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END OF LIFE: a better way?

what the Bible says about euthanasia

assisted suicide in the UK

a good end to life

nucleus

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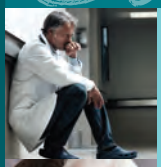
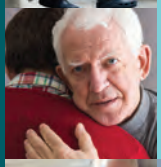

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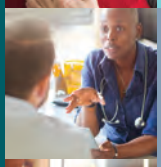
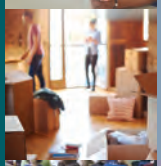

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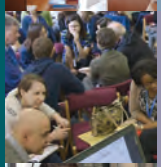
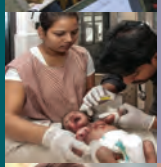

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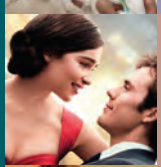


CULTURE

Editorial

the end of life – a subject for all

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

All your patients will end up in the mortuary. Your personal mortality rate will be 100%.

Think about it for a moment. The young patient who has poor veins after years of intravenous drug use whom you 'save' by heroically cannulating at 3am, will die eventually; she may conquer her addiction but succumb to a stroke in her late 80s. The emergency aortic aneurysm repair patient from the night before may have survived to discharge, but your assistance in surgery doesn't save him from a fatal road accident three months later.

End of life care is a subject for every healthcare professional. No specialism is free of dying patients. But the way we die has changed over the years. Up until the last century, a significant proportion of deaths happened quite quickly. People died in accidents, or developed infections for which there were no effective treatments. Of course some people did survive into old age, but there could be no expectation that everyone would.

Now infections rarely cause death in someone otherwise healthy, at least in the developed world. Public health measures mean that fewer infections spread in the first place. Some 'new' diseases like HIV are a threat, but treatments have been developed relatively fast. Many of us will now live into old age. We will still die, but often of conditions like Alzheimer's disease where our decline is long and slow.

This brings challenges. The very elderly often need social rather than medical care, which is labour intensive. Who should pay? Many are frightened that they will lose dignity at the end of their lives, becoming dependent on others for their basic needs, just as they were as a newborn baby. Some are so frightened of being left dependent on others that they want to end their lives before they reach that stage, leading to pressure to allow assisted suicide or euthanasia.

This edition of *Nucleus* contains a variety of articles that look at medical care at the end of life. We look at practical (page 14), political (page 8), and biblical (page 4) viewpoints, both around euthanasia, and end of life care more generally.

We hope that you'll finish reading convinced that deliberately ending someone's life is not God's way, and with some facts to back yourself up. But we also hope that you will see the wider picture. Of older people respected, included and cared for. Of understanding that 'loss of dignity' may actually be an opportunity for others to serve.

End of life care is a subject for every healthcare professional. No specialism is free of dying patients.

The care of our patients should be our first concern. Doctors cannot ultimately prevent death; but merely postpone it. Ensuring that our dying patients receive the best possible care at the end of life must surely therefore lead us to consider what will happen after they die. This edition's back to basics article (page 18) looks at ways in which sharing our faith may become part of everyday clinical practice.

Although death is a certain clinical outcome eventually, it isn't the end. Holistic end of life care will not only encompass the here and now, but will consider the patient's future as well. ▪

what the Bible says about euthanasia

Laurence Crutchlow explains the Bible's clear teaching of a better way

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

Has modern medicine fallen victim to its own success? UK life expectancy continues to increase, though at a slowing rate. The last 150 years have seen a significant fall in infant mortality, followed by advances in treatment of infectious disease. Many more people live into their 80s, 90s and beyond (my longest lived patient so far reached 106!).

When such longevity is accompanied by reasonable health, albeit often with a chronic condition or two, it is usually welcome. But sometimes the later years herald a diagnosis like dementia where there is a heavy burden of care for years. Worries about care costs are shared by families and governments alike. Perhaps more than cost, there is a strong fear of 'losing dignity', which also applies to much younger patients with terminal conditions.

All this is a big change from less than a century ago when many deaths were due to infections, to which patients either succumbed, or fairly quickly recovered.

Euthanasia is often proposed as a 'solution' to these problems. Occasionally someone makes a financial argument for it, but more often the arguments centre around autonomy. For some patients the idea of 'losing dignity' is enough that they want to be able to die with medical assistance before such a loss of dignity occurs. There are plenty of 'secular' rebuttals to the common arguments against euthanasia. We will not recount these here, but instead focus on what scripture has to say.

I use 'euthanasia' as a catch-all term in this article for simplicity. The arguments made from scripture can equally be applied to assisted suicide (often labelled 'assisted dying' in the media).

The term *euthanasia* is derived from Greek, and literally means an 'easy' or 'good' death. It is often called 'mercy killing'. But we can't forget that someone is killed when euthanasia is performed, whatever the motives.

how does the Bible view killing?

The sixth commandment, traditionally rendered 'Thou shalt not kill' is of course widely known well beyond Christian circles. But the Old Testament gives further information that helps us determine exactly what this commandment means.

'You shall not murder'[1] actually restates the earlier commandment of Genesis 9:6: 'Whoever sheds human blood, by humans shall their blood be shed; for in the image of God has God made mankind'. Killing is wrong; in fact it is so serious that the death penalty is warranted. The reason is given clearly – humans are made in God's image; in effect, an attack on a human is an attack on God.

The fact that the death penalty is mentioned here implies that there are some exceptions to this law. It is not quite as simple as 'do not kill'. Indeed *murder*, used in most modern translations, has varying definitions in law around the world. What does the Bible mean by it?

exceptions

The Pentateuch lays down four main circumstances in which killing another human is not murder:

FIRST

There is an *accidental killing* provision. Intention is important. Anyone who had killed *unintentionally* could flee to a 'city of refuge', in which he had some protection from 'the avenger of the blood'. When the High Priest died (naturally), this would atone for the killing, and the killer would be free.[2] This was a very limited provision – Deuteronomy 19:5 gives the example of an axe head flying off and killing someone. Negligence was not considered unintended,[3] and neither was killing 'in hostility', even if not premeditated.[4]

SECOND

Killing in self-defence was allowed.[5]

THIRD
Killing in the context of holy war was permitted. Again, strict conditions applied,[6] and outside the Promised Land only men could be killed, and only then if a preliminary offer of peace was refused.

FOURTH
Capital punishment was permitted in certain circumstances. More than 20 offences were included, ranging from murder to contempt of court.

It is clear that the Bible does *not* permit the shedding of 'innocent blood', which is condemned repeatedly in scripture.[7]

Putting these together shows that the Bible prohibits the *intentional killing of innocent humans*. This remains the case whatever the current legal definitions of murder, which may have begun from the sixth commandment, but are often narrower.

does this definition apply to euthanasia?

Euthanasia is certainly intentional. Indeed, in jurisdictions where assisted suicide has been legalised, there are usually strict procedures to follow which certify that it is intended. Those requesting euthanasia are neither guilty of a capital crime, nor enemy combatants in war. It should be clear that euthanasia does not fall into any of the 'exceptions' to the sixth commandment.

It should be clear that euthanasia does not fall into any of the 'exceptions' to the sixth commandment.

A story from later in the Old Testament helpfully illustrates this. Although we should be wary of drawing our morality entirely from narrative, David's actions very much fit the interpretation of the law proposed here. 2 Samuel 1 recounts an Amalekite's despatch of the mortally injured Saul, still alive after a failed attempt at suicide.

'I happened to be on Mount Gilboa', the young man said, 'and there was Saul, leaning on his spear, with the chariots and their drivers in hot pursuit. When he turned around and saw me, he called out to me and I said, "What can I do?"... Then he said to me "Stand here by me and kill me. I'm in the throes of death but I'm still alive." So I stood beside him and killed him because I knew that after he had fallen he could not survive.'[8]

Whether the story is true (it varies from the account of Saul's death at the end of 1 Samuel 31) or the Amalekite's fabrication in order to win favour in David's eyes for despatching Saul and delivering him the crown, the new king's reaction is interesting.

'Why weren't you afraid to lift your hand to destroy the Lord's anointed?',[9] he asks. Then, apparently before receiving a reply, as if the confession in itself were sufficient grounds for a judgment to be made, he orders the Amalekite's execution.

In the mind of David at least, the compassionate killing of Saul constituted a capital offence, despite him being in great pain (presumably with peritonitis) and close to death without the possibility of analgesia and, most significantly of all, despite Saul's own request to be killed.

so if the Bible is clear, why don't all Christians agree?

We will put to one side here the question of Christians who don't accept the supreme authority of the Bible. But many who do claim to respect the authority of scripture argue that surely compassion and mercy must outweigh the requirements of the law in a situation like Saul's.

A famous UK example is Most Rev Dr George Carey, formerly Archbishop of Canterbury. Writing in the *Daily Mail* in 2014,[10] he supported a change in the law to permit assisted suicide. Openly acknowledging that he'd changed his mind, he wrote that 'the old philosophical certainties have collapsed in the face of the reality of needless suffering'.

He went on to explain his position:

'I began to reconsider how to interpret Christian theology on the subject. As I did so, I grew less and

less certain of my opposition to the right to die… both the Bible and the character of God laid far more importance on open-hearted benevolence than on upholding this particular law.

As I reminded myself, one of the key themes of the gospels is love for our fellow human beings.

Indeed, Jesus's mission was underpinned with compassion for those suffering from the most dreadful conditions.'

Love and compassion are key themes of the gospels. But surely the law is also an expression of God's love for his people. Carey and others believe that the law must give way to 'compassion' – an example of *situationism*. A situationist would hold that in some situations, the 'higher principle' of love for a neighbour[11] leads to suspension of certain commands. Effectively a Christian could be breaking God's law, but still acting in love.

This isn't consistent with scripture. Jesus was clear that obeying the greater commandments of the law didn't negate disobedience over the lesser ones.[12] Scripture does not define 'love' as breaking God's law. Indeed the sixth commandment is specifically included in the summary 'love your neighbour as yourself'.[13] This may come from a wrong view of scripture and poor understanding of law.

Other distortions of Christian morality that can lead to problems here include *antinomianism* ('I am saved by grace therefore the law does not apply') which is clearly rebutted by Paul in Romans 6. *Legalism* can lead us to become so obsessed with avoiding killing that we fall into *vitalism*, trying to sustain life at all costs, even in a patient that is terminally ill.

how does this look today?

Jesus was neither a situationist or an antinomian, nor a legalist or a vitalist. His way was to serve those he came into contact with, often at great cost. Following his way is not easy.

The way of the cross calls us to give our whole selves to the love and service of others, expending our time, money and energy in finding compassionate solutions to human suffering.[14] It has found practical shape historically in the hospice movement and in good palliative care – pioneered in large part by Christian doctors and nurses. When a person's physical, social, psychological and spiritual needs are addressed requests for euthanasia are very rare indeed.

Jesus' way was to serve those he came into contact with, often at great cost. Following his way is not easy.

But perhaps the most powerful Christian argument against euthanasia is that death is not the end. God's intervention through Christ's death and resurrection for our sins[15] means that through the eyes of faith we can look forward to a new world after death with God where there is 'no more death or mourning or crying or pain'.[16] For those, however, who do not know God euthanasia is not a 'merciful release' at all. It may rather be propelling them towards a judgment for which they are unprepared. It may be the worst thing we could ever do for them![17]

Other articles explore the defence of his teaching in the public square (page 8–13), and its practical outworking on the wards (page 14–16). The more we are convinced that euthanasia is not God's way, the greater I hope our motivation will be to practise the compassionate, costly alternative and reflect the gospel in how we do this. ■

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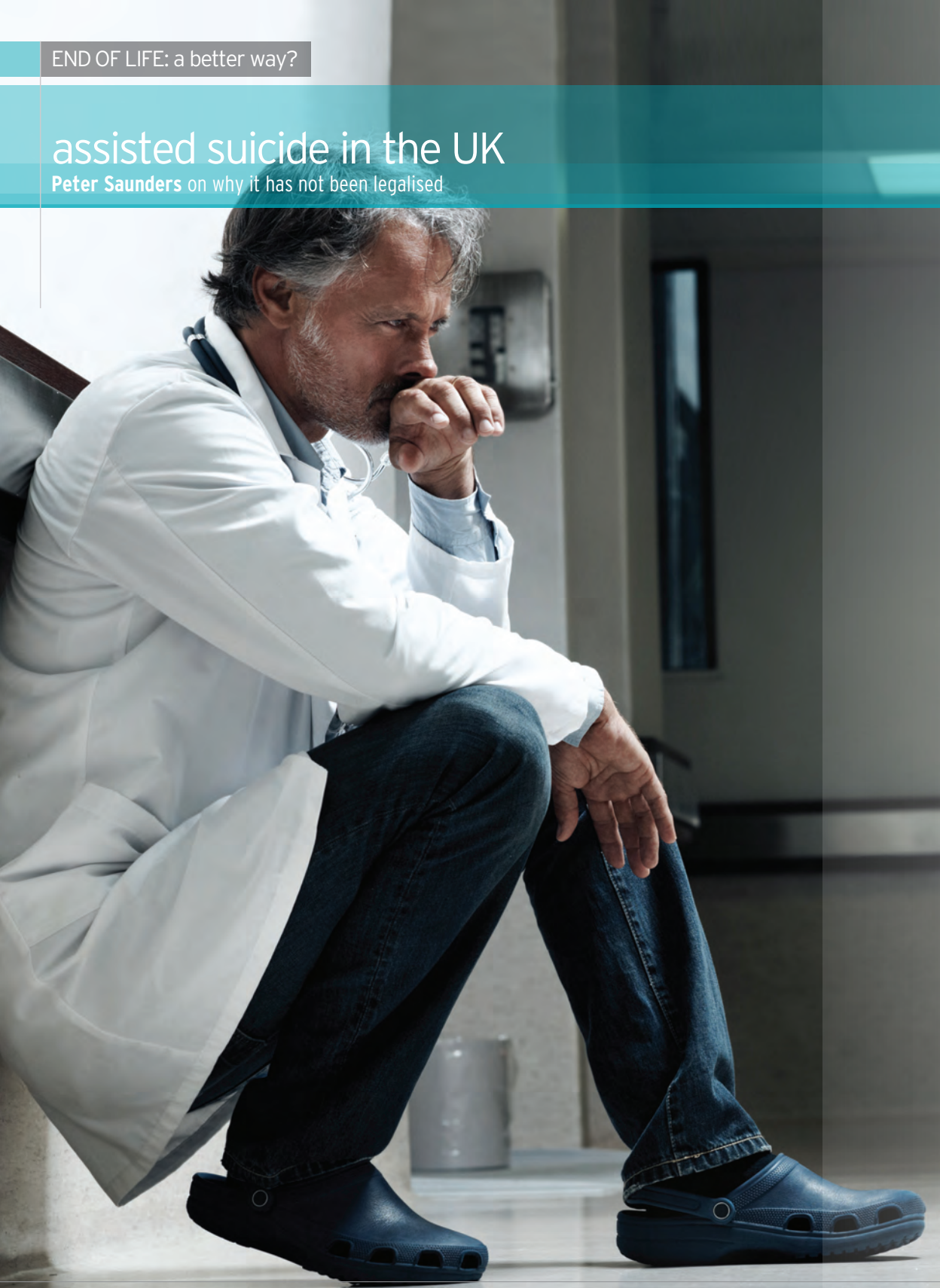
assisted suicide in the UK

Peter Saunders on why it has not been legalised



Peter Saunders is CMF Chief Executive

Assisting or encouraging suicide remains a crime in Britain under the Suicide Act 1961,[1] but over the last 14 years there has been relentless pressure to change this.

More than ten attempts to legalise assisted suicide (AS) have been made through British Parliaments since 2003 – three by each of Lord Joffe and Lord Falconer in the House of Lords, two in the Scottish Parliament by Margo MacDonald and Patrick Harvie, one by Robert Marris via the House of Commons and one in each of Wales and the Isle of Man. Every single one has failed and the last attempt by Robert Marris was defeated by an astronomical margin of 330-118 on 11 September 2015.[2]

We have seen additional attempts to change the law through the courts – again all unsuccessful. Diane Pretty went all the way to the European Court of Human Rights in 2002. Debbie Purdy managed to force the Director of Public Prosecutions (DPP), after a major consultation, to publish a list of criteria he takes into account when making a decision to prosecute in 2010 and in 2014 three men – Tony Nicklinson, 'Martin' and Paul Lamb brought cases which eventually reached the Supreme Court. At the time of writing, the case of Noel Conway, a 67-year-old with motor neurone disease, is being heard in the High Court.[3]

This raises two key questions:

1. Why is there such pressure to change the law?
2. Why has it so far been unsuccessful?

pressure to change the law

Pressure for assisted suicide is in some sense inevitable in a post-Christian society that is increasingly hostile to Christian faith and values. When people no longer believe in the sanctity of life, life after death or judgment and see no meaning in suffering, euthanasia becomes more attractive as an escape from a bad situation.

But there have also been powerful, well-resourced lobby groups pushing for a change in the law. The most prominent is Dignity in Dying (formerly the Voluntary Euthanasia Society), which has a number of affiliates such as Health Professionals for Assisted Dying (HPAD). But in recent years pro-euthanasia groups with widely varying agendas have proliferated dramatically: Society for Old Age Rational Suicide (SOARS) (now My death, My decision), Humanists UK (formerly the British Humanist Association), My Life My Death My Choice, Friends at the End (FATE) and Exit International.

When people no longer believe in the sanctity of life, life after death or judgment and see no meaning in suffering, euthanasia becomes more attractive as an escape from a bad situation.

These groups have been supported by powerful celebrity advocates and sections of the media – especially the left-wing press and the BBC. They have two main arguments: autonomy (the so-called 'right to die') and compassion (the relief of suffering), which are backed by personal testimony.

In the face of this onslaught it is remarkable that the law has not changed but there are also powerful forces defending the status quo.

why has it been unsuccessful?

The four main groups resisting the legalisation of assisted dying in this country – doctors, disabled people, faith groups and parliamentarians – do so primarily because they are anxious about the consequences of licensing doctors to dispense lethal drugs.

Their concerns are both about how such a system could be regulated and also about the

pressure legalisation would place on vulnerable people to end their lives for fear of being a financial or emotional burden on others.

This is heightened by the evidence of incremental extension or 'mission creep' in other jurisdictions.

lessons from abroad

■ Switzerland

Switzerland, where assisted suicide is legal, first released assisted suicide statistics in 2009, laying bare a 700% rise in cases (from 43 to 297) from 1998 to 2009.[4]

should lethal drugs be prescribed to people who feel their lives no longer have meaning and purpose?

Amongst those travelling from abroad to end their lives at the notorious Dignitas facility have been many people who could not by any stretch be described as terminally ill – and included cases of people who could have lived for decades ending their lives[5] – with arthritis, blindness, spinal injury, diabetes, mental illness or people who were essentially well but could not bear to live without their spouses.

Dignitas has attracted much criticism in recent years over accounts of discarded cremation urns dumped in Lake Zurich,[6] reports of body bags in residential lifts, suicides being carried out in car parks, the selling of the personal effects of deceased victims and profiteering with fees approaching £8,000 per death.

■ Oregon

In the US state of Oregon there has been a 550% increase in assisted in suicide deaths since legalisation in 1998. Notable are two people with cancer – Randy Stroup and Barbara Wagner – who were told that the Oregon Health Authority would not pay for their chemotherapy but would happily pay for their assisted suicide, which was of course much cheaper.[7]

Were AS to be legalised in the UK end of life care would be likely to worsen under financial pressures because it costs on average £3,000 to £4,000 a week to provide in-patient hospice care, but just pounds to pay for the drugs which would help a person commit suicide. Cancer treatments like chemotherapy, radiotherapy or surgery cost much more.

Is this really the kind of temptation that we wish to put before NHS managers in Britain? Is it any wonder that over 120 attempts to change the law through other US state parliaments have so far failed?

In 2016, 89.5% of those undergoing assisted suicide in Oregon cited 'loss of autonomy' as their reason, 89.5% said they were 'less able to engage in activities making life enjoyable', 65.4% listed 'loss of dignity' and 48.9% said they felt they were a burden on family, friends or caregivers. These are not physical but existential or spiritual symptoms.[8]

But should lethal drugs be prescribed to people who feel their lives no longer have meaning and purpose?

■ Netherlands and Belgium

The laws in the Netherlands and Belgium allow euthanasia as well as assisted suicide but illustrate further how any law giving doctors the power to dispense lethal drugs is subject to extension and abuse.

In the Netherlands, which legalised assisted suicide and euthanasia in 2002, there has been an increase of 10 to 20% of euthanasia cases per year from 1,923 in 2006 to 5,306 in 2014. The 2014 figures included 81 with dementia and 41 with psychiatric conditions.[9]

In addition, in 2001 about 5.6% of all deaths in the Netherlands were related to deep-continuous sedation. This rose to 8.2% in 2005[10] and 12.3% in 2010. A significant proportion of these deaths involve doctors deeply sedating patients and then withholding fluids with the explicit intention that they will die.

In the Netherlands children as young as twelve can already have euthanasia and a 2005 paper in

the *New England Medical Journal* reported on 22 babies with spina bifida and/or hydrocephalus who were killed by lethal injection in the Netherlands over a seven year period. It estimated that there are 15 to 20 newborns being killed in this way per year – despite this still being illegal. The culture and public conscience have changed.[11]

In Belgium, which legalised euthanasia in 2002, there was a 669% increase[12] in euthanasia deaths between 2003 and 2013, and assisted suicide and euthanasia now account for 6.3% of all deaths.[13] High-profile cases include Mark and Eddy Verbessem (deaf and blind twins),[14] Nathan/Nancy Verhelst (depressed following gender reassignment)[15] and Ann G (anorexia).[16]

Organ donation euthanasia is already practised in Belgium[17] (transplanting organs from people who are then euthanised) and the country recently extended euthanasia to minors. A *New England Medical Journal* study on the practice of euthanasia in the Flanders region of Belgium found that in 2013 1.7% of all deaths (more than 1,000 deaths) were assisted deaths without explicit request. Half of Belgium's euthanasia nurses have admitted to killing without consent although only doctors are authorised to perform euthanasia.[18]

why incremental extension is inevitable

Any law allowing assisted suicide will carry within it the seeds of its own extension.

Whilst Dignity in Dying may claim to have limited objectives (assisted suicide for mentally competent adults with six months or less to live) on its coat tails are a host of other UK groups with more radical agendas who will see this only as a first step.

They will not be satisfied with so-called modest changes – they want euthanasia as well as assisted suicide – but they are all using the same arguments to advance their case.

The essential problem is that the two major arguments for euthanasia – compassion and choice – can be applied to a very wide range of people. This means that any law which attempts to limit them, for argument's sake to mentally competent people who are terminally ill, will in time be interpreted more liberally by sympathetic or ideologically motivated 'assisters' and may also be open to legal challenge under equality legislation on grounds of discrimination.

- If adults can have it, why can't children who are judged to be Gillick competent make up their own minds?
- If competent people can have it, what about those with dementia who, it is argued, *would have* wanted it?
- If people who are terminally ill, why not the chronically ill or disabled who are suffering unbearably?
- If it's for those with physical suffering, why not those with mental suffering?

Or as Philip Nitschke of Exit international asks: why not the elderly bereaved and the troubled teen?

Any law allowing assisted suicide or euthanasia in any circumstances at all will be subject to extension – or abuse.

There will inevitably be pressure to extend the boundaries that may well not survive legal challenges under equality legislation once the so-called 'right' is available for some. Any law allowing assisted suicide or euthanasia in any circumstances at all will be subject to extension – or abuse.

why doctors cannot be trusted

Changing the law would also give doctors a degree of power over life and death that some will inevitably abuse.

It will be doctors who see the patients, fill out the forms, dispense the lethal drugs. Some of them will push the boundaries. Some will falsify certification. There may be some who, like Harold Shipman, will develop a taste for killing and they will be very difficult to detect.

But many will simply be too busy, too pressured

end of life resources

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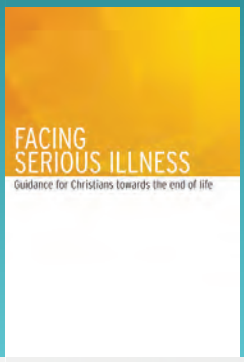

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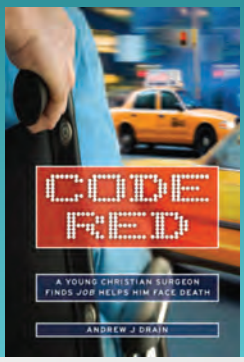

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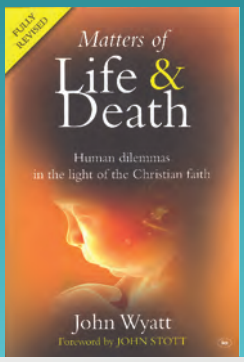

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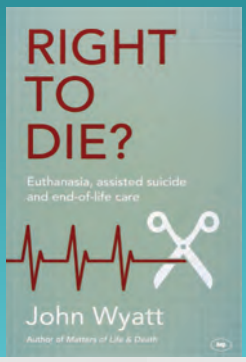


and facing too many demands to make the kind of cool comprehensive objective assessments that this kind of law requires. And very few of them will really know the patients or their families.

We have seen this already with abortion. We began with a very strict law which allowed it only in limited circumstances. Now there are 200,000 cases a year. Most of them fall outside the boundaries of the law.[19] There is illegal pre-signing of forms, abortion for sex selection, abortion on demand for spurious mental health reasons, and only one conviction for illegal abortion in 45 years.

> the overwhelming majority of people with terminal illnesses want 'assisted living' not 'assisted suicide'.

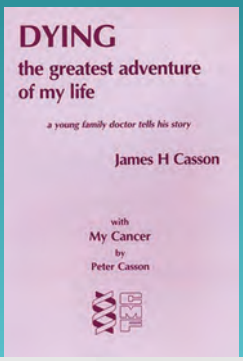
Society is reluctant to touch and question doctors. The police are reluctant to investigate. The DPP hesitates to prosecute. The courts are unwilling to convict. Parliament turns a blind eye. It is simply not safe to give doctors this sort of power because some will abuse it, as they have in other countries, and it will be very difficult to stop them. It's far better not to go there at all.

dangerous and unnecessary

The legalisation of assisted suicide and/or euthanasia is dangerous – but it is also unnecessary because requests for euthanasia or assisted suicide are extremely rare when people's physical, social, psychological and spiritual needs are adequately met. This is a powerful argument for making the very best palliative care accessible to all who need it. The overwhelming majority of people with terminal illnesses, even those with illnesses like motor neurone disease, want 'assisted living' not 'assisted suicide'.

The best system available is that which we have currently – a law carrying a blanket prohibition on both assisted suicide and euthanasia but with discretion given to both prosecutors and judges to temper justice with mercy in hard cases – the current law has both a stern face and a kind heart. In other words the penalties that it holds in reserve act as a powerful deterrent to exploitation and abuse of vulnerable people. And it works – there

Dying:
The Greatest Adventure of My Life & My Cancer
James Casson & Peter Casson
ISBN 906747325, CMF, 1999, £2



The Human Journey
Dr Peter Saunders
ISBN 9780906747582
CMF, 2014
£2 from *cpo.org.uk*

CMF files:
- *62 (2017): withholding and withdrawing medical treatment*
- *56 (2015): assisted suicide*
- *22 (2003): euthanasia*
- *19 (2002): advanced directives*
- *13 (2001): do not resuscitate dilemmas*

All files are free and can be downloaded at:
cmf.org.uk/resources/publications

are very few cases observed (just 15–20 per year make the trip to Switzerland) but also very few prosecutions.

Let's keep it that way. ▪

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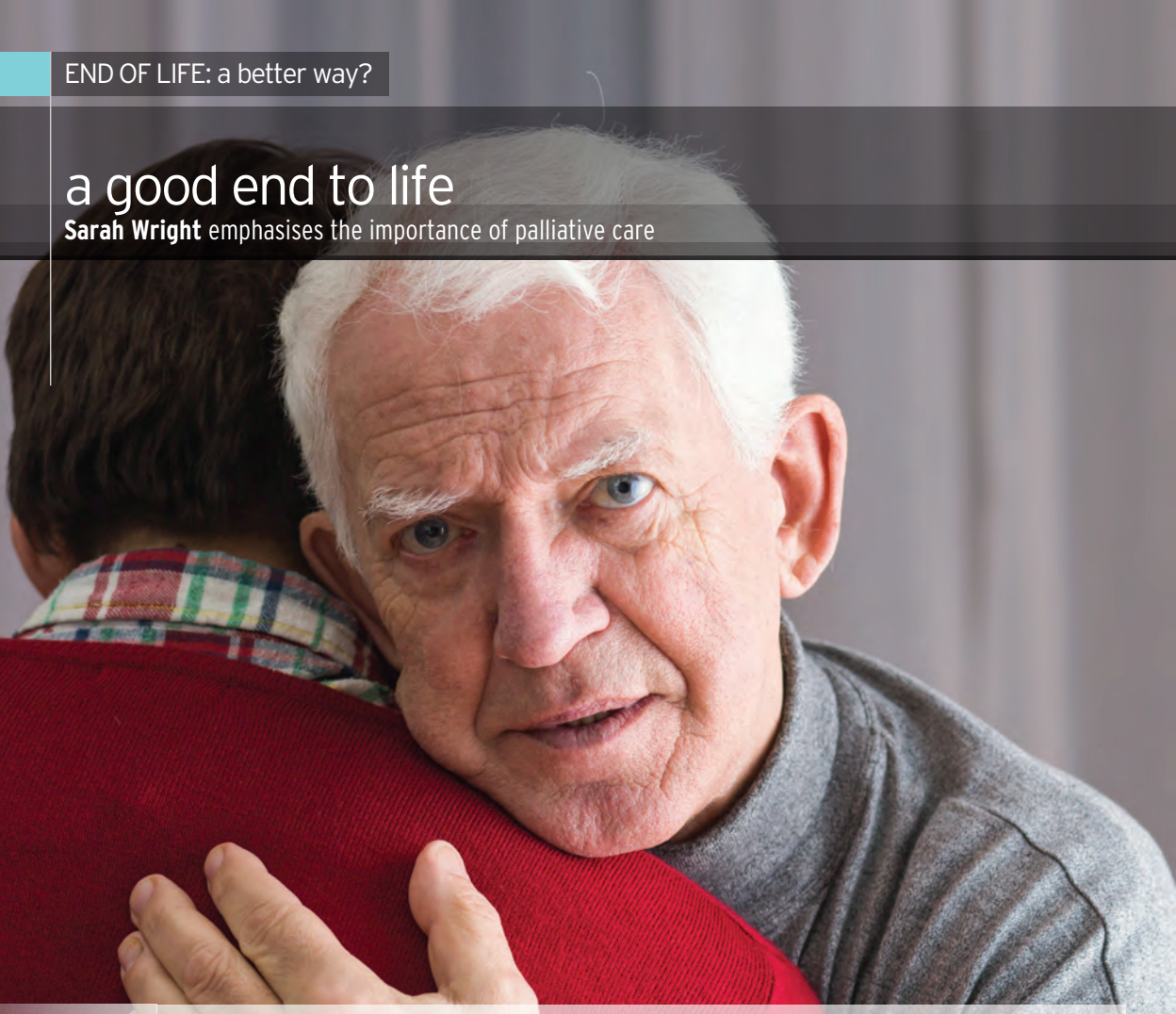
a good end to life

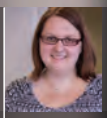
Sarah Wright emphasises the importance of palliative care



What is the first thought that comes into your head when someone says 'palliative care'? Sadness? Death? Hospices? Cancer? To me, when someone mentions palliative care I think of love, comfort and peace. Here's why.

Palliative care is defined as 'active holistic care of patients with advanced progressive illness'[1] and encompasses physical symptoms as well as psychological, social and spiritual support. The National Council for Palliative Care states that palliative care is not only provided by specialist teams in the hospital, but by 'those providing day to day care to patients'. We don't need to be experts in dosing alfentanil or levomepromazine, have a degree in counselling or be confident in sharing our faith with patients; offering simple paracetamol or an empathetic ear can massively help someone to feel more at peace.

Since qualifying three years ago and working in a number of specialties – from respiratory medicine to oncology and A&E to pancreatic surgery – not one day has passed where I haven't been in contact with someone in their last days of life. Many of our patients fear death. In today's society it is viewed as one of the worst things that can happen to you. We see people trying to delay ageing, find new ways to extend life or look for hope in being cryogenically frozen. But why do we fear death? Maybe it's leaving others behind, or regretting unfulfilled dreams, or fearing the unknown? These fears are not restricted to non-Christians. Many Christians also worry about these things. Have they truly been forgiven? What about their family? What if Christianity is a lie? But we have to trust that God is alive, he walks with us through our life and death and he has appointed our time in advance.[2] And we



Sarah Wright is a junior doctor in Swansea

have hope. Hope in eternity with Jesus, hope that all pain will cease and hope that we'll see loved ones again. Paul writes in 2 Corinthians 4:18: 'So we fix our eyes not on what is seen, but on what is unseen, since what is seen is temporary, but what is unseen is eternal', and Jesus himself told us that he has prepared a place for us in heaven so that we can be with him.[3]

Many patients are etched into my memory and I still recall their names and diagnoses, but I especially remember their last days and hours. I remember the family that screamed at me, thinking that I'd killed their uncle; the family who refused to accept their father with metastatic prostate and bowel cancer and anuria would be unlikely to survive the night. However, I want to tell you about a patient I met as an SHO. He had necrotising pancreatitis due to alcohol excess, despite his protests that he 'didn't drink that much – only half a bottle of whisky a day and a few cans of lager'. Initially very hopeful that with careful medical management he would improve, over the course of weeks he gradually declined. He refused nutrition, became depressed and hopeless, and eventually was bedbound. As he became less lucid, we called the family to discuss the situation. That first meeting with his sisters was very difficult. With no senior members of the team available, I was left to discuss his declining health, the DNACPR decision and end of life care. Despite a rotation in oncology and watching seniors, I had never had these conversations with a family before. Reading the notes beforehand, the ward sister said to me 'You'll be fine. You've got a lovely manner. Just be honest and straight with them'. She'll never know how much those words of encouragement meant to me. And she was right too – I was fine.

The next few weeks passed in a series of ups and downs for everyone. As I had an interest in palliative care and established a rapport with the family, I was the first point of contact for the family and responsible for his end of life care. It was both terrifying and encouraging that my consultants felt I was able to manage that level of responsibility. Those few weeks taught me so much – the medications, doses, communication skills, and when to ask for specialist help. I learnt the importance of regular meetings, that taking time to review the drug doses in a syringe driver early prevents the nurses from needing to refill the driver twice because you've changed a dose late, and that checking that there is a clear weekend plan in the notes can help the ward cover immensely.

why do we fear death? Maybe it's leaving others behind, or regretting unfulfilled dreams, or fearing the unknown?

Especially in his final couple of days, the family expressed their thanks for the care and support I was giving, and to my surprise I realised that I was providing good palliative care and making a real difference. It was such an honour to be able to demonstrate God's love, even if they didn't know that's what it was. A few days later the sister called me into her office. Usually that means something negative has happened and I need to sort it quickly, however this time it was to show me a card from the patient's family thanking the ward for everything they had done and 'thank you especially to Sarah for all her support and care'. I think it was the first time that I had received written thanks and I realised just how much of a difference good palliative care makes.

So why should we be so concerned with providing the best palliative care possible? Because Jesus would. Throughout his ministry Jesus cared for and spent time with the most vulnerable groups he encountered. He cared for Mary and Martha when they grieved for Lazarus, for the centurion

when his daughter died and for the man lowered through the ceiling by his friends. Whenever Jesus came across someone in need he cared for them – not just physical healing or comfort, but spiritual care too. In Matthew 9 Jesus encounters a paralysed man and says 'Take heart, son; your sins are forgiven'.[4] Jesus was accused of blasphemy, but he showed the man compassion and also healed him physically. Speaking to a group of followers, Jesus invites them to 'Come to me, all you who are weary and burdened, and I will give you rest'.[5] This is the essence of palliative care: providing care for those burdened with illness and giving them rest. Rest from physical symptoms, from mental anguish and spiritual pain.

So how can we show God's love to our patients and their families at the end of their lives?

1. **Take time to build a relationship.**
   Having a family's trust makes initiating challenging conversations easier, and allows you to address issues before they cause distress.
2. **Practise good communication skills.**
   It's so easy in medical school to neglect communication skills – I know I did! Take time to discuss examples of good practice with friends, and role play to improve your own skills. Watch more senior doctors and ask them how they approach difficult subjects with patients.
3. **Be aware of the specialist palliative care services within your local area.**
   This can include hospital teams, community clinics, hospices and voluntary organisations.
4. **Refer to specialist palliative care early.**
   For the patients, early referral allows time to plan for the final days, and to discuss resuscitation, syringe drivers and where they would like to die whilst they are physically and mentally strong enough.
5. **Be familiar with local prescribing guidelines and where you can find them.**
   Practise whilst you're a student or ask the doctor you're with to explain their choices.
6. **Prayer is so important in medicine.**
   Pray before meeting a family that God will help you be clear and empathetic, pray for patients and their healing, pray for families when a patient dies. When a family has known I am a Christian, offering to pray with them or for them has been welcomed gladly. Often the only thing I feel that I can do for a patient who has died is to pray for the situation.

Finally, palliative care is not just for the specialists – everyone can be involved. The last few days are sometimes the most distressing and painful times that will be experienced. Words left unspoken, family members unreconciled, debts unpaid or secret guilt can form a heavy burden adding to the weight of declining health. Of course some know this day is coming and have prepared as best they can. But for those whose health has taken an unexpected turn for the worse, they often choose to keep these burdens hidden and as medical students and doctors we feel unqualified to help. Yet, as Christians I think we have a unique opportunity to provide hope to these people, because God 'comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God'.[6] ■

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just ask
questions from students

CMF dissects your dilemmas

low mood

'I've been feeling low for six months, and have lost enjoyment in meeting with others. I feel I'm a bad witness as Christians should be full of joy. I don't really want to get medical help but do you think I should see a doctor?'

First of all, let's debunk the myth that Christians are immune from suffering from low mood. We're all human with the vulnerabilities and tendencies of our human condition. And let's face it, life isn't always joyful. We face various challenges, genetic predispositions, and stressful circumstances that might trigger a depressive episode in our lives.

Jesus was described as a 'man of sorrows, and acquainted with grief'.[1]

As healthcare students you will also at some stage face the realities of illness, chronic suffering and even death in your workplace. Doctors and nurses have to balance needing to be empathetic and relating to patients without becoming over-involved, which can be tricky.

Indeed, a 2016 *BMJ* study[2] concluded that doctors (especially juniors) are particularly vulnerable to stress and mental health issues owing to the demands of their jobs. The reasons are complex, ranging from long hours and sleep deprivation to bullying by more senior doctors.

We'll be limited long-term in how well we'll be able to help our patients if we don't properly care for ourselves.[3]

So, if you're struggling with low mood don't be slow at getting help and medical advice. It may be a case of just needing to rest more, to learn ways to de-stress, or to cut back on some of your extra-curricular activities for a time. Equally, you may benefit from counselling or anti-depressants. It also helps to confide in a trusted friend or church member, to rally support and prayer, and to have someone who keeps a loving eye on you.

Doctors and nurses have to balance needing to be empathetic and relating to patients without becoming over-involved, which can be tricky.

But whatever the way forward for you, remember that many Christians and many healthcare workers do suffer low mood at some stage of their lives.

It is nothing to be ashamed of, and help is there for you. If we're honest about our own struggles, it frees others to also open up. Maybe the Lord will even redeem this tough period to enable you in the future to better comfort others in their distress. 2 Corinthians 1:3–4: 'the God of all comfort… comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.' ■

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essentials: back to basics

Stephanie Moss explores sharing faith with patients

'If there is a God, I'd like to tell him or her that I did not ask to be born' – this came from my patient, a burly retired truck driver who had come to see me about his varicose veins. I'd never met him before; he had started telling me about his loneliness and how his children don't bother with him any more... and then this sentence. In the faith-sharing Saline Solution course we are encouraged to spot a door in front of us and to walk through open doors.[1] What would you have said next if you were me? By the end of the conversation I had offered to pray that he would have a vision of Jesus – in between I found he had been born a Muslim but rejected that faith and was now interested in the more mystical Sufism, hence my boldness about a vision.

'Yes please' was his parting shot.

Saline tools give me confidence to start where the patient is and ask questions to see where they want to go with the conversation. It has relieved me of the pressure to give answers. We are taught to check that we are following the patient's agenda and not forcing our own.

What I have learned from using Saline principles is that God really is at work in the lives of our colleagues and patients and, amazingly, he wants to include us in his work. There is ample evidence to show that faith (of all kinds) is important in healthcare and affects outcomes and so often we have been scared by a secular agenda and denied our patients the opportunity to speak about matters close to their hearts. It seems to me that our secular colleagues often do not feel equipped to speak about matters of faith at all. Are they not more likely to be breaching GMC guidelines[2] by ignoring spiritual aspects of care than Christians are by addressing them?

Stephanie Moss is a GP in Birmingham and CMF Associate Staffworker

I remember a while ago a couple of young Pakistani sisters who came frequently to us, their GPs, with lists and lists of complaints. One day I asked them:

'Why do you have so many things wrong with you?' and quick as a flash they said, 'We have been cursed. There is a curse put on our family'.

I brought this up at a team meeting where no one else was a follower of Jesus and one of my colleagues said 'I don't know how you get people to tell you these things'. So I asked what he would do if they had said this to him. 'I would have referred them to psychiatry', he said.

I am a semi-retired GP and don't have a whole career ahead of me to fear losing. I also work in situations where usually I am alone with a patient. Younger medics who are usually in a team setting understandably find more constraints on their conversations about faith. The Saline course shows us how the fragrance of Jesus is on us when we spend time with him and that people who are being drawn to Christ will find that attractive.[3] We often forget that people spending time with us – long hours working in stressful situations with colleagues come to mind – will see Jesus. We can gain the confidence to pray as we go along that his life will flow through us by the Holy Spirit who lives in us.

At Saline we learn about having a Christ-like character and I have recently used an image of God holding out to me a box every day full of all the resources I need for that day. All the patience, all the grace, all the energy, all the wisdom and so on. Embarrassingly, I sometimes seem to say 'No thanks, God, I'll see how I get on myself. I can cope. And I like feeling sorry for myself and being grumbly'. Nursing those hurts and judging others and feeling mean inside and I reject his gift. In the stressed world of the NHS, people who have Jesus' life in them are like a cool drink on a hot day. And others notice.

Many people remember faith flags from Saline where we drop small sentences into a conversation hoping that someone will take our bait, and these are a very useful tool. I gave a gastric protector, omeprazole, while handing ibuprofen to a man with arthritic pain and he said 'Is that so that I don't sue you if I die?' Jokingly I said, 'Not much good if you are dead. I can't send a cheque to heaven or wherever you are going'.

He then asked, 'You don't believe all that do you?' and so we had a good chat about his upbringing in the Caribbean and his mother's prayers and how he could not accept the gospel account to be true. All from an inadvertent faith flag. This man has just started therapy for prostate cancer. I am praying for him and excited to see what God does to change his heart.

My little grandson started walking with small unsteady steps and a lot of help. We loved to watch his progress. God loves to watch us as we trustingly take small steps to be salt and light in the workplace. Is it by chance that you are at that medical school? Is it by chance that you have those friends? Do you sense that a patient has spiritual need? Have you noticed a colleague who is struggling? My advice is to pray. Spend time with Jesus so that his fragrance is on you. Trust God. Take small steps with sensitivity and respect and leave the outcome to him. ▪

Saline Solution is a one-day course designed to help Christian healthcare professionals and students bring Christ into everyday work. The course helps us recognise God-given opportunities to demonstrate Christian love and concern. The day looks at evidence linking faith and health, and explores practical tools which help give patients the chance to discuss faith in a way which follows their agenda. Many students have benefitted from this course. For more details see: *cmf.org.uk/doctors/saline-solution*

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leadership: vocational discipleship

John Greenall reflects on what it means to lead in healthcare

John Greenall is CMF National Field Director and a Paediatrician in Bedfordshire

At CMF, we want to develop leaders who are passionate about disciple-making, helping medics and nurses to live and speak for Jesus Christ not only on Sundays or at small groups, but in the nitty gritty of daily life.

Many of us know Matthew 28:19–20 well: 'Therefore go and make disciples of all nations… teaching them to obey everything I have commanded you'. This is a call to evangelism but, ultimately, to make disciples. Arguably, the key word in this great commission is 'all' – teaching obedience to all that Jesus has commanded. We spend a lot of our time studying or working – choosing to submit to a consultant we find difficult,[1] electing to not be anxious about our futures in an uncertain NHS[2] and so on.[3] Vocational discipleship resists a leisure time mentality – that my faith impacts my evenings and weekends, but not my work. Instead, we are called to take Christ seriously wherever we are and in whatever we do.

Of course, churches play a key role, as we have written elsewhere.[4] CMF is not a substitute for church. And yet we might have only one to three hours a week in contact with the local church, but perhaps 50 hours in our studies/placements. It is in these places where you spend most of your time that you are being formed and influenced. I have seen so many medics come through university who know their Bibles and know how to evangelise, but they have fallen away because they hadn't prepared for the (inevitable) challenges ahead; they hadn't grasped that they needed to be discipled (and to then disciple others) in and through their vocation.

So, as we consider what it means to be leaders where we study and work in healthcare, it is crucial that we are making vocational disciples, in partnership with the local church. But what might this look like?

becoming Christ-like in the everyday

My oldest son loves nothing more than 'helping me', be it in the garden, or making something like the BBQ we recently built. In the same way, God wants to get to know us in the context of a shared task, perhaps especially when that task becomes a real fight. Interestingly I often hear people say they want to take 'time out' to 'serve God'. Of course, taking this focused time to do things you can't do as a full-time student is a valid option – that's why we have a Deep:ER programme![5] But so often we grow in our faith amidst our daily tasks and, perhaps especially, our struggles – exams, a family tragedy, a distressing case on the ward and so on.

it is crucial that we are making vocational disciples, in partnership with the local church.

Jesus met Peter while at work as a fisherman, and God met Moses at a bush while shepherding. Will we meet Jesus in and through our studies and our work? Leading others to Jesus and grow in their faith in the everyday is part of what leading in CMF is all about.

engaging with the big issues in healthcare

Let's be honest, encouraging people to stay in medicine is not always the sexy option. But it seems clear to me that, in general, keeping people in medicine has great kingdom impact. After all, only someone engaged in their work can ask and begin to answer questions such as:

- What are the battlegrounds in our workplace and how can we apply biblical principles to respond in grace and truth?
- What does it mean to grow in faith in our profession?
- What are the principalities and powers at play in this world?

CMF is about connecting students with local

graduates who are several steps ahead. You can grapple with these questions together, gaining their insight, and see how they model Christ even when being a disciple at the coal-face is costly. Will you lead your colleagues to connect in this way?

grasping God's mission in us more than his mission through us

Dr Helen Roseveare, a recently deceased medical missionary,[6] had just arrived on her first assignment to the Democratic Republic of Congo. She got off the plane and met the local field director at his Jeep who said to her:

'If you think you have come to the mission field because you are a little better than others, or as the cream of your church, or because of your medical degree, or for the service you can render the African church, or even for the souls you may see saved, you will fail. Remember, the Lord has only one purpose ultimately for each one of us, to make us more like Jesus. He is interested in your relationship with himself. Let him take you and mould you as he will; all the rest will take its rightful place.'[7]

Real vocational discipleship isn't about 'doing more'. Medics can look impressive on the surface. In fact, many in church won't ask you how you really are, because they will assume you have got it all (well mostly) together because you do so much. This is where vocational discipleship hits the road. As a leader, no, as a friend, don't simply ask people 'how is your family?', or 'how are your studies?' Instead ask 'how is your walk with Jesus? Do you know him? Are you prioritising your growth in Jesus more than your medicine?'

The Christian life is about realising that we are called to be with Jesus and made like Jesus. Let's lead ourselves and others in this way.

prioritising depth over breath

I confess that I can sometimes get frustrated that I'm not making more headway in seeing the kingdom come where I work. Sometimes a CMF group can seem so small and feeble. I want to see big growth! But reflecting on the life of Jesus, the temptation must have been great for him to 'go global'. Indeed, the first century crowd expected fireworks… but they got someone talking about a mustard seed.[8]

We can perhaps produce quick results with the right technique. But effective kingdom growth will come in the way that Jesus did it – taking a small group to firstly spend time with them.[9] Let's consider what that means. Jesus wants to be with you, not to simply use you and your gifts. In fact, God doesn't need you in his mission, but he calls you to the privilege of being part of what he is already doing in his world. Does that excite you?

As a student, this means spending time in his Word and in prayer. It also means spending time with others (the 'fellowship' part of CMF). After all, Jesus devoted most of his time to a group of twelve and to three of them in particular – his leadership was relational not transactional. Like Jesus, your leadership may not be a platform to millions, but as we intentionally invest in the lives of a few, we will see disciples developed who have real depth, and whose lives are transformed to bring glory to God.

This is the high calling – we've been discipled… to be disciples… to disciple others… even to the end of the wards. ▪

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be prepared: relocation

Natasha Ramsden reminds us that God is with us wherever we go

Natasha Ramsden is an 'FY3' doctor in Emergency Medicine in Canberra, Australia

For doctors in training, relocating is common and brings many challenges but also blessings. During medical school, and since qualifying three years ago, I have moved house, church and job multiple times including a complete fresh start when I relocated to Australia for a year after FY2. Everyone's experiences will differ, but here are some things I found helpful along the way.

We can hold on to the knowledge that God is consistently present and never changes. When moving it can be hard to leave behind friends, familiar places and things you enjoy to head into something unknown. However, we cannot go anywhere without God and so wherever we are we can turn to him and know that he is right there! Psalm 139:8–10 says about the Lord: '*If I go up to the heavens, you are there; if I make my bed in the depths, you are there. If I rise on the wings of the dawn, if I settle on the far side of the sea, even there your hand will guide me, your right hand will hold me fast*'. When faced with uncertainty in a new place, we can be sure that God will be with us the whole way.

Practically, I have found getting involved in a local church as quickly as you can when moving to an area is an important way to make a new place feel like home. I have been lucky that whenever I have moved I have felt warmly welcomed into the Christian community, which has both helped me to feel more involved in the local area and not to miss the friends I left behind so much. It takes time and effort to get to know new people but it is so worth it. When moving to a new place, I have had more time to get to know work colleagues and do hobbies, which also can make relocating easier.

My final piece of advice is to be prepared to be pleasantly surprised about the adventure God has in store for you. After finishing FY2 I moved to Canberra, Australia, to work in Emergency Medicine. Lots of people were negative about Canberra as a place to live and I was nervous about spending a whole year doing shift work. However, one year on I have had a great time and now it is nearly time to leave I am finding it much harder than I could have expected. It has become clear that God knew what he was doing when he sent me here. God has made plans for each one of us and knows what we need more than we do.

> we cannot go anywhere without God and so wherever we are we can turn to him and know that he is right there!

Like many doctors in training, I will be moving again this August. I am so grateful for what God has given me in the past, which makes me sad to move on. However, I am excited about his plans for me in the new place I will call 'home'. ▪

distinctives: thriving in Babylon

Paula Busuulwa considers Daniel's example

'Also seek the peace and prosperity of the city to which I have carried you into exile. Pray to the Lord for it, because if it prospers, you too will prosper.'[1]

The prophet Jeremiah, in his letter to the Jewish exiles taken to Babylon, exhorts them to seek the peace of the city, encouraging them to build, marry and settle down.[2] What a remarkably strange thing to say to a group of people who have been forcefully taken from their own country into the land of their enemies.[3] The captives from Judah, to whom the letter in Jeremiah 29 was addressed, might have been perplexed at this advice but God promises this situation will be temporary and that he will bring about a positive end for his people.[4]

At the 2017 CMF Student Conference, Professor John Lennox challenged us to learn from the example of Daniel.[5] As one of the captives taken from Judah, Daniel would have been one of those to whom Jeremiah's message was directed and his life shines as a positive example of how to thrive in Babylon. Like the Jews who were only to remain in Babylon for 70 years,[6] we the church are only called to earth for a short time and know this world is not our home[7] but whilst here we should make the most of the time because the days are evil.[8] How then might we apply the principles learnt from Daniel and the instructions of the prophet Jeremiah to our lives as 21st century Christian students and doctors in order to thrive in modern day Babylon?

Seeking the peace of the city means that we are keepers and seekers of the peace in our environment. We should still speak on issues which are important and demand a response, but serve without complaining and be active in seeking solutions to the challenges which we face in our work as students and doctors. A powerful example of this is seen in Daniel 2 where King Nebuchadnezzar makes a harsh decree ordering

Paula Busuulwa is an FY1 doctor in London

for the deaths of all the wise men in Babylon when none of them are able to tell him his dream and its interpretation.[9] On hearing this, Daniel sought the king's permission to take time to understand the dream (in fact he prayed and sought God)[10] and provided a God-honouring solution to Nebuchadnezzar's problem.[11] Daniel demonstrated leadership and was active in seeking a solution to the problem. It's important to understand that although Daniel may not have agreed with the king's request he did seek a solution when a problem arose.

Specific examples of what this might look like include being part of a local medical school or hospital juniors doctors' committee as well as engaging with national organisations like the BMA.

his life provides us with a good example of how to thrive in a foreign land and excel even in the face of opposition.

In doing so, we can speak up on issues affecting us and our colleagues, we can also pioneer changes and improvements to the way things are currently done in our organisations that may alleviate stress and inefficiencies which frequently occur. If we are able to meet, either as individuals or through representation, then we should not shy away but rather embrace the opportunity to be a voice for others and let our light shine.[12]

Secondly, we find that seeking the peace of the city requires an action on our part. The captives are to build houses, plant gardens and eat of their produce, which implies being productive and fruitful in Babylon. We are fortunate as medical students to have many opportunities to develop in a multitude of areas such as such as writing, debating, research, leading and organising teams, all of these given by God and to be used to honour and glorify[13] him as well as serving his people. Daniel used his gift of dream interpretation to serve successive Kings (see Daniel 2, 4 and 5) and flourished in Babylon.[14]

Thirdly, seeking the peace means we actively pray. Though last, this is by far the most important. Daniel prayed and God did amazing things through his life so we too need to pray for each other, our medical schools, hospitals, colleagues as well as those in positions of power in the NHS and beyond. If we hope to flourish in Babylon we need to pray not only that God would work through us and in us as individuals but also work in the lives of the people around us, for prayer can do great things as evidenced by the life of Daniel.

Daniel understood that in order to be successful in Babylon he had to engage whilst remaining undefiled and his life provides us with a good example of how to thrive in a foreign land and excel even in the face of opposition. Daniel's bravery, integrity and wisdom are amongst the many things we admire most about him and what ultimately allowed him not only survive but thrive in Babylon. It's something we can learn from even today.[15] ■

RESOURCE

If you are interested in reading more about this theme, CMF has recently published a booklet looking at how Christians can be fruitful yet distinctive as they serve God in the UK NHS. Christians face challenges not that different to those of Daniel. Living and serving as 'aliens and strangers' can lead to great pressure to close ranks or to forget who we are. £2 from *cmf.org.uk*

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1. Jeremiah 29:7
2. Jeremiah 29:5-7
3. 2 Chronicles 36:20
4. Jeremiah 29:10-11
5. These talks are available at: *cmf.org.uk/resources/media*
6. Jeremiah 29:10
7. Hebrews 11:13-16
8. Ephesians 5:16
9. Daniel 2:12
10. Daniel 2:16-19
11. Daniel 2:18-49
12. Matthew 5:16
13. Colossians 3:23-24
14. Daniel 1:17, 2:46-49
15. 1 Corinthians 10:11

local groups: Cambridge

Stephen Hogg discusses the day conference Burnout or Resilience?

Stephen Hogg is an FY1 doctor in Northern Ireland

CMF and the Lawyers' Christian Fellowship (LCF) co-hosted this engaging, practical conference in Cambridge in March 2017 and I had the pleasure of attending. The day addressed important questions: how do Christians working in the public sphere navigate careers that are becoming increasingly demanding of our time and energy? How do we live in a world that is becoming increasingly hostile towards the values of Christian people?

Peter Saunders opened the conference by sharing some reflections on Elijah's 'burnout' in 1 Kings 19. Elijah has fled Queen Jezebel and, fearing for his life, runs to Beersheba and then into the wilderness from where we hear of his exhaustion. He cries, 'It is enough; now, O Lord, take away my life, for I am no better than my fathers'.[1] The angel of the Lord appears and food and water is miraculously provided for Elijah. Elijah is reminded that he ought to 'Arise and eat, for the journey is too great for you'. From this, we are reminded to avoid neglecting our physical needs when facing times of challenge. I think of how my sleeping and eating habits go out the window when I become particularly busy!

Next we see Elijah bringing his problems before God. He lodges in a cave and waits upon the Lord. Eventually he hears God's voice in a whisper. When you're busy, do you bring your many jobs and long 'to-do' lists before God and ask him to give you the strength to work for him in all that you have to do? Often my quiet time gets shorter and shorter as the pace of life gets quicker and quicker. The busy times are the times when we are most in need of the nourishment that comes with feeding on that pure spiritual milk.[2] Only in Jesus do we find true rest for our souls.[3]

Following Peter's talk, we spent some time in groups with new friends where we discussed personal experiences and prayed for personal challenges. Lawyer Christopher Townsend shared wisdom on the importance of 'emotional intelligence'. He spoke of the practical wisdom of being 'politely assertive', dealing promptly and discerningly with challenging circumstances as they arise. He encouraged us to think about building 'margin' into our lives, time for 'shock-absorption', time that enables us to deal with the unexpected yet maintain spiritual and physical discipline.

Sunil Raheja, consultant psychiatrist and blogger, reminded us of the fact that we live in a world that is VUCA – Volatile, Unpredictable, Complex and Ambiguous. We are working in an NHS that is proclaimed to be at 'breaking point' in politically tumultuous times. We face unprecedented numbers of choices every day. Our senses are overwhelmed by multimedia. This predisposes us to burnout.

May God grant us the wisdom as we seek to navigate our brave new world and, by the power of his Spirit, find resilience and true rest by coming to Jesus, whose burden is light. ▪

REF

1. 1 Kings 19:4 (ESV)
2. 1 Peter 2:2
3. Matthew 11:28-30

crossing cultures

Andrew McArdle shares some 'dos' and 'don'ts'

Andrew McArdle is a paediatric trainee. He recently spent a year working in Freetown, Sierra Leone and was previously part of the NHS Ebola response there

I make no claim to be vastly experienced in working in different cultures, but through my elective, summer trips with CMF and later overseas medical work I have had some opportunities to gain insight. I will start with my own 'don'ts'.

Don't over-prioritise cultural understanding – it is only one of many things that will make you effective in an overseas role. Although crosscultural issues often receive a great deal of attention, in my experience a greater personal challenge overseas is often the interpersonal relations between outsiders, even though all may be working towards the same goal. My experience is mostly in the secular sector, but I hear enough to suspect that this is also true when Christians are working together.

Though there are innumerable ways in which people differ the world over, there are far more similarities. Don't allow yourself to be distracted by the obvious differences and neglect to see the unchanging humanity wherever you go. And don't be a crosscultural perfectionist, feeling that you need to understand every aspect of every culture that exists where you may work. Think about your home life – do you understand everything about the cultures of your own town or country? And yet you get by perfectly well. And while you can have expectations or spot patterns, don't make assumptions about your colleagues or patients. People will defy your expectations!

I worked in a hospital mostly frequented by those of limited means. One of my roles was running the cardiology clinic. I had little expectation that families would make it for follow-up appointments, living spread apart in a city with frequently gridlocked traffic. And yet, week in week out, the majority of my patients would dutifully turn up close to the time of their appointments. I was further surprised when one of my patient's mothers was able to put me in touch with a rich businessman leading a charity trying to send children overseas for heart surgery.

And so, to my 'dos'. Be yourself and be open. You may work alongside people with extensive history of working with outsiders, and not all their experience may be good. If they can get to know you well, including your own culture, they are more likely to trust you. Aim to do your work well, whatever that is: in general, if people sense that you are interested in them, there to help and have something to offer, you will have a wide degree of cultural latitude. Nonetheless, seek to be aware of cultural norms and where it clearly makes sense, adopt them or adapt to them.

I am often a busy person, frequently in a rush. Though I was aware of the expectation to stop and exchange greetings in Sierra Leone, I struggled hard to move from my British standard of a brief 'hello' without breaking step. In this, I went against a cultural norm. And yet, I never had a sense that this was held against me. Perhaps in a different country, I might not have been treated so kindly, but I believe that because my contribution was valued I was given this latitude. ▪

my trip to... India

Sophie Bloomfield describes her elective in Berhampur

I had the privilege of spending my elective in Berhampur, India, doing community paediatrics. Needless to say it has a very different style in India! Without newborn screening there are frequent late presentations of congenital malformations and advanced disease. There is no healthcare provision for the poor and government hospitals are full to bursting, unclean and the systems are corrupt. In the middle of this, Love the One (LTO) is an organisation that has a holistic model of healthcare, education and nutrition delivered to children through Early Paediatric Intervention Care (EPIC) centres for 0–5 year olds, a school and a centre for disabled children as well as community outreach clinics.

Charity directors Dr Mary and Dr Cat explained to me that when they had started they had been treating the big killers: malaria, typhoid, diarrhoea, malnutrition. But when these children recovered, they went straight back into their homes with no sanitation, not enough food, poor quality or no education at all and it made them wonder: what were they saving children from? Now, instead of catching the children downstream from the problems, as it were, LTO is now paddling upstream to tackle the root of deprivation.

My job was mainly doing six-monthly health checks in the centres. The fruit of the projects was evident with children slowly crossing weight centile lines! Dropping the children off to their homes was one of my favourite times of the day; there were about 30 kids and five adults crammed into one jeep. I watched one of the girls with cerebral palsy be greeted by her mother and carried out of the jeep. They were both laughing and joyful and I knew it hadn't always been like that for them; that this child had spent many years in a dark corner of their one family room without stimulation. Her being able to go to the children's centre in the day had altered Neha's disposition into a much

Sophie Bloomfield is a clinical medical student in Nottingham

happier girl and rescued her mother from being overwhelmed by the task of raising a disabled child in a society that rejects them.

When I was wandering conspicuously near their home around Ghetta Slum – a group of corrugated iron shacks built on a rubbish heap, one of the LTO staff members turned to me and said 'How does this make you feel?' When I thought about the answer I knew I didn't feel sad at all. Had I become hard-hearted? Wasn't I supposed to feel heartbroken? I knew these kind of daily hardships break God's heart. But I looked around at the side and saw many children running around, laughing and playing in bright red, blue and green EPIC centre polo shirts. They stood out against the dismal backdrop and what I felt most strongly was hope. What is wonderful about early intervention with the poorest children is the ripple effect it has throughout the community – women are employed through the day centres, the children's mothers are able to go to work, children are not forced into labour jobs or beaten at school, but receive free education and full bellies.

As a white woman in Odisha, I had the novelty of being automatically respected (and stared at often!). I was not naïve to the issues that women face in the culture but it was still shocking to see how ingrained the gender discrimination is. Whilst I was in Odisha, a baby girl had been so unwanted she had been buried alive in a rubbish dump. For reasons like this it has been illegal to perform gender determining ultrasound scans since 1971 due to high rates of girl feticide. Towards the end of my trip, I ended up sharing accommodation with a single mother with three young children who had been evicted by her landlord for not having a high enough social standing; with no regard to her welfare.

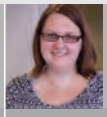
I remember one of clinical interactions trying to communicate with a mother of an eight-year-old boy with a ventricular septal defect who came to clinic to discuss upcoming cardiac surgery. Part of the job was ensuring that consent would be given at the time of the operation – in the past parents could withdraw consent due to religious beliefs that illness was an affliction from the gods and intervention would be futile. For that reason, I asked her questions about her own beliefs and family life. Connecting whilst talking through a translator is never easy but I was frustrated as to why she would not respond to my questions and instead the child's 'uncle' (a family friend) talked throughout the consultation. It was afterwards explained to me: she's probably never been asked her opinion before in her life. This woman had been raised under oppression, arranged to be married to someone she barely knows and subject to domestic violence and rape as part of her everyday life. The sad thing is, by the end of my trip, meeting wives and mothers like this was not a surprise to me but instead a cultural norm.

My reflections on the trip are ongoing. It is easy to be overwhelmed looking at the enormous number of children that would benefit from the most basic interventions. Dr Cat and Dr Mary taught me through their words and actions that we are called to love one child at a time (hence the name of the charity). I was personally encouraged that God has different areas for each of us and we are not called to try and change everything at once, but we are called to do the best we can with the calling and resources he has given us. The community of people I spent time with has transformed my own attitude – admittedly a tad tired and cynical that is often too contagious – and replaced it with a new passion to align myself to Jesus' teachings; to 'love' my patients and colleagues better.

Please join me in praying for the ongoing resources to reach more of the most vulnerable children and communities in Odisha. ■

a day in the life

Sarah Wright thinks about the stigma of mental illness on the wards



Sarah Wright is a junior doctor in Swansea

Recently I heard the sister talking to one of the nurses about a patient – 'they're bonkers apparently, and the police don't want to stay now they're admitted!' The response? 'Oh, great! That's all I need – another nutcase!' I was sat at the desk chasing results before I went home and was unable to ignore this conversation. I remember thinking that I'd meet this patient the next day and wondering what they meant. Over the next couple of days it was clear that the patient had mental health problems and needed specialist support.

It made me consider what my response should have been. What would Jesus' have been?

Sadly, I overheard many derogatory comments and gossip among the staff. Despite trying to remain impartial, I failed to challenge the stigma and prejudice against mental illness that I was seeing. Yes, the patient had a psychiatric illness, but they were still a person needing care. Did they really deserve to have the staff gossiping and complaining about them? It made me consider what my response should have been. What would Jesus' have been? In the Sermon on the Mount, Jesus speaks about loving our enemies and treating others how we would like to be treated.[1]

Paul tells us to 'not let any unwholesome talk come out of [our] mouths, but only what is helpful for building others up'[2] and 'to slander no one, to be peaceable and considerate, and always be gentle toward everyone'.[3] We are also told that every human is made in the image of God and are therefore precious (not just people like us).[4] As Christians we should guard our tongues and not speak words that are harmful, not only to the person we are speaking about but also harmful to ourselves. We are not called to be involved in gossip or judge people based on their health or

lifestyle, but to 'act justly and to love mercy and to walk humbly with your God'[5] and 'love one another. By this everyone will know that you are my disciples'.[6] I can't help but think that I should have spoken up for that patient who couldn't stand up for themselves. Jesus wouldn't have stayed silent listening to those hurtful comments, he would have spoken up and demonstrated his love to that patient by showing a better way to act. Why shouldn't we follow his example? ■

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2. Ephesians 4:29
3. Titus 3:2
4. Genesis 1:27
5. Micah 6:8
6. John 13:34-35

counterparts : Thailand

Supredee Pongrujikorn shares his experience of Thai CMF

Supredee Pongrujikorn is a medical student in Thailand

Only 0.6% of people in Thailand are Christians. Studying in Thai medical school is never easy. Moreover, being a Thai Christian and medical student is even more challenging. It is really difficult to find friends who are believers. One of our priorities is connecting Christian medical students in Thailand together because knowing you are not alone on this journey is important. Thus, we started CMF Thailand.

Last March, I had a chance to visit CMF UK in London. It was so touching to see a strong group of Christian medical students in the UK and I knew this was not a coincidence, it was definitely God's plan. The quote Dr Peter Saunders told me, 'Think globally, act locally' was still in my mind. So, after coming back, CMF Thailand was formed by only six Christian medics from students in my faculty. In May we decided to have the first Thai Christian medical student camp – The Faith's Anatomy.

On the first day of the camp, there was heavy rain then an unpredictable transformer explosion and blackout. At that time, I could not understand why God let this situation happen but I knew that we were in an out-of-control situation. The things we could do as limited humans were praying and letting God do his plan. We carried on running every programme in the darkness with many candles. Then I saw one candle that was short and faint but still trying to light up the room. It made me think of hospitals in Thailand that contain not only needy people but also colleagues who are unbelievers, 99.4% are in the darkness. We, Thai Christian medical students, are short and faint candles. We have to survive in an educational system that forces us to study hard to be smart doctors. Sometimes we are tired but still try really hard to shine. Jesus once said 'You are the light of the world... let your light shine before others, that they may see your good deeds and glorify your Father in heaven'.[1] This is true. After the camp, I saw pictures of the first day and was so surprised because the

pictures were so beautiful, candles were shining and you can see smiles from everyone in the room.

This camp had around 40 Christian medical students from all over Thailand participating and around 90 students are interested in joining us moving forward to form fellowships in their medical faculty to study God's Word and become confident Christian witnesses. We are also supported by IFES (International Fellowship of Evangelical Students) of Thailand. Ten of us are planning on joining SEAMMC (South East Asia Medical Mission Conference 2017) in Bali this August as well.

> I could not understand why God let this situation happen but I knew that we were in an out-of-control situation.

Please do kindly pray for:

- CMF Thailand's active vision and plan for our next year.
- For student leaders to keep being passionate and encourage Thai Christian medical students to put gospel first and have deep faith.

We are so excited to let God light CMF Thailand and we will shine for more and to more people in Thailand. ■

REF

1. Matthew 5:14-16

Review

film: *Me Before You*

A suicide note urges Louisa to 'live boldly' and to 'just live', but what does this mean? The movie opens to our dashing male protagonist, Will. We see him rushing off to a busy business deal when a tragic accident strikes that leaves him paralysed from the neck down. Louisa is an optimist with a quirky fashion sense. She instantly brightens the screen and hints us towards the romance which is about to develop between the two. Unexpectedly, Louisa is unemployed from her waitressing job and finds an opportunity to become a caregiver for the self-isolating and cynical Will. With Louisa's influence, and by her side, Will learns to appreciate things in his life. It was all planned to be happily ever after. Until Louisa finds out that Will is preparing himself for physician-assisted suicide.

The viewers follow Louisa's determination to change Will's heart. She plans for once-in-a-lifetime experiences, and ticks off the bucket list in Mauritius. The cinematography of their dream holiday highlights the beauty and goodness of life. Along with a beautiful soundtrack and Will's growing affection for Louisa, we were all sure of a happy ending. But the movie was known to be a tear-jerker, and the sudden turnaround happens in the last 15 minutes, where we see Will prepare for his death at Dignitas.

Will is depicted as a young, privileged man with the best kind of private medical and social care. His decision to die is described by Louisa in the film as 'selfish', and could plant an uneasy feeling for viewers with disabilities in a worse position than Will. The film emphasises autonomy, choice and 'Will'. But I cannot help but feel the undertone of the movie is to affirm physically disabled people in their decision to end their lives. If a physically-abled person decides to kill themselves, we try our best to prevent this from happening: we offer them psychological and emotional support, sometimes coupled with psychiatric drugs. Yet why is society so quick to welcome and support suicide among the physically disabled?

This movie had a great platform to display hope and love, yet the main effect was to romanticise euthanasia and Dignitas, an organisation with an 'atheist basis of self-determination' according to their founder Ludwig Minelli. *Me Before You* emphasises choice as the most sacred thing in life. Yet the final moment of Will's life is in a room with white curtains and bright light shining into his bed, perhaps using the imagery of heaven. This near ending is an apparent allusion to life after death for Will, and the scene raises a lot of questions for viewers.

The movie departs with a narration of Will's suicide note, where he reminds Louisa to 'just live' as he allots some of his fortune to her. We then see Louisa wearing stripy tights, a gift from Will, which represents the 'bold' life he prescribed. The audience only sees the positive effect Will's decision had on Louisa, with his fortune and the experience she will have in Paris. But what about his death? The scene after Will had the lethal dose of drug is not shown, but we are shown a bright white light and falling leaves. If Will's choice to die was a realistic one, as argued by some, is this the reality of death? Or am I just expecting a little too much from a summer rom-com? ▪

Chieun Han is a medical student in Manchester

Reviews

film: *Still Alice*

'You are more than what you can remember [and] you are more than what you do for a living.' So says Lisa Genova, the author of the book on which this film is based. *Still Alice* was inspired by Genova's recollection of her grandmother's experience of Alzheimer's. She wanted to depict what it might feel like to look in the mirror, and not be certain of who you see; to work so hard to build a successful career and make fruitful relationships, but have them torn away from you as your memory fades.

Still Alice tells a heartbreaking story about the brilliant Professor Alice Howland, who lectures on Linguistics at Columbia University. After experiencing worrying symptoms of memory loss aged 50, Alice is diagnosed with the rare and rapidly progressing Familial Early Onset Alzheimer's Disease. The condition worsens month by month until Alice struggles to remember her children, has to give up her career, and relationships within her family become strained.

One scene in the movie was particularly heartrending. Alice watches a video she prerecorded for herself in the past, which tells her how to commit suicide once she's no longer able to cope with the memories she's lost. As she tries to follow the instructions, she inadvertently forgets the steps to take, and has to watch the video again and again before she finally gets interrupted mid-attempt, and spills the lethal pills all over the bathroom floor. In that moment, I felt so sad to see the angst Alice felt being fed up with living as the shadow of her former self.

So, what can we learn from all this? As medics, we are certainly at risk of making our careers what drives us most in life. The desire to achieve excellence in the medical profession is a wonderful one, but if my identity is my career, what will be left of me when I can no longer work? Alice's story reminded me that I must live my life for so much more. We have no idea what will happen tomorrow, and this life really is just vapour that will vanish away.[1] However, the joy of the Christian faith is that I can live with the knowledge of the hope I have in Christ: his return will restore all things to perfection, including our broken bodies and minds. ▪

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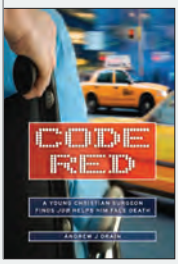
REF
1. James 4:14-15

Code Red

Andrew J Drain

ISBN 9780906747407, CMF, 2010, £3 from CMF

How would you react knowing that you only had a few more months to live? Andrew J Drain, a cardiothoracic surgeon at the peak of his career, experiences a role reversal after he is diagnosed with acute lymphoblastic leukaemia. One day he was a doctor making a living treating the dying, the next he was a patient struggling to live. In an effortless manner, he aptly weaves together Job's story with his own, delving into some of our most basic questions about suffering.



Although he knows his death is imminent, he has a strong confidence that his suffering is of the Lord's permission and that God is in control of his suffering. This gives hope to those who are suffering not just from chronic illness but from other conditions – pointing to the ultimate sufferer who has been there before us and will be with us through it all.

Code Red is not all sombre though; it is presented with creative and animated storytelling, taking us on a journey from the Bronx to Northern Ireland, and even on a music tour for the musical aficionados!

I highly recommend this short, rewarding book not just for those with chronic illness, but for medical practitioners, or anyone with questions on Job and suffering in general 'pointing to the hope of the gospel in the midst of despair'. ▪

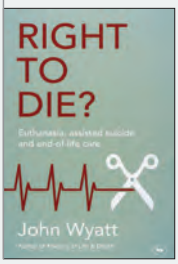
Joanna Obire is a medical student at St George's, University of London

Right to Die

John Wyatt

ISBN 9781783593866, IVP, 2015, £7 from CMF

An initial survey of recent UK and world events sets the scene for a discussion of euthanasia, assisted suicide and end of life care. A particular strength is the perspective on recent events, laying out the ideas and arguments that have led to such pressure to legalise assisted suicide in the UK and elsewhere.



'Compassion' and 'autonomy' are the two major arguments used to promote euthanasia. The author not only describes these, but seems to have really wrestled with them, putting these arguments clearly and empathetically. There is no doubt that he has given them a fair hearing; he's also considered the reasons why Christians have sometimes advanced these arguments.

Even so, the case against assisted suicide is made clearly. Biblical arguments around the image of God and the value of human life are made, and will be familiar to many readers. Particularly powerful points are made about human dependency; dependency is *part* of God's design, not a distortion of it. The place of suffering in God's plan is also considered: 'Suffering is not to be sought, but there are times when it should, at least to some degree, be accepted'.

The book ends by looking at medical and legal factors, and palliative care. This work is a good place to start looking at this issue, particularly for the layperson or a healthcare student new to the topic; the author's compassion is obvious throughout, and the basic arguments are well covered. More senior readers might want to make use of the extensive reference list to delve deeper into the topic. ▪

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

news reviews

BMA abortion debate; assisted suicide case

BMA backs abortion decriminalisation

The BMA's Annual Representative Meeting (ARM) voted in June 2017 to support decriminalisation of abortion. The motion passed appears to envisage that abortion would be treated like any other medical procedure, regulated by the GMC and other professional bodies, but not explicitly in law.

The full motion was in six parts,[1] with about two-thirds of delegates supporting parts ii) and iii), which backed decriminalisation. Prior to the vote, more than 1,000 doctors had signed an open letter to the BMA opposing decriminalisation.

The footnotes are clear that there should still be a 'statutory right of conscientious objection' for healthcare professionals, although there is no clarity over how this would be administered given that abortion would be removed from criminal law.

The 2016 ARM had mandated the preparation of a discussion paper,[2] and there had already been discussion of the issue in Parliament in early 2017, in the form a ten-minute rule bill looking to decriminalise abortion. Further debate on decrimalising abortion is expected after the parliamentary recess.

Abortion in England and Wales is currently governed by the Offences Against the Person Act (1861), and the Abortion Act (1967, amended 1990). Essentially, the 1861 Act criminalises abortion. The 1967 Act does *not* in itself annul this, but defines certain circumstances in which abortion is not considered an offence. These circumstances have been interpreted increasingly broadly, and there were 190,406 abortions in England and Wales in 2016.

The 1929 Infant Life Preservation Act outlaws destruction of a 'child capable of being born alive', (defining this at 28 weeks gestation). Parliamentary discussion earlier this year implied that this act also be repealed if abortion were decriminalised, which would effectively remove all legal gestational limits on abortion.

The British Pregnancy Advisory Service (BPAS) among others supported decriminalisation, but the vote attracted some hostile comment in media outlets.[3] A Christian critique of the procedure and vote is on the *CMF blog*.[4]

assisted suicide returns to the High Court

Noel Conway, a 67-year-old man from Shropshire, is involved in a High Court case which attempts to overturn the law prohibiting assisted suicide. Hearings took place during July 2017.

The case, backed by Dignity in Dying (formerly the Voluntary Euthanasia Society) argues that the Suicide Act breaches Articles 8 and 14 of the Human Rights Act. Article 8 concerns the right to a private and family life, while Article 14 deals with non-discrimination.

Mr Conway suffers from Motor Neurone Disease, and was too unwell to attend court. His case has many similarities with those of Paul Lamb and Tony Nicklinson, although they were not terminally ill as Mr Conway is. In Lamb and Nicklinson's case, the court ruled against any change in the law, stating that such a change was a matter for Parliament. Since that ruling, a bill which would have legalised assisted suicide has been rejected in the House of Commons by a substantial margin. A decision is expected in the autumn. ▪

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HEROES + HERETICS

Alice Gray describes two heroes of palliative care

HERO + HERETIC 20/21:
Dame Cicely Saunders (1918–2005)
Anne Merriman (b1935)

There are now more female medical students than male in most medical schools across the UK, peaking in 2003 at 61%.[1] But it has not always been easy to be a woman in medicine, and certainly not to lead transformation in healthcare culture. However, this did not stop Cicely Saunders and Anne Merriman, two women who were driven by their faith, to challenge the way that we view dying and care for those at the end of life.

Dame Cicely Saunders (1918–2005)

Dame Cicely Saunders

Dame Cicely Saunders graduated from medical school at 39; her route was unconventional. After giving up Philosophy and Economics at Oxford University, she trained as a 'Nightingale Nurse' at St Thomas' Hospital to help the war effort.

dying people have physical, spiritual, psychological, and social pain that must all be addressed in good palliative care.

Unfortunately she gave up nursing due to back problems, but returned to Oxford to train as a 'lady almoner' (social worker) so she could continue to be closely involved in patient care.

At 27, Cicely became a Christian and described the change in her life 'as though I suddenly felt the wind behind me rather than in my face'. Following this she became an enthusiastic member of All Souls, Langham Place, and was driven by her prayer and desire 'to know how best to serve God'.

She felt that God gave her the answer very quickly when she met a terminally ill Polish Jew called David Tasma. She helped him come to terms with his imminent death, given the difficult life he had led. Following their discussions about improving care for the dying, he gave her £500 to begin a movement that would better manage pain and also provide better overall care. She said this felt 'like God tapping me on the shoulder and saying, "You've got to get on with it"'. She began to explore a concept she later described as 'total pain', that dying people have physical, spiritual, psychological, and social pain that must all be addressed in good palliative care.

Through working at St Luke's Hospice for the Dying Poor she saw the benefits of compassionate nursing care plus good, regular pain control. This

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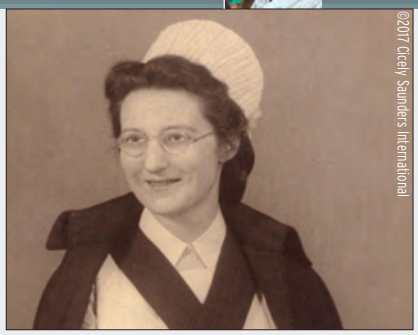

was unusual, as doctors were afraid of giving patients access to regular morphine for fear of addiction. Patients would often be begging for pain relief, only to be given small amounts of morphine by injection, which was itself painful. Despite seeing the benefits of giving dying patients regular analgesia, pre-emptive of pain, Saunders saw there was a serious lack of professional medical help, as doctors had given up on these patients. This made her sure that care of the dying needed to be a lot better and was work that she could do. However, this was not going to be easy and it was a surgeon she had been working with who advised her: 'Well, you've got good ideas, but you won't get anywhere unless you become a doctor. It's the doctors who desert the dying'. Cicely qualified as a doctor at St Thomas' Medical School and went straight into work on pain control for the terminally ill, based at St Joseph's Hospice in London in 1957.

'Commit thy way unto the Lord; trust also in him; and he shall bring it to pass'[2] was the verse that she came across in her daily Bible reading that convinced her to build her own hospice for the dying. 2017 marks the 50th anniversary of St Christopher's Hospice in Sydenham, London. Palliative care was not integrated into the NHS at this point and so the building of the hospice came completely from charitable donations, which was no mean feat! St Christopher's offered individualised patient care, but was also active in research and education as Saunders saw that this would be crucial to advances in end of life care. From then, hospice care has spread across the world and there are believed to be 8,000 hospices in over 100 countries.

Throughout her life, Cicely was consistently opposed to euthanasia, saying 'anything which says to the ill that they are a burden to their family and that they are better off dead is unacceptable'. She believed that if patients' symptoms, physical, psychological and spiritual, could be properly managed, there would be no need for euthanasia. This continues to be a perspective maintained by the Association for Palliative Medicine who released a public briefing outlining serious concerns about the legalisation of assisted suicide.[3]

Cicely died peacefully at St Christopher's in 2005. But this shy girl, who spent a lot of her teenage life feeling like an outsider,[4] completely transformed both our view of dying and made care of the dying a priority in our healthcare system. Her philosophy still drives research and policy to improve end of life care for every patient and their families: 'You matter because you are you, and you matter to the last moment of your life'.

But the story does not end with Cicely Saunders or in the UK...

Anne Merriman

Dr Anne Merriman was born in Liverpool in 1935 to a devout Catholic family. At the age of four she announced to her mother that, 'I want to go and help the suffering of Africa when I grow up'. She was inspired by Jesus' example of showing love to the poor and marginalised, and continued to be inspired by hearing about missionaries travelling across the world, spreading the gospel and showing the love of Jesus to those in need. Wanting to follow in her brother's steps, she had been bitterly disappointed when she discovered that as a woman she could not be a priest. However, little did she know that she would establish the first hospice in Uganda, and be part of the next step in revolutionising end of life care across the world.

Anne Merriman (b1935)

Anne described days where it felt like she has nothing left to give and prayed 'Oh God I am helpless. Please help my patients'.

She graduated from University College Dublin in 1963, and after a year's internship began her career as a Medical Missionary in Nigeria. However, it was when she had to return to the UK for family reasons that she describes the need for palliative care as part of her work in geriatrics, 'the elderly needed pain and symptom control and a... team to bring them to peace'. She got in touch with Cicely Saunders and began to bring her palliative care teaching to the northern part of the UK.

However, her call to work abroad never went away and in 1981 she embarked on a Masters in International Health that led her to work in India and Singapore. With a growing ageing population, Dr Anne saw a desperate need for holistic palliative care in Singapore. As a result, she went on to not only introduce some of Dr Saunders' principles but in 1989 set up the Hospice Care Association of Singapore that continues to offer one of the best palliative care services in South East Asia.

But Anne had not forgotten her first experiences of medicine in the developing world. The invitation to become the first Medical Director of Nairobi Hospice, Kenya, took her back to Africa in 1990. Her work in the hospice made her realise the desperate need not only for good palliative care but also affordable pain relief to enable patients to die peacefully at home with their families. She describes this realisation: '*while working in Nigeria as a hospital doctor, I was one of the many doctors who, when we could do no more, would ask the families to take the patients home. For the first time in Nairobi I was seeing what was happening to the patients who were sent home. And it broke my heart*'. With growing numbers dying from cancer and an exploding AIDS epidemic, need seemed to outstrip the resources available. In addition to coping with death and dying in a culture so far from her own, Anne described days where it felt like she has nothing left to give and prayed 'Oh God I am helpless. Please help my patients'.

But like Cicely before her, Anne was motivated by faith in God's provision, and a 'determined, stubborn' character.[5] This 'fire in my belly' determination that had overcome so many obstacles thus far, made her persevere in the fight against the 'bureaucracy inherited from the British... [that remained] still alive and well in the African health systems' and in the early 1990s

'Hospice Africa' was introduced. The aim would be to initiate a model of affordable palliative care services that was also culturally acceptable.

In 1993 Dr Anne began in Uganda with three months' worth of funding and a team of just three nurses. More than 20 years later, Hospice Africa Uganda has over 130 staff, a budget of 2.8 million and palliative care has been now incorporated into Uganda's Strategic Health plan, making it a national health priority. A big shift in culture was needed in regards to the vital role of nursing staff in palliative care, particularly for prescribing. With the ratio of doctor to population in Africa varying from 1:4000 to 1:100000 (in the UK it is roughly 1:450), relying on doctors to prescribe morphine left many dying patients with no access to vital analgesia.[6] Dr Merriman made the training of nurse prescribers a priority and it is having a significant impact on access to morphine across particularly rural part of Uganda.

Although Hospital Africa continues to expand, with Anne supporting initiatives in many countries across Africa including Tanzania, Malawi and Sudan, the work of palliative care is nowhere near complete.[7] Currently 100 million people across the world have some form of palliative care need, but only eight million have access to even the most basic service. Despite the World Health Organisation stating that access to analgesia is an essential human right, each day six million terminal cancer patients across the world suffer pain needlessly, because they cannot access or afford morphine.[8]

Where other doctors saw failure and the end of the road, Cicely Saunders and Anne Merriman saw people at their most desperate and in their time of greatest need. These women were motivated by their faith in God and love for people and could see there was a better way. Their autobiographies are littered with stories of patients that they learnt something from or people who meant something to them. To them, patients were so much more than statistics, bodies in beds, numbers on a jobs list. *'How can I understand a figure or a statistic unless I have held the hand that it represents? The people we are talking about are the same as us. By the way we treat them we know just how much like Jesus we have become.'*[9]

The challenge for us is this: will we stand on the shoulders of these giants, to continue their work? The issues our palliative patients face today are no less pressing, no less challenging, and they deserve no less an urgent and sustained response. ■

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