatever rules we choose so long as our fun doesn't hurt anybody else. This does not fit with the biblical view where mankind is dependent on God who 'gives life to everything'.[17] True freedom is not being able to do whatever we like. It is being free to choose to follow God's commands, no longer being 'slaves to sin'.[18]

doctors: solely service providers?

The growing emphasis on libertarian autonomy in medical ethics threatens the doctor-patient relationship, reducing the doctor to a service provider whose only duty is to carry out their patient's wishes. The renal consultant treating Kerrie stated that he felt it was his 'duty to follow her wishes'.[19] Secular ethicist Marian Verkerk argues against this attitude, saying that 'an overemphasis on self-determination and non-interference can leave patients without appropriate care'.[20]

We must be careful not to coerce or force treatment on vulnerable patients, but we must be equally as concerned not merely to accede automatically to what patients say they want. John Wyatt, Professor of Ethics and Perinatology at University College London, suggests doctors adopt an expert-expert relationship where the doctor works in partnership with the patient to help them work out what they really want, meeting their needs along the way.[21]

called to care

who? everyone

Patients, like Kerrie, who have repeatedly attempted suicide can often be regarded as nuisance patients by staff. In a busy casualty department their needs can sometimes be overlooked in favour of the more acute or sometime more 'deserving' cases. As Christians our attitude should be different. Each human bears God's image and Christ was born as a man. Proverbs 22:2 says 'Rich and poor have this in common: the Lord is the Maker of them all'. For this reason, each human being is worthy of respect. Thomas Sydenham, a leading English physician in 17th Century, makes this point well:

Let him (the physician) remember that it is not any base or despicable creature of which he has undertaken the care. For the only begotten Son of God, by becoming man, recognised the value of the human race and ennobled by his own dignity the nature he assumed.[22]

> Jesus never failed to get to the heart of people's problems

If we have this view of individuals then this will shape how we talk to our patients and how we talk about them. It's often tempting to make jokes or comments behind the patient's back. This is incompatible with a Christian view of human dignity and the Bible warns us against such talk:

The tongue also is a fire, a world of evil among the parts of the body. It corrupts the whole person, sets the whole course of his life on fire, and is itself set on fire by hell.[23]

What if patients seem to be making an unwise choice? We should continue to respect our patient even when they make decisions that we do not understand at all. There may be a case where someone appears to have complete capacity, yet still refuses life saving treatment despite your best efforts to persuade them. It is important to maintain a supportive approach. Hopefully if time is taken to listen to the patient they may change their mind. If not, they still ought to be treated with respect.

what? carry each other's burdens

Doctors can sometimes be quick to deal with a patient's immediate and pressing needs, but neglect to explore the deeper underlying concerns. Jesus never failed to get to the heart of people's problems. The healing of the paralytic man in Mark 2 is well known often from Sunday School days, but isn't it striking that Jesus is not content to heal the man's physical needs. In addition he exposes and cures the man's deeper spiritual need.[24]

Whilst it may be entirely appropriate to speak of Christ directly to our patients, this will not always be the case. However, we can strive to be doctors who take the time to listen to our patients, to understand their concerns and look for ways to ease these burdens. Paul tells the Galatian church to 'Carry each other's burdens, and in this way you will fulfil the law of Christ'.[25]

when? all the time

Caring is not just a 9 to 5 calling! Christ calls us to take this attitude of care and concern back home with us too. It is not sufficient to care solely in a professional capacity. Christ commands us to love our neighbour. The Parable of the Good Samaritan is a clear example that our neighbour can be anyone who we see in need.[26] Who are the Kerries in your year? Your church? Your sports team? We are Christ's mission team chosen to show his care for those around us.

how? look up!

I must admit that this doesn't sit comfortably with me. I like the easy life. I choose to spend my free time doing what I want to do. I want to spend my money on my hobbies. I prefer relaxing with my friends. If I continue to look at myself and my wants and needs I will never be motivated sacrificially to serve others.

Such a radical change in outlook is only possible by seeing Jesus' example. The one who had everything gave it all up, becoming nothing[27] and serving those he had created even though it would cost him his life. Paul makes it clear that this should encourage and spur us on so we consider others' needs more important than our own.[28]

so who really cared for Kerrie?

Kerrie was a troubled young woman, clearly lacking support. Everyone involved in the case wanted to do what was best for her. However the current preoccupation with unrestricted patient autonomy reflected in English law resulted in a troubling outcome. As Christians we need to be distinctive in the way we treat patients and also each other. Following Christ's example we should show a concern for the whole person, a desire to share in their struggles and a willingness to meet their needs even if it comes at a cost. In a society obsessed with the right to personal autonomy we are called to restrict our own freedom in order to care for others.

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REFERENCES

1. *tinyurl.com/yhcwfbl*
2. *tinyurl.com/ydkyntp*
3. *tinyurl.com/ye3tpjz*
4. Paul J. *CMF File* 19 (2002) Advanced Directives. *tinyurl.com/ydyrmdx*
5. McLean S. *BMJ blogs* 1 October 2009. *tinyurl.com/yc9hqr4*
6. Mental Capacity Act 2005, *tinyurl.com/ybqwzba*
7. *Ibid, Part 1, Section 3, Clause 1.*
8. *Bashir F, Crawford* M. Autonomy or life saving treatment for the mentally vulnerable? *BMJ* 2009;339:b4400
9. *Mental Health Act*. 1983. London: MPS, 1998
10. Rae S, Cox P. *Bioethics*. Grand Rapids: Eerdmans. 1999:199
11. Harris J. *The Value of Life: An Introduction to Medical Ethics*. London: Routledge, 1985:80
12. Barrratt H. *CMF File* 29 (2005) Autonomy- who chooses? *tinyurl.com/y9w8k25*
13. *Ibid*
14. Branch JA. Autonomy and the Health Sciences: Clarifying a Broad Concept. *Intégrité* 2003;2.2:20-33
15. Genesis 1:26-30
16. Deuteronomy 10:18-19
17. 1 Timothy 6:13
18. Romans 6:6
19. *tinyurl.com/ybhtq9w*
20. Verkerk M. A Care Perspective on Coercion and Autonomy. *Bioethics* 1999; 13(3-4):358-368
21. Wyatt J. *Matters of Life and Death*. IVP and CMF.
22. Payne, JF. *Thomas Sydenham*. Charleston, Bibliolife 2009, p118
23. James 3:6
24. Mark 2: 8-12
25. Galatians 6:2
26. Luke 10: 25-37
27. Philippians 2:7
28. Philippians 2:3

the worldview... at ground level

***Clare Bird** helps us to ask 'why'?*

Relativism, pluralism, scepticism, exclusivism ... all of these are interesting academic concepts, but surely have no real use when talking to your average student colleague? I beg to differ. How many times have you heard the phrase, 'your faith is so lovely, but it just isn't for me' or 'you may think that's not right, but it's fine in my morality'. When discussing end of life ethics, many will say 'surely nothingness (referring to death) is better than suffering?'

All of these statements are based on truth claims about life, the universe and everything. Even the classic relativist's statement 'there is no absolute truth' is a truth claim. If there is really no absolute truth, then surely the statement can be only relatively true – in which case it is it self-refuting! Such truth claims inform our view about the world and influence our decisions and opinions. Even though everyone holds a set of beliefs about the world, not all would recognise it as a worldview. Evaluating a worldview is not just the role of a philosophy professor; it can be a helpful tool in everyday discussions with friends. Such evaluation may help us to challenge friends about their beliefs.

A few months ago, I attended CMF's *Answering Other Faiths* course. As part of the day, we discussed the bases behind different religions and worldviews with the aim of becoming better prepared to share the gospel with proponents of these views. Since attending the course, I've been surprised how often I've heard people making decisions or expressing opinions which imply a great deal about their worldview.

Let me give you an example. This week I was talking to my ward partner about an ethics project; he'd concluded his essay by saying 'there is no difference between humans and animals, because when we include the young or the demented, we cannot draw a line between their specific skills and capabilities'. Does he have a worldview? His comment implies that he views mankind as the most recent step in the evolutionary process, here on this earth by chance and with no ordained value other than that which we give ourselves. Yet there's an inconsistency here. He continued to tell me that he still considers it favourable to use animals, over humans, for experimentation. Why?

The simple challenging question 'why?', gently and genuinely presented, can work as a great conversation starter. It is neither rude nor offensive to question the beliefs that influence the thoughts of our friends and colleagues. Here, the art of listening is valuable; it is often very interesting to see the way

others consider the world, and their response can also inform future conversations. Sometimes 'why' will be a challenge in itself, but at other times it may be helpful to highlight the inconsistency in their worldview. This should be done gently and with respect, as Peter reminds us.[1]

Some helpful resources:

Bethinking.org – a website full of articles tackling a huge range of apologetics issues. It includes some really helpful articles explaining the 'isms' of different worldviews and the consequences of these in today's society.

Questioning Evangelism by Randy Newman[2] – this book has some practical suggestions and transcripts giving examples of how to use simple questions in evangelism.

Francis Schaeffer is a Christian thinker who wrote '*The God Who is There*';[3] he discusses the cultural shift towards relativism and how to confront it.

how can we diagnose a worldview?

To determine someone's worldview, there are a few helpful questions we could ask such as 'What are human beings?' or 'What is God?' or 'How do we decide on right and wrong?' or 'What is the point of life?' The answer to each of these questions guides the thinker towards the foundations of their own beliefs, and helps us to understand them.

why diagnose a worldview?

The student mission field has changed greatly over the last hundred years. When Christian Unions were established, most students were familiar with the church and had some basic grasp of the gospel. The aim of evangelistic events was to provide a forum for students to respond to the great news and to choose to follow Christ. Today, church attendance has dropped and increasing numbers of students arrive at university with little or no Bible knowledge or understanding of Christianity. There are increasing numbers of international and home students from diverse backgrounds. Discussing worldviews helps us to identify a friend's starting point, rather than making assumptions about what they already know.

The last 50 years have also seen a cultural shift towards the need for 'tolerance' of everyone's view, and a resulting intolerance of any suggestion that one view is right and another wrong. For example, a Christian Union may be considered 'intolerant' for wishing to define its beliefs with a doctrinal basis and therefore restrict leadership. It seems rather hypocritical that this need for 'tolerance' has been strictly imposed upon us by

regulations that do not tolerate dissent, and which we must conform to. Allowing everyone equal 'rightness' breeds pluralism (the idea that all paths reach the same destination). This shift in thought creates a great stumbling block for Christian mission today. Truth is foundational to the gospel. The good news would be yesterday's news if Jesus was just one of the many ways to reach God; it would barely be news at all if God only existed for me. There is very little value in explaining 'what Jesus means to me' to a friend who sees no link between what is right for me and what is right for her. The result of this shift is that we must be aware of what a friend understands by the words we use. We can do this by considering their worldview.

Whilst writing this article, I find myself once again in a tangle of 'isms', searching for a formulaic solution. It needn't be this way. All one needs is to understand the societal shift towards so-called 'tolerance' of all beliefs and to consider the impact that a worldview has on the way a person directs their life. Then take a step back into ordinary, everyday life. Especially in medicine, it doesn't take long for me to stumble into another conversation which is influenced by someone's view of the value of life or the source of morality. Some well placed 'whys?' and a timely 'could you explain that to me?' might be all you need to gently expose the flaws in a misformed worldview and open the door for gospel conversations. What a great opportunity to explain the way you see the world and how this influences the way you see the situation!

Often it can be much easier to pray for opportunities to speak to friends than it is to actually take them. So here's a challenge… over the next week listen carefully to your friends or colleagues as you talk. See if you can diagnose their worldview from the decisions they make or the opinions they give. And when you do, ask them 'why?'

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CMFs **Answering Other Faiths** course goes into greater detail about worldviews. As well as learning how to diagnose a worldview, participants learn about some of the different worldviews commonly encountered today. The course looks at ways of identifying the truth contained within a given worldview, challenging the falsehood, and inviting the holder of that view to consider the claims of Jesus. The course is usually run as a Saturday day conference, although other models are possible. Details of upcoming events can be found at *www.cmf.org.uk/students/events.asp.* If no course is listed in your area, why not ask your CMF reps (listed on the inside back cover of *Nucleus*) about organising one?

REFERENCES

1. 1 Peter 3:15
2. Newman, R. *Questioning Evangelism: engaging people's hearts the way Jesus did.* Kregel, 2004
3. Schaeffer, FA. *The God Who Is There*. IVP, 1968

medical ethics for beginners

***Giles Cattermole** explains the basics of medical ethics*

Ethics is far more than the life and death issues currently popular in the media. It's about every decision we make; 'I should do this' or 'I shouldn't do that'. This article introduces the sorts of questions that ethics is concerned with, the answers that humanist frameworks offer, and a critique of these from a Christian perspective.

what is ethics about?

On a ward-round, it's easy to think that prescribing antibiotics is a 'scientific' decision, without the need for ethics or 'value judgments'. But If the patient is foreign, unconscious, terminally-ill, with life-threatening pneumonia, and if the antibiotics are very expensive with nasty side-effects, all sorts of ethical considerations become apparent: how we treat patients who can't consent; which people are entitled to NHS treatment; how good and bad outcomes ought to be balanced. Even for everyday cases, value judgments are intrinsic to medicine. 'Patient' implies a particular relationship of duty and care. 'Infection' suggests something that is bad. Medicine presupposes that disease is 'bad' and health is 'good', and that clinicians 'ought' to help people from disease to health. These are value judgments, this is ethics.

Ethics is about deciding what is morally right and wrong, about what we should or shouldn't do. Medical ethics therefore is concerned with the obvious issues like abortion, cloning, and euthanasia. But also with what life is and what a person is. What disease and health are. Our attitudes to disability and mental illness. Justice and rationing. Confidentiality, dignity, consent, truth-telling, paternalism, professionalism, research and much more.

how can we know what is right?

Is morality revealed, discovered or chosen?

In the West, morality was once generally accepted to be 'revealed'; God tells us, in the Bible, or in nature, what is right and wrong. Our task is to discern his will. Enlightenment deism saw morality as 'discovered'; there is moral truth 'out there', but God won't tell us what it is; we have to work it out for ourselves according to a moral framework. Post-modernity says that there is no absolute moral truth; morality is 'chosen'. Ethics becomes no different from aesthetics.

For some people, value judgments, whether aesthetic or ethical, are merely matters of personal preference. But even though they sometimes behave as though all that matters is their personal pursuit of happiness, in practice few people consistently live as

what is truth?

Some philosophers use the categories of 'factual' and 'value' judgments. Factual judgments concern scientific truth and logical truth. The former is determined empirically, the latter is self-evident based on first principles. Value judgments concern aesthetics and ethics. For example:

- **Wales is west of England -** scientific truth, observed on a map or on a visit
- **2 + 2 = 4 -** logical truth, assuming the rules of mathematics
- **Coffee is nicer than tea** - aesthetic judgment, 'true' for some but not all
- **Murder is wrong** - ethical or moral judgment

though there is no moral truth at all. Just ask them whether Hitler was wrong. Or whether rape or racism are acceptable. Instead, most people still think that some actions really are 'right' or 'wrong', even if they disagree about which are which. They operate according to some sort of moral framework, even if they don't know it.

humanist ethics

Three classic theories:

- **Virtues**[1]
  BE the right person
- **Duties (Deontology)**[2]
  DO the right action
- **Consequences (Utilitarianism)**[3]
  WILL the right outcome

virtue

Virtue ethics are concerned with the *character* of the moral agent. By becoming the right sort of person, what Aristotle called 'the great man', one will naturally behave correctly.

Many people think this sort of theory too vague and incomplete for practical use, but there is still an assumption that doctors and nurses should be competent, compassionate, altruistic people.

duty

Duty based ethics are concerned only with the rightness or wrongness of an *action* itself, not with its outcomes. Some things are universally right, some universally wrong. Kant's 'categorical imperative' was to 'act only according to that maxim whereby you can at the same time will that it should become a universal law'. Not to lie, for example. The Hippocratic Oath[4] was a list of duties.

But many people object to the idea of absolute, exceptionless duties:

Imagine you are sheltering a family of Jewish refugees in your home in 1940s Holland, and a Nazi patrol asks if there are any Jews there. Would you tell the truth?

utility

Consequence-based ethics look to the *outcome* of any action to determine whether it is right or wrong. The end justifies the means. 'Utilitarianism' is a form of consequentialism in which the desired outcome is the greatest net happiness of all concerned.

However, one can never be sure that an action will achieve its desired end. Even if it did, it's difficult to sum 'happiness' and 'sadness' for different people who might appreciate happiness differently from each other. It's also obvious that this sort of thinking is very dangerous for individuals and minorities:

Imagine a very unpopular colleague. If you kill that person, there is a very negative outcome for that individual. But you might create a small degree of happiness for many other people. If the many small happinesses outweigh the one big unhappiness, then for a utilitarian, this would be the right thing to do.

rights

For many, virtue ethics were too vague and duty-based ethics were too absolute. As governments took over the role of providing heath care, the driving ethic became more utilitarian: an ethic of efficiency, maximising the good of the whole population. But the atrocities carried out for the 'greater good' in the Second World War led to the adoption in 1948 by the United Nations of the Universal Declaration of Human Rights,[5] rights to protect individuals and minorities from unfettered utilitarianism. Duties can be perceived as the corollary of rights: if I have a right to healthcare, then someone has a duty to provide it. Confidentiality is not seen as an absolute duty as Kant would have defined it, nor as the

characteristic of a virtuous clinician, but as respect for the patient's right to confidentiality. These duties are now often described in professional codes of conduct, such as the UK General Medical Council's 'Duties of a doctor'.[6]

principles

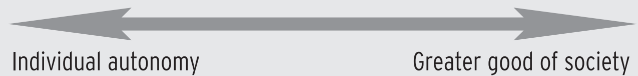
Virtue, duty and utility-based ethics are ethical *theories*, from which principles and rules can be derived for practical decision-making. In the 1970s, Beauchamp and Childress[7] famously promoted the idea of 'principles' of medical ethics: most people, of whatever religious or cultural background, tend to agree on certain basic ethical principles. The standard four principles they described were: autonomy (respect for a person's choices); beneficence (doing good); non-maleficence (not doing harm); justice (fair distribution of resources).

principle-based ethics

- Autonomy
- Beneficence
- Non-maleficence
- Justice

Beneficence is what clinicians have always wanted: to bring healing. Non-maleficence was Hippocrates' first aphorism: 'primum non nocere',[4] first do no harm. This is the attitude that safety comes first. These two principles can be put together as 'balancing risks and benefits'. People want fairness, even if they don't agree how it's best defined. But autonomy is sometimes criticised as being too Western and individualistic. Another problem with this approach is that sometimes the principles conflict. Autonomy is often assumed to trump the others.

There is a tension between utilitarianism (balancing risk-benefit outcomes in order to maximise the greater good for society as a whole) and rights (autonomy):



Individual autonomy — Greater good of society

A shocked trauma patient needs a splenectomy, but blood transfusion is refused on religious grounds. She requests an expensive artificial oxygen-carrying compound as a substitute for haemoglobin. A balance of risks and benefits would suggest that the operation should only go ahead if blood or its substitute is available; operation alone would make things worse. Autonomy says she should be allowed to refuse blood. Justice might suggest it is unfair for this patient to have an expensive blood-free option that other patients are not offered.

Duty, utility, rights and principles can all be criticised as being 'mechanical'; applied without emotional or personal involvement.

In practice, decision-making involves 'blended ethics', using different theories and principles to support an argument, or to suit different circumstances. What seems to be an attempt to discover what is really the right thing to do (as the Enlightenment philosophers intended), becomes instead an exercise in justifying one's own preferences. Ethics becomes relative, a matter of personal choice.

what should Christians do?

Our starting point in Christian ethics must be God, and what he has told us is good. But we also need to recognise that human nature is sinful, in rebellion against God. We'll get nowhere without repenting of our sin, trusting only in God.

The problem with all the secular

ethical approaches is that they take no account of sin. Utilitarianism denies any need for virtue or duty, and ignores God's concern for the weak and helpless, his love for individuals. Ends don't justify means. Duty-ethics fail to take account of our inherent disobedience, and we cannot rely on our character as a 'virtuous' clinician, because we are sinful and our consciences have been corrupted. We cannot 'discover' universal duties independently from God's revelation, and similarly the idea of autonomy is to assume that we determine what is right and wrong ourselves. Whether creating duties, or insisting on our autonomy, we are merely repeating the sin of Adam and Eve: usurping authority from God and taking the law into our own hands. Rights and autonomy are also essentially selfish; we prioritise the fulfilment of our own needs over those of our friends, family, society, and most importantly, over the will of God and his Kingdom. Autonomy is not the solution to ethical dilemmas; it's the cause of the problem!

But there is at least a glimmer of truth in these approaches too. We are concerned with end results, but the end result we're concerned with is God's glory. Consequences do inform our decisions: we should act in ways that maximise his glory. But we know that this shouldn't result in atrocities, because God is glorified not just in results, but in the actions performed and the character of the person performing them, and because God is concerned with each individual. God has given us duties: but the primary purpose of the law is to show us how sinful we are, so that we trust in Christ and his work on the cross, for our forgiveness and restoration to relationship with God. God enables us to obey him by the power of the Spirit. The Bible makes clear our duties to one another and to God, but they are not a mechanical check list of do's and don'ts. They can't be performed outside of loving relationship: 'Love the Lord your God with all your heart... love your neighbour as yourself'. [8] Finally, Christian ethics are virtue ethics: we seek to be like Jesus. To the extent that we become more and more like him, we will act in the way that is most pleasing and glorifying to God.

Christian ethics are therefore revealed in God's Word, the Bible. They are not discovered or chosen by us. God defines what is good. So let's listen to him. Christian ethics are concerned with all aspects of our behaviour: our character, our deeds, the outcomes. We have 'relational responsibilities': our responsibilities to each other and God, revealed to us in his Word, are lived out in personal, loving relationship. We seek to live like Christ; we seek to glorify his name. So let's pray that we do this, because without him, we can't.

***Giles Cattermole** is CMF Head of Student Ministries*

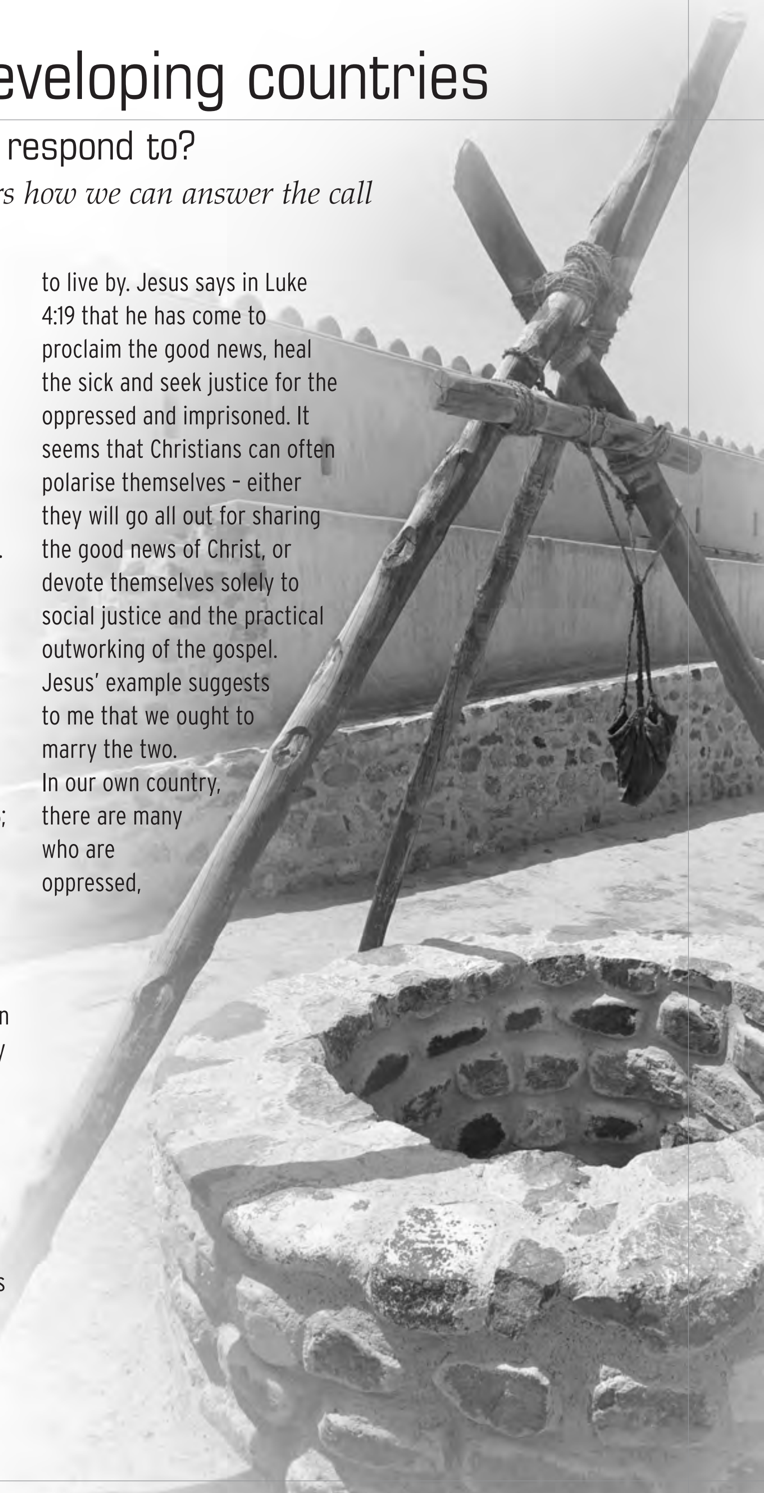
REFERENCES

1. Aristotle. The Nicomachean Ethics. London: Penguin; 2004. MacIntyre A. After Virtue. 2nd ed. London: Duckworth; 1985.
2. Kant I. The Moral Law. 2nd ed. London: Routledge; 2005.
3. Mill JS, Bentham J. Utilitarianism and other essays. London: Penguin 2000.
4. Hippocrates. Hippocratic Writings. London: Penguin, 2005.
5. General Assembly of the United Nations. Universal Declaration of Human Rights. *www.un.org/en/documents/udhr* [accessed 2 March 2010]
6. General Medical Council. Good Medical Practice: Duties of a Doctor. *www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp* [accessed 2 March 2010]
7. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 6th ed. Oxford: OUP; 2008.
8. Luke 10:27

health in developing countries

– a call we can all respond to?

***Katie Dexter** considers how we can answer the call*



In Angola, 180 out of every 1,000 children die before the age of five – nearly 20%; in Britain, four out of every 1,000 children die before the age of five – barely 0.5%. In Zambia, life expectancy is 40 years; in Australia, life expectancy is 81 years – double.

In Uganda, 77,000 people die of HIV annually; in Canada, 500 people die of HIV annually in a similar sized population.

In Afghanistan, total clean drinking water coverage is 22%; in Norway, it is 100%.

Should Christians take a real interest in the health of people living in developing countries? International health can be seen as something which should only really concern those who feel 'called' to work abroad. What does the Bible say – should we be bothered?

the 'call'

In Matthew 6:33, Jesus instructs us to seek first the kingdom of God, and his righteousness. By coming to earth, Jesus showed us what the kingdom of heaven will be like, giving us a pattern to live by. Jesus says in Luke 4:19 that he has come to proclaim the good news, heal the sick and seek justice for the oppressed and imprisoned. It seems that Christians can often polarise themselves – either they will go all out for sharing the good news of Christ, or devote themselves solely to social justice and the practical outworking of the gospel. Jesus' example suggests to me that we ought to marry the two.
In our own country, there are many who are oppressed,

many who need healing, and many who have not yet heard the good news.

Wherever we live, we are still part of a global family. The statistics on how we in the UK act towards our global family don't reflect well. For example, it is estimated that it would cost roughly $13 billion to provide everyone in developing countries with basic health and nutrition. The world's annual spend on pet food is currently $77 billion.[1]

We know that we are called to take the good news of Christ throughout the world. We are called to love one another as we are loved by Christ. Luke 12:48 says that from those who have been given much, much will be expected. Medical students from the UK have been given much. How then can we respond as Christian medics to the challenges in health around the world and the teachings of Jesus?

our response...

Historically, Christian medics have responded to Jesus' words and instructions throughout the gospels to care for the poor and spread the good news by setting up mission hospitals in parts of the developing world. It is thought that the first mission hospital was set up in 1518 in Mozambique, and in the 1850s, mission hospitals spread into sub-Saharan Africa and elsewhere. John 10:10 illustrates the purpose of mission hospitals – to bring life in all its fullness to everyone, physically, psychologically, *and* spiritually.

A simple response to this call is to go

A simple response to this call is to go. This could be long or short term, and involve anything from going on an elective to a developing country to working for years in a hospital or research institute. When considering longer term mission, an important thing to consider is whether your trip will contribute to sustainable development in international health. It can take a long time to learn a language and begin to understand a different culture and way of life, even in a Christian country!

Traditionally, medical mission was seen as dedicating your whole life to living and working in a mission hospital. However, dependence upon the skill of foreign workers is not necessarily a sustainable way to provide healthcare in developing countries. There is a real need to contribute to the training of local staff, allowing hospitals to develop in a sustainable manner. It is a great witness to share the privilege of knowledge and ensure that the basics, such as childhood illness management or ante-natal care are done for the glory of God.

Research also has an important role to play in international health. One example of this is Dr Paul Brand's work on leprosy. Born to missionary parents in India, Dr Brand returned after training to Vellore in India, where he researched leprosy, discovering that many leprosy related problems were due to pain insensitivity. He spent his career pioneering techniques of tendon transfer and ulcer management, which transformed the lives of many with leprosy, and are also used today in the management of diabetes mellitus.[2]

Although these ideas all sound very practical, we can remember that being a Christian pervades all parts of our lives, and through our work and example, we may win

opportunities to share Christ and fellowship with others around the world.

So for those who are currently in the UK, how can we impact international health for Christ? Firstly, we can inform ourselves about our global family. Talk to people who have worked in developing countries, pay attention to national news, and the updates of charities like WaterAid and Tearfund. Books are a great way to learn – both the stories of Christian missionaries (see the CMF student reading list)[3] and of those working for humanitarian agencies – try *An Imperfect Offering*, by James Orbinski[4] – can help us to begin to understand how others have to live.

Another way in which to inform ourselves, apart from going to see for yourself, perhaps on elective, is to consider studying international health at some level – some universities offer intercalated degrees in international health, or for those thinking bigger, Master's or other degrees in public health or tropical diseases. Many focus on health system development, governance, and learning how to plan strategically to improve health; all valuable skills which both challenge and broaden our attitudes to healthcare and its provision.

There are plenty of places to find out more about how we might respond to the challenges of international health as Christians – a good place to start is *www.cmf.org.uk/internationalministries*

Tearfund[6] also often produce prayer leaflets focused around the world which might guide your prayer life.

Although not all of us can do this as students, providing financial support to those involved in improving health in developing countries is another way to respond; particularly when as doctors, we may earn enough to support others in their work, either charities or individual colleagues and friends.

Thankfully, we live in a country where we are privileged to each have an opportunity to speak our minds, and this is a tool we can use to speak for those who cannot speak, as we are instructed to (see Proverbs 31:8-9). We can lobby governments and others in power in all sorts of ways, including regarding climate change, which is a major health threat for developing countries. We can vote with our feet by buying fairtrade goods, supporting charities and people on the ground who are spreading the good news of Jesus and fullness of life for all. We can also put on events at university, both as CMF groups and through organisations like Medsin,[5] such as debates or talks which raise the profile of the health of others around the world.

And above all – pray! This is always the most valuable thing we can do as Christians. Even if we do not feel called to 'go', hopefully this article has touched upon some of the ways that to care about international health is a call we all can respond to.

***Katie Dexter** is an intercalating medical student in Leeds*

REFERENCES

1. *www.petfoodindustry.com/ViewNews.aspx?id=27134*
2. *en.wikipedia.org/wiki/Paul_Wilson_Brand*
3. *www.cmf.org.uk/students/booklist.asp*
4. Orbinski, J. *An Imperfect Offering*. New York, Doubleday 2008
5. *www.medsin.org*
6. *www.tearfund.org*

choosing a church

***Giles Cattermole** helps us with an important decision*

Dave had just started medical school. He didn't know many people, and was keen to find a lively and welcoming church. Ideally with free food. He soon found a large, student church near campus, with achingly cool people and awesome worship music. The viral video loops they used instead of sermons were really cutting-edge stuff, quality productions. He'd have no problem bringing his mates along, even if all they did was chill and eat pizza.

Gordon was in a similar position. He'd been brought up in a small chapel, and loved old hymns. He found what he was looking for on the other side of town, with a faithful congregation of about 20 stalwarts. He was the only student there, and he struggled to get to know the other folk over tea and digestives after the morning service. He couldn't always understand the King James Version, or the sermons, but he knew the Bible was being taught.

What made Dave and Gordon choose their churches? What motivated you to choose yours? Perhaps you're still looking for a church after coming to university or becoming a

Christian. Perhaps you know that you'll soon be sent away on placement for a couple of months, or you'll be off to another part of the country for your F1 job – and you'll be looking again. What will shape your decision? I want to suggest two practical questions you need to ask of any church you're considering attending.

- Does it teach people the Bible?
- Can I bring my mates?

These questions need some unpacking. But before we do that, let's remind ourselves that the goal is to glorify God, that God is glorified as his kingdom grows,[1] and that God does the work of growing his church.[2]

Growth is both in *breadth* as more people turn to Christ, and in *depth* as each believer becomes more like Christ.

teaching the Bible

Dave's church doesn't appear to be strong on teaching the Bible. Gordon's does, at first glance. But why is Bible teaching important, and what does it mean?

God's Word is the means by which he grows his kingdom. Throughout the whole Bible, it's God's Word that creates, sustains, sanctifies.[3] It grows God's people. It's why the church of Acts 2 was devoted to the teaching of the apostles,[4] and why the apostles in Acts 6 devoted themselves to the ministry of the Word.[5] Paul stresses again and again to Timothy the importance of Word-ministry. For us today, this means that faithful Bible teaching is essential. A church without this emphasis will not help us grow. When we choose a church, it needs to be one that will teach us the Bible.

But Bible teaching is never in isolation. Word-ministry goes with prayer.[4] A Bible teaching church will be one that prays

and praises together.[3] Its corporate worship – sermons, prayers, songs, everything - will all be solidly rooted in God's Word. We praise God for what he's done for us, and pray for what he wants for us, according to what he has revealed to us in his Word. Bible teaching is not just something that the pastor or the music leader does.

As we all speak and live God's Word to each other, the church will grow.[6] A Bible teaching church should encourage everyone in their Word-ministry to each other. When we choose a church, we should look for one that is teaching the Bible in all its activities and through all its members.

bringing your mates

This leads us to the second point. Because of course, we shouldn't just 'teach the Bible'. We should teach *people* the Bible. The emphasis mustn't just be on the transmission but on the reception, not just on being faithful to the Bible, but on being helpful to the hearer. In Hebrews we're urged to keep on meeting together to encourage one another.[7] When we choose a church, we need to consider how it communicates the message of God's Word to the people who meet there.

Some churches will be better at reaching students, some better with families, some with internationals, and so on. The building they meet in, the types and timings of meetings, the sort of music, the clothes the pastor wears, all these and more, are not matters of 'right and wrong', but they may be matters of wisdom.

It's vital to remember that it's not just about you: it's about *other* people. And that means non-Christians as well as Christians. Word-ministry grows the church outwards as well as upwards: it is the means of discipleship *and* evangelism.

As students, your mission field is most likely to be other students. Not always: some students have children, for example, and their family may be their priority. But whatever our mission field is, we need to consider the people we want our church to reach with the Gospel. If your friends are from very traditional backgrounds, an informal free church might be inappropriate. If your friends speak English as a second language, perhaps a church that uses old versions of the Bible might be unhelpful. If they love music, perhaps a church that has good music would be preferable over one that doesn't.

Dave's church was great at reaching students, but it wasn't reaching them with God's Word. Gordon's church was teaching the Bible, but it wasn't reaching Gordon or any friends that might have gone there. Both of them needed to find a church that faithfully taught people the Bible, and did it helpfully and winsomely.

Looking back at our two questions, the first is absolute. If a church does not teach people the Bible, don't go there. The second is relative; it will depend on how well a particular church reaches you and your friends. Go somewhere that will most effectively help you bring your friends to Christ. Pray for discernment and wisdom!

***Giles Cattermole** is CMF Head of Student Ministries*

REFERENCES

1. Ephesians 1:3-6,9-11
2. Colossians 2:19
3. Genesis 1, Exodus 20, Ezekiel 37, Matthew 4, John 1
4. Acts 2:42-47
5. Acts 6:1-4
6. Ephesians 4:15
7. Hebrews 10:25

God-man-God…

Laurence Crutchlow suggests an easily remembered gospel outline

You've just enjoyed a discussion about patient autonomy in an ethics seminar, and on the way to coffee before the next lecture, your friend Steve walks with you. He says 'you Christians seemed to have a lot to say in that session. What do you actually believe?' There's only five minutes before the next lecture. What will you say?

Being prepared for such a situation is important, and many Christians memorise a 'gospel outline' to help – much like the way a medic would use mnemonics to prepare for an anatomy exam. But aren't there hundreds of gospel outlines around? How do you know which one to learn?

what makes a good gospel outline?

1. **start in the right place.** Many outlines assume too much – if you start with sin, you assume that the listener knows God exists, and understands his character as pure and holy. Begin by affirming that God is real, and describe him briefly.
2. **being Christ centred**. All too often Jesus features merely as a mechanism to solve a moral conundrum for a God who has to work out how to reconcile his own mercy and justice. We can't ask people to trust Jesus if we don't tell them about him!
3. **calling for repentance.** The term 'repent' is repeatedly used in the New Testament.[1] We must include it, however unfashionable.
4. **putting the cross centrally, but not first.** The cross is central,[2] but some things must be explained before it will be understood. The important fact is not that someone was crucified, but who was crucified. We want people to trust in 'Jesus Christ and him crucified'.[3]
5. **faithfulness about judgment.** If judgment is ignored, what is the point of the gospel? If we are not going to be called to account for how we have lived, why do we need forgiveness? Without the reality of judgment, the entire logic of the gospel collapses.

why this outline?

Many outlines require much memorising. Others (like 'two ways to live'[4]) work best if you have good drawing skills! This outline is succinct (only five points), and adaptable to a one minute answer to a question or a whole hour's lecture (if anyone will listen for that long!)

five points

- God
- man
- God
- what if I don't?
- what if I do?

God (ruler)

God exists. Not only did he create the universe,[5] but he sustains its very existence.[6] Humans were made for a relationship with him. God is holy[7] – that is, he is pure, perfect, and unable to relate to that which is not holy. We know this because he has revealed himself to us through the person of his Son, Jesus Christ.[8]

man (rebel)

God created humans to be holy[9] - pure and perfect like him. But none of us lives consistently as if God were truly our ruler and creator.[10] We all assume (wrongly) that we are to govern our own lives. This results in either wilful disobedience of God (sin), or at other times

plain ignorance of him. Rebels like us are no longer holy. We deserve God's judgment,[11] and have no right to be in his presence.

God (rescue)

God's love for us means that he wants to rescue us from punishment – despite our rebellion.[12] Only someone who has always lived consistently with God's commands could take that punishment in our place – as everyone else deserves punishment of their own.[13] Only Jesus has lived a life free from rebellion against God.[14] Jesus Christ was sent to earth by God. His three years of public ministry in the Middle East about 2,000 years ago culminated in his execution on a cross. In dying, he received the punishment we deserved for our rebellion against God. On the third day after his death, Jesus came back to life — not just in a spiritual sense, but fully alive — walking, talking, eating. Jesus had showed he was victorious over the power of sin. Jesus was given all authority in the universe by God. Our punishment had now been meted out to someone else, leaving us an offer of forgiveness that demands a response. Jesus' teaching whilst on earth invited us to repent (turn from our rebellion against God) and believe in him (trust he is God's son, and live in obedience to him).

what if I don't? (rejection)

If we ignore or reject Jesus' offer of forgiveness, we remain banished from God's presence because of our rebellion. There is no hope for us. Nothing that we can do will repair our broken relationship with God. We will receive the judgment we deserve, and be in hell for ever, cut off from God.

what if I do? (reconciliation)

If we repent and believe that Jesus has taken our punishment upon himself, God forgives our wrongdoing. We are treated as if we had never rebelled in the first place. The Holy Spirit is given to us, enabling us to live a life pleasing to God, and in which we obey his commands. The Holy Spirit is also a 'deposit' - a guarantee that we will spend eternity with God in heaven, adopted as his children into his family. We must choose soon whether to accept God's offer, since only God knows when the world will end, and tomorrow may be too late.

how to use it

This outline really helps if someone asks 'What do Christians believe?' It could also be used by a speaker at a dialogue dinner,[15] or you could also use individual sections to answer questions such as 'You don't really believe in hell, do you?' To learn more about sharing the gospel with friends, why not come to a *Confident Christianity* day conference? The CMF website has details of upcoming conferences.[16] If none are planned in your area, why not ask your local CMF reps to organise one?

Laurence Crutchlow
is CMF Associate Head of Student Ministries and a GP in London

REFERENCES

1. Acts 2:38, 3:19; Revelation 2:5
2. 1 Corinthians 15:3
3. 1 Corinthians 2:2
4. *www.matthiasmedia.com.au/2wtl*
5. Genesis 1:1
6. Hebrews 1:3
7. Leviticus 19:2
8. Hebrews 1:1-3
9. Genesis 1:27; 1 Peter 1:16
10. Romans 3:23
11. Romans 6:23
12. 1 Timothy 2:3-4
13. 1 John 1:8
14. Hebrews 4:15
15. For a fuller discussion of dialogue dinners see Pickering M. Dialogue Dinners. *Nucleus* 2009; Christmas: 23-25
16. *www.cmf.org.uk/students/events.asp*

how to read the Bible for all its worth

***Giles Cattermole** looks at different Bible versions*

'The Holy Bible, as originally given, is the inspired and infallible Word of God...' CMF doctrinal basis.

the basic tool - choosing a good translation

This series is summarised from Fee G, Stuart D. *How to Read the Bible for all its Worth* (3rd ed). Grand Rapids: Zondervan, 2003

Most of us don't read Hebrew or Greek. So to read the Bible we need a good translation. For regular quiet-times and memorising verses, it's best to use one version we can become familiar with, and many churches also stick with one version for public use.

But for deeper study, it's good to use several versions, especially if they differ in their approach to translation. Why? Because although we believe the Bible as originally given is infallible, translators are not. Translating from one language to another inevitably involves a degree of interpretation by translators, as they struggle to be both faithful to the text, and understandable to the reader. If one translation appears to say something different from another, then at least one must be mistaken. Sometimes footnotes give an alternative translation. Sometimes they don't, which is why it's good to compare translations.

How do these differences arise? To answer this, we need to consider the question of the text itself, and the theory of translation.

text

There are no original documents available today, handwritten by the Bible authors themselves. We rely on hand-produced 'manuscripts', copied repeatedly over many years, until printing presses made this process unnecessary and helped ensure uniformity. This is true of all ancient documents, and there are many more Bible manuscripts available than for any other text. The wealth of evidence means that there is a high degree of certainty about the original text, even though no two manuscripts are absolutely identical.

The science of textual criticism relies on external evidence (to do with the quality and age of the manuscripts), and internal evidence (to do with the mistakes made by copyists). Sometimes though, scholars still can't agree. In these cases, many Bibles use the majority choice, but include the alternative reading as a footnote.

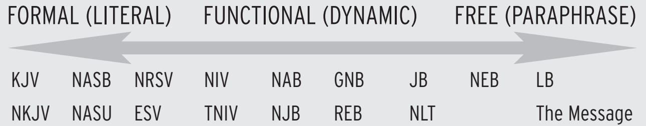
cattle or young men? 1 Samuel 8:16.

'the best of your cattle and donkeys' (TNIV) 'your finest young men, and your donkeys' (NKJV)

NKJV uses a mediaeval Hebrew text; TNIV here uses the Septuagint, a Greek translation from 250-150BC. The Hebrew for 'cattle' and 'young men' differ by one letter. The Septuagint was translated before the mis-copy, preserving the original 'cattle'. The error came later, affecting mediaeval Hebrew manuscripts, but not the Greek ones.

The KJV (AV) was the most widely used translation in the world, and significantly shaped the English language. However, for the NT it used a Greek version called the 'textus receptus', based on late manuscripts, which included many

copying errors (mostly trivial). Modern translations therefore attempt not just to update the language, but to use the most reliable ancient manuscripts.



translation

This leads us to the theory of translation: how are words and ideas best transferred from the original language into English?

- Formal equivalence: keeping as close to the words and grammar of the original, as can be put into English. 'Literal' translation.
- Functional equivalence: using more natural English grammar, and idioms that mean the same thing as the original. 'Dynamic' translation.
- Free translation: trying to convey the ideas of the original with less concern about the actual words. 'Paraphrase'.

There are several issues aside from vocabulary and grammar that translators grapple with:

1. Weights, measures, money. More literal versions transliterate the original word, such as Isaiah 5:10, 'a homer of seed shall yield but an ephah' (ESV). More free translations use terms used today: 'ten baskets of seed will yield only one basket of grain' (NLT). In both these versions, footnotes give the alternative.

2. Euphemisms. Saul went into a cave, in 1 Samuel 24:3, 'to cover his feet' (KJV, following the Hebrew idiom), 'to relieve himself' (many modern translations), or 'to go to the bathroom' (LB).

3. Wordplay and poetry. In Amos 8:1-2 (NASB), Amos sees a basket of 'summer fruit', and God tells him that 'the end' has come to Israel. In Hebrew, the words for 'summer' and 'end' are pronounced nearly identically. Literal translations lose the subtlety. TNIV tries to capture some of the wordplay as Amos sees a basket of 'ripe fruit', and God tells him that 'the time is ripe'.

4. Gender. TNIV and other newer translations avoid the use of masculine pronouns where the original meaning is non-specific. ESV deliberately doesn't. When Jesus tells us who does not live by bread alone in Luke 4:4, the Greek word translated 'man' (NIV, ESV) or 'people' (TNIV, NLT) does not specify maleness. Avoidance of the masculine often pluralises, which in Luke 4 is probably trivial, but in Revelation 3:20, 'I will come in and eat with them...' (TNIV) the personal, one-to-one nature of the promise could be lost.

summary

Don't choose a version simply because it's traditional or readable. It should be a faithful attempt to translate God's Word into your own language: both reliable and understandable.

Giles Cattermole is CMF Head of Student Ministries

TOP TIP

Use a dynamic translation (eg NIV, TNIV) for regular reading. More literal translations (eg NASB or ESV) will help you in further study to be closer to the words of the original language. Free translations (eg NLT, The Message) can also be useful for an overview or sparking ideas about the meaning of the passage.

ABBREVIATIONS

KJV/NKJV. King James Version (aka AV, Authorised Version), 1611 / New KJV, 1982.
NASB/NASU. New American Standard Bible, 1960 / NAS Update, 1995.
RSV/NRSV. Revised Standard Version, 1952 / New RSV, 1991.
ESV. English Standard Version, 2001.
NIV/TNIV. New International Version, 1984 / Today's NIV, 2002.
NAB. New American Bible, 1970.
JB/NJB. Jerusalem Bible, 1966 / New JB, 1985.
GNB. Good News Bible (aka TEV, Today's English Version), 1976 / 2nd edition 1994.
LB/NLT. Living Bible, 1971 / New Living Translation, 1997.
NEB/REB. New English Bible, 1961 / Revised EB, 1989.

Alex Bunn considers Dr Luke and Pontius Pilate

HERO 3: DR LUKE + PONTIUS PILATE

HERO: Dr Luke – a doctor who wrote the highest impact text of all time

The author of the third gospel is an obvious hero for medics. The 'beloved doctor'[1] wrote a gospel and Acts, accounting for about 30% of the New Testament. His training as a Greek physician prepared him for painstaking research, thorough history taking and meticulous documentation. He outlines his research methods in his abstract:

Many have undertaken to draw up an account of the things that have been fulfilled among us, just as they were handed down to us by those who from the first were eyewitnesses and servants of the word. Therefore, since I myself have carefully investigated everything from the beginning, it seemed good also to me to write an orderly account for you, most excellent Theophilus, so that you may know the certainty of the things you have been taught.[2]

Luke never met Jesus, so like us he had to follow the trail of evidence wherever it led. He was not a religious fanatic twisting the truth for his own ends, but rather a scholar who wanted to be found 'on the side of truth',[3] rightly aligned with reality. He took case histories from eyewitnesses, and carefully investigated the facts, and wrote up his findings in an orderly account for publication. I sometimes joke with my surgical colleagues that the New Testament would have been much shorter and scrappier if Luke had trained in surgery! Would Luke have imagined that his own paper, one of many circulating at the time, would be disseminated in *the highest impact text of all time*, the Bible? I suspect he would be delighted that countless 'God lovers' (that is the meaning of Theophilus' name) have gained confidence in Christ as a result. So why did the early church choose to keep Luke's research?

First, Luke was very conscious of writing history. Each gospel has a different emphasis. Luke grounds his account of Jesus' life and the early church in the context of time, person and place. He wants us to know the gospel is not a spiritual fantasy, however heart-warming. Luke-Acts is littered with hundreds of names of historical figures by which we can precisely date the events, and places. Luke has given sceptics every opportunity to refute him. But where his record can be tested, time and time again Luke has been vindicated.[4]

Second, Luke shows great *humanity*. Whilst Mark records the healing of a man's shrivelled hand on the Sabbath, Luke the physician notes that it was his *right* hand.[5] Presumably it was his dominant hand, which caused a greater disability and social disadvantage. Luke especially detailed the breadth

of God's compassion for the marginalised and excluded, and in Acts his grace extending to 'the ends of the earth'.[6]

Third, Luke gives reason for real *hope and healing*. As a doctor Luke knew about the brokenness of humanity. Not just bodies disintegrating fast, but lost souls without a future.[7] Luke described many healings, but the greatest he described was resurrection. He realised that Jesus' resurrection changes everything, it offers real hope. Jesus didn't come to empty the hospitals, but the graveyards!

As he was perhaps the first doctor to write up a resurrection, he was careful to refute the differential diagnoses of hallucination by the witnesses, mistaken identity[8] or merely resuscitation.[9] Luke writes the 'fleshiest' account of Jesus post-resurrection,[10] describing Jesus' body as recognisably human (walking, talking, and eating) but transformed. But the glorified Jesus seemed less limited by the usual physical constraints of doors and walls! Those who 'follow Jesus' will also follow him in resurrection transformation, the greatest healing of all.[11]

Antonio Ciseri's depiction of Pontius Pilate presenting a scourged Christ to the people Ecce homo! (Behold the man!).

HERETIC: Pontius Pilate – the dangerous relativist

Contrast Luke with the infamous Pontius Pilate. Luke followed the evidence where it led, and encouraged others to do the same. He had a high view of truth, meaning that reality is bigger than us, and we are not free to manipulate it for our own convenience.

In his trial, Jesus claimed that his life's mission was to reveal truth. In fact he had even called himself *the Truth*.[12] This truth is bigger than each one of us, a truth we must listen to, and submit to. But Pilate rejected the very notion.

You are right in saying I am a king. In fact, for this reason I was born, and for this I came into the world, to testify to the truth. Everyone on the side of truth listens to me. 'What is truth?' Pilate asked.[13]

Pilate was the worst kind of politician, for whom there was no truth, only opinion. For him, public opinion was all that mattered. Pilate's attitude is commonplace today, it's called *relativism*. Arguably it is the greatest modern myth, and the most basic heresy, in the light of God's revelation. It's the idea that truth (outside oneself) is unknowable, based on the assumption that God has not made himself known. Even when, as in Pilate's case, he is speaking to you face to face! Pilate demonstrated a commitment to remaining uncommitted, and as a result knowingly sent an innocent man to his death.

Relativism can sound tolerant and humble, but it is at best naïve, and at worst dangerous and arrogant. This is a key issue for any thinking Christian; hopefully that means every *Nucleus* reader!

There are many great resources on it,[14] but here is a short response to Pilate's question.

To say 'there are no absolute truths' is *self-contradictory*, the same as a statement like 'every sentence in English has three words'! If it is absolutely true that there are no absolute truths, then that is an example of one! Or if it is only relatively true, there must be exceptions which therfore are absolutes!

Relativists are not as humble as they first sound. They say that much of what we believe is shaped by our time and place in history, and we should agree. And it is the case that as finite individuals, any one of us has a limited grasp of universal timeless truths.

Yet relativists break the very rules they want to impose on others. Consider the classic metaphor of the mountain of truth. Mere mortals scale a variety of paths (representing different religions, philosophies etc), but the relativist assures us that we all arrive at the same place. Now where is the relativist in this picture? He must be the *only* one who has already arrived at the top, the *only* one with a 'God's-eye view' of ultimate reality. That is a phenomenal claim to omniscience! Christians are accused of arrogance when we make truth claims from the Bible, but these are only on the basis that God himself has come down the mountain to meet us, not that we have arrived before other mortals at the top! Dogmatic relativists need to be politely challenged that their position is *arrogant* and *hypocritical*.

Consistent relativists do not exist, any more than unicorns do. But there are many *selective relativists*. When it comes to the relativist's own cherished beliefs or vested interests, they become strangely moralistic. A Christian speaker tells of an occasion when he was invited to a student's room to continue a heated discussion about morality. The student was adamant that the 'God squad' should not impose any morality on society, although he was mostly upset about rules on sexual behaviour. The speaker then picked up the student's prized *iPod*, and made for the door. The student was outraged and told him to stop. The speaker defended himself: 'Don't you impose *your* morality on *me*!' We all live as if there are moral standards above us, which we did not invent. The next time someone disputes this, just ask them 'so exactly when do you think it is allowable to be racist?' I hope never.

Alex Bunn *is CMF Southern Team Leader*

SUMMARY

HERO

DR LUKE

I thank God for Dr Luke, and pray that we would share his appreciation of God's compassion for all, and his hope for the greatest healing offered to all, the resurrection. And I pray that as medics, we would share that hope faithfully with all who are ready to receive it.

REFERENCES

1. Colossians 4:14
2. Luke 1:1-4
3. John 18:37
4. For example Ramsay W. *www.facingthechallenge.org/luke.php*
5. Compare Mark 3:3 with Luke 6:6
6. Acts 1:8
7. Luke 15
8. Luke 23:53
9. Luke 23:46
10. Luke 24
11. Paul explains this promise in 1 Corinthians 15
12. John 14:6
13. John 18:37-38
14. Copan, P. *Is Everything Really Relative? Examining The Assumptions Of Relativism And The Culture Of Truth Decay*. RZIM, 1999

FURTHER READING

- **Relativism - a central heresy of our culture**. CMF. tinyurl.com/yk5h3xl
- **Truth and the Bible**. CMF. tinyurl.com/yjo7mga
- **Fergusson, A. What is truth?** Nucleus. 1992; April:10-15. tinyurl.com/yl6l657

student services

These include literature, conferences, elective advice, international links and Christian Union support.

Reps can supply joining forms, literature, extra copies of *Nucleus* and information about conferences and activities. Further information is on the CMF website: *www.cmf.org.uk* or from *students@cmf.org.uk*.

Ideas or feedback can be sent to the National Students' Committee through its chair, Lloyd Thompson, on *lloyd@cmf.org.uk*

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