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for today's Christian doctor

triple helix

spirituality in clinical practice

primary care chaplaincy, resilience, marriage as a medic, juniors' forum, you are not your mistake

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contents

Looking to the future without forgetting the past

Two of the besetting sins of humanity are found in our attitudes to the past and the future. At one extreme we cling to the past, decrying the present and fearing the future; the cry of our heart is 'Things are not what they used to be!' At the other, we decry the past and look only to a golden future; the cry of our heart is 'Let's not get dragged down by what went before!' They are both forms of idolatry.

What we learn instead from Scripture is to remember from where God has led us through the cross of Jesus,[1] and to hold on to the hope that we have in his resurrection.[2]

Above all, we live in the present moment – built on a foundation of what God has done, looking to a future God has promised, but living and serving in a present that God has given us for his glory.[3]

So, while it won't have escaped your attention that the National Health Service (NHS) turned 70 last year, many of our readers may not realise that CMF reaches the same milestone this year.

Growing out of an increasing recognition of the need to equip Christian medical students to grapple with the ethical and professional issues of their day in a godly and biblical manner, CMF was formed out of the Medical Prayer Union and the IVF Graduates' Fellowship movement in June 1949.

It was a time of turmoil – four years after the Second World War, and eleven months after the founding of the NHS. Europe was still living in the wreckage left by seven years of brutal warfare and nearly two decades of unrest and political tyranny. Children still played in the craters and burnt-out shells of buildings destroyed in the Blitz; an impoverished nation that had once been at the centre of a globe-spanning empire was now having to painfully rebuild its infrastructure and learn to find a new place in the world.

The NHS was an expression of a desire to retain the national solidarity hard won in the war. Born out of a belief that none should be denied essential medical care because of poverty or social status, the NHS was one of a raft of changes that created the welfare state.

But these changes also had an impact on the Christian faith. Previously church-run and faith-based institutions became secular, state-run hospitals and clinics. The church was being moved to society's margins, and Christians in medicine and nursing found that they were having to express their faith in an increasingly secular workplace and wider culture.

When CMF started therefore, it faced some of the same challenges we are familiar with today – a country facing huge social and political change, recovering from over a decade of austerity, and a culture moving further and further away from its Christian roots. When CMF was founded it was felt that there needed to be a space for Christian medics to come together and address the ethical and spiritual challenges of their day. That need is, if anything, far greater now than it was 70 years ago. We face a rapidly changing world of new medical and communication technologies, upended social norms and values, and a nation facing significant new social divisions and political uncertainties.

We have much to learn from what God did through our predecessors and how CMF has navigated these waters before.

CMF has grown and changed a lot from that small group of doctors who met together in central London in 1949. We now include nurses and midwives as members, and have a global focus through our membership of ICMDA (an international network of Christian medical fellowships that CMF helped found in the 60s). We have hundreds of members working in global health and mission, and thousands more working at every level within the NHS.

We continue to look at this changing world and ask how we should respond as Christians. Our one constant is God himself and the gospel of Jesus – the greatest hope we have to share with this hurting world. So, we remember and learn from our past with thankfulness to him, prepare for the future in hope of him, and live and work in the present for his glory.

CMF remains a fellowship with a simple vision – to unite and equip Christian doctors and nurses to live and speak for Jesus Christ. This year, we have a new Chief Executive, Mark Pickering. Mark shares his thoughts on the past, present and future of CMF in the spring edition of *CMF News*.

We face new and uncertain times, but as we look back we see that this is nothing new.[4] We serve a God who remains unchanging, who upholds the foundations when they shake,[5] and it is in him, not in our organisation, our culture or our profession that we place our trust and hope.[6]

Steve Fouch *is CMF Head of Communications*

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news reviews

Backing a dangerous and unnecessary change

Royal College of General Practitioners support decriminalisation of abortion

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

In February this year, the Royal College of General Practitioners (RCGP) announced their support for the decriminalisation of abortion.[1] This followed a consultation to which only 8.2% of their members responded – 4,429 of 53,724 members. 62% of those responding said they supported decriminalisation, which would entail removing the current laws on abortion and replacing them with various medical regulations.

The RCGP now joins the British Medical Association, Royal College of Obstetricians and Gynaecologists, Royal College of Nurses, Faculty of Sexual and Reproductive Health and Royal College of Midwives who have all proclaimed support for decriminalisation.

In a press release the RCGP state: '*This is about providing non-judgemental care to our patients so that women who face the difficult decision to proceed with an abortion are not disadvantaged by the legal system.*'[2] However, it is not evident that women in Great Britain are in any way being 'disadvantaged by the legal system' from having an abortion. With around 200,000 abortions per year taking place in England and Wales and just two convictions of women who have unlawfully procured miscarriages in the last ten years (each acting well after viability),[3] it is a false premise that women who seek abortions are living under the constant shadow of arrest. Maria Caulfield MP describes decriminalisation of abortion as '*...a response to a non-existent threat...*'[4]

Moreover, decriminalisation would remove some of the few protections and regulations in abortion law, fuelling unethical and unsafe practices. The CQC in 2016 found thousands of unsafe and unprofessional practices in abortion clinics.[5] It would also exacerbate the dangers posed by increased availability of abortion pills.[6] The general public has consistently said that abortion is too readily available.[7] It is also likely that removing current laws would impact the freedom of conscience for medical professionals, who do not consider abortion as being in the best interests of their patients.

It is very disappointing to see the RCGP has joined the abortion decriminalisation bandwagon, especially given that it seems to be the abortion industry and ideology, not evidence, driving the change.

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Children with gender dysphoria

Is it time to press pause on hormone 'treatments'?

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

When Marcus Evans quit his governorship of the Tavistock and Portman NHS Trust in February this year, it was over the 'climate of fear' and attempts to 'dismiss or undermine' concerns being raised by its own clinicians. While many of his claims are contested, an independent report backed up some of his concerns.[1]

The Tavistock Centre is one of only two clinics in England managing children presenting with gender dysphoria. In the last eight years, the number of children being referred has gone through an exponential increase from around 200 in 2011 to over 2,000 in 2017.[2]

One of the first stages of treatment is the use of so-called puberty blocking drugs, usually early in adolescence. However, the clinical evidence for both the efficacy, safety and long-term health impacts (physical and mental) for treatment with Gonadotrophin-releasing hormone agonists (GnRHa) is poor. Most studies have been small, lacked a control group and lost a significant number of patients to longer term follow up. A recent clinical summary in the *BMJ* concluded that 'The current evidence base does not support informed decision making and safe practice.'[3]

Blocking puberty seems to increase the desire to identify with the non-birth sex, while not intervening with GnRHa sees roughly 75% of those children presenting with gender dysphoria naturally resolving their gender identity back to birth sex, at or shortly after the onset of puberty. Meanwhile, interfering with normal puberty leads to sterility and may have adverse impacts on the maturation of the brain.[4]

Concerns are being raised about treating children who may not fully understand these life altering consequences. The 'profound scientific ignorance'[5] of the long-term impact of puberty blockers has given clinicians cause for concern, with many urging caution. However, as Evans' resignation letter suggests, pressure from activists and lobby groups may be influencing clinical practice more strongly that clinical evidence (or the lack thereof). At the same time, we have no clear reason why the massive increase in referrals for gender dysphoria has happened – another area in serious need of research.

For the sake of a very vulnerable group of children and adolescents, doctors should now press pause and take time to gather good quality evidence on the best way to support, treat and care for the physical and mental health of this emerging generation. Otherwise we may be storing up a mass of problems for the future, that few have even begun to consider.

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Fetal analgesia guidance

After three decades the Department of Health recognises fetal pain

Review by **James Evans**
CMF guest blogger

The 18th century philosopher Jeremy Bentham wrote of animals: 'The question is not *"Can they reason?", not "Can they talk?", but "Can they suffer?"*' Professors Glover and Fisk, in their 1999 paper[1] say that Bentham caused such a change in attitude towards animals that in the UK, even frogs and fish are required by Act of Parliament to be anaesthetised during invasive procedures.

Within the living memory of some clinicians, medical students were taught that unborn babies did not feel pain and did not need such consideration.

It was not until 1997 that the first official investigation by the RCOG recommended fetal analgesia for diagnostic or therapeutic procedures on the fetus *in utero* at or after 24 weeks – notably omitting abortions. After the Science and Technology Committee's paper on abortion in 2007,[2] the Department of Health commissioned a second review by the RCOG which was published in 2010.[3]

This RCOG report remains in place as the official position on fetal awareness, despite drawing both national[4] and international[5] criticism (including from CMF[6]) for flying in the face of scientific literature.

However, it now seems the Department of Health has finally done a U-turn, despite maintaining their denial of the existence of fetal pain as recently as January 2019.[7] Following an announcement that fetal surgery to address spina bifida *in utero* will be made routinely available on the NHS,[8] the Government was asked about fetal pain relief in such cases. In response, a written parliamentary answer on 14 February this year, states that: '*Pain relief for the unborn baby will be delivered intra-operatively. This is administered before the fetal surgery, after the uterus is opened…The surgery takes place between 20 and 26 weeks of gestation.*'[9]

Will this guidance be extended to other invasive procedures? What will be the lower limit for the use of fetal analgesia? Will the current NICE Consultation on Terminations consider fetal analgesia for abortions?[10] Will DFID change its guidance on late term abortions that the British government funds overseas?[11] And will any of this influence the Dáil in drafting Ireland's new abortion legislation?[12]

To achieve the best patient care and to restore trust, surely the way forward now is for a comprehensive, fully transparent review around fetal awareness by a multidisciplinary team, including expertise in paediatrics, fetal surgery, neurology and anaesthesia. They should use the scientific evidence to inform a compassionate clinical approach and recommend a starting point for fetal analgesia that errs on the side of caution.

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RCP assisted suicide poll

Royal College of Physicians polls its members on assisted suicide

Review by **Rosemarie Anthony-Pillai**
CMF Associate in Public Policy

The Royal College of Physicians (RCP) announced on 10 January this year, its intention to poll its 35,000 members on assisted suicide. The poll commenced on 5 February and finished on 1 March 2019. The college last polled its members in 2014 when 44.4% of its membership thought the college should oppose a change in the legislation, 31% said the college should be neutral and 24.6% felt the college should support legislative change.[1] These results affirmed the college's position of opposition, a position the college clarified in 2018.[2]

One of the primary purposes of the new poll is to identify what the college's position on assisted suicide should be. However, the college has taken the unusual step of stating that after the poll the college will adopt a position of neutrality unless the results indicate a 60% supermajority for either support or opposition. The final results (published 21 March) showed little shift from the 2014 poll, only the support for a neutral position had shrunk to just 25%.[3] This has caused anger among many college members and fellows, 23 of whom signed a letter in *The Times*. A petition delivered to the college president contained 1,500 signatures opposing the RCP's actions. They accuse the RCP of playing into the hands of pro-assisted suicide lobbyists; Dignity in Dying has welcomed the RCP's intention to become neutral.

The framing of the poll has been called a 'sham' with a 'rigged outcome' by their ex-ethics committee chair. The RCP is facing the prospect of a judicial review.[4] The RCP has stated that a position of neutrality means they neither support or oppose any change in legislation and that neutrality will allow the college to represent the views of its members. Fellow and council member, Raymond Tallis, who has provided the RCP's argument for neutrality has also been quoted as saying 'I am an optimist and I believe that we shall bring these bodies round to an appropriate stance of neutrality and that, with this obstacle out of the way, Parliament may indeed come to support legislation in favour of assisted dying.'[5]

There is deep concern that in adopting neutrality the college may find itself in a position not dissimilar to that of the BMA, when they went neutral for one year and found themselves almost side-lined from the debate.[6]

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Peter Ravenscroft
looks at practical ways of addressing spiritual needs in the clinical setting

INCLUDING SPIRITUALITY IN CLINICAL CARE

key points

- Most people understand that social, psychological and spiritual factors affect their health and recovery from illness, even if they do not use those terms.
- Spiritual distress is a distinct form of suffering and needs distinct diagnosis and interventions – some of which require specialist skills. However, all health professionals can be involved in spiritual care at some level.
- Basic spiritual assessment tools can be a part of clerking and assessing all patients and the article outlines some simple tools.

Christian healthcare professionals may wonder how they might effectively interact spiritually with their patients. There are many ways to do this, the one presented here provides a way that will cover different modes of spirituality that might be encountered in clinical practice. This method aims to include people who do not understand what spirituality is, or reject spirituality, yet suffer the spiritual distress that often accompanies severe illness.

Spirituality can be thought of as a generic term that covers many concepts outside biopsychosocial parameters. Although spiritual issues have been considered by health practitioners since ancient times, in modern times they were highlighted by Cicely Saunders, who started the modern hospice movement. She included spirituality as a component of 'total care' that she aimed to provide to those in a hospice setting.[1] Viktor Frankl, after his experience of suffering during World War II, wrote, 'Man is even ready to suffer, on the condition, to be sure, that his suffering has a meaning'.[2] That is an affirmation that spiritual values are critical to our well-being.

> 'Man is even ready to suffer, on the condition, to be sure, that his suffering has a meaning'

A study of our patients in Mercy Hospice, in Newcastle (Australia) revealed that about 30% of those patients being admitted to a hospice acknowledged that emotional suffering was the major reason for their admission.[3] The development of spiritual care has been reviewed by Kelly and Morrison[4] and positive outcomes for quality of life have been shown using spiritual support for patients with advanced cancer.[5]

Definition

More recent models of healthcare include spirituality (Fig. 1). There are numerous definitions of spirituality, but here are two useful examples:

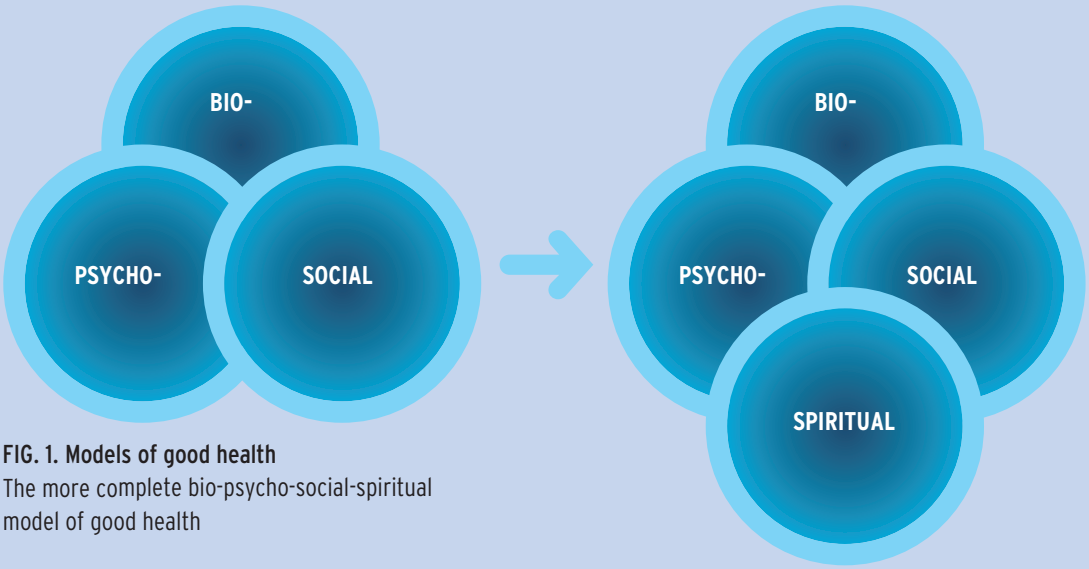

FIG. 1. Models of good health
The more complete bio-psycho-social-spiritual model of good health

(1) Allan Kellehear[6] defines spirituality as three groups of needs:

- **Situational needs**, including needs for purpose, hope, meaning and affirmation, mutuality, connectedness, and social presence.
- **Moral and biographical needs**, including need for peace and reconciliation, reunion with others, prayer, moral and social analysis, forgiveness, and closure.
- **Religious needs**, including need for religious reconciliation, divine forgiveness and support, religious rites/sacraments, visits by clergy, religious literature, discussion about God, eschatology, or eternal life and hope.

(2) Relationships are key to spirituality, so spirituality can be expressed as a relationship:

- **to self** (self-worth, dignity, meaning and purpose, guilt and shame).
- **to significant others** (love for family and friends, loneliness, reconciliation, gratitude, being remembered).
- **to the community** (status, dignity).
- **to places and things** (that represent precious values or give special pleasure).
- **to transcendence** or what is beyond this physical life (faith in God, anger towards or perceived abandonment by God, being remembered and leaving memorials).

An individual's spiritual needs may spread across these groups. We also need to consider and manage those who are not religious by considering their needs as well. They often have spiritualty not focused on a supernatural being or doctrine, but they share many of the situational and moral issues listed above.

Diagnosing spiritual distress in the dying

Spiritual distress is the distress that comes from unresolved spiritual issues. The symptoms of spiritual distress (Table 1) may seem like those resulting from psychological issues, but most patients we care for do not have psychological disorders. They are reacting to the stress that is a normal part of dying. Psychoactive drugs are not indicated in spirituality distressed patients, at least initially, unless there are clear indications to do so.

Table 1.
Some typical ideas suggesting spiritual distress

- Why is this happening to me?
- Why are my beliefs being challenged?
- What hope do I have?
- What is the purpose of living?
- Am I being punished?
- What is my value or self-worth?
- What will happen after death?
- How can I transcend this suffering?

Listening for clues in patient interviews

Emotions or expressions of deep personal disturbance are reactions to inner turmoil. Emotions may be expressed directly (I am angry or I am anxious about the future) or indirectly (the care is poor, the food is dreadful, the bed is uncomfortable) (Fig. 2).

FIG. 2. Effects of spiritual distress

Underlying these expressions there may be troubling thoughts about hope, meaning, guilt, or relations with family members occurring during a review of life. Empathetic listening and assessment skills will allow a clinician to detect distress expressed directly or indirectly during the conversation with the patient.

Acknowledging these emotions and deeper issues is the first step in assisting the patient to process them. For example, expect that it will take some time

Underlying these expressions there may be troubling thoughts about hope, meaning, guilt, or relations with family members occurring during a review of life.

we should not use the power differential in relationship between the practitioner and the patient to influence the patient at a time when they are vulnerable.

and several conversations for the patient to begin to appreciate the different relationships, expectations and changes in body image, that life with a terminal illness can bring. Many patients, given the time and help they need, do a pretty good job of dealing with their changed circumstances and their forthcoming death. Family have an important role in this process and bringing the family members together and helping them share the issues can be pivotal in assisting the patient.

Some patients are unable to express their spiritual distress either because they cannot find the words or are too sick. This is the time when just being with the patient, particularly if they are alone, is so important. Arrange to do this yourself, or arrange for a staff member or family member to be there. If you talk about the patient, always remember they may be able to hear you even though they do not reply.

What do I do when a patient asks me, 'What are your own spiritual beliefs?'

Medical students have told me that one of their major concerns when talking about spirituality to patients is that of the patient asking them, 'Do you believe there is a God?' How do we answer? Consider this situation very thoughtfully.

A patient who is terminally ill is generally unlikely to ask a recent graduate about their spirituality, whereas it is more likely if the health professional is a more mature and empathetic person who has a good relationship with the patient. If a patient asks early in the relationship, it is more likely to come from their spiritual distress than a genuine concern about spiritual issues. A good question to ask yourself is, 'Do I know this patient really well or not?' Explore with the patient why they are asking these questions. Most of the time they are rhetorical questions coming from a need for more meaningful communication. Be sure that you are answering the patient's questions and not putting forward your own spiritual views.

Christian or other religious witnessing is often done out of concern for the patient's spiritual well-being or out of felt responsibility to spread the gospel. Junior staff and students are generally not in a good position to do this, whereas a GP or specialist who knows the patient well may be. We need to remember that attempts at evangelisation when the patient has a terminal illness are complicated by the beliefs of family members or the views of other staff. Also, the patient may listen to you, not out of interest in your spirituality, but out of respect for you, or to maintain your attention at a time of crisis.

Ethics involved in the doctor-patient relationship suggest we should not use the power differential in relationship between the practitioner and the patient to influence the patient at a time when they are vulnerable. If the distress is coming from religious concerns, eg. is God punishing them? It is important that a representative of the person's religion or a pastoral care person be involved.

Medical students and interns often ask me about how they should engage with spiritually distressed patients when their time is limited by heavy medical commitments. I suggest that they listen empathetically to the patient for as long as possible and acknowledge their distress, then explain to the patient that you will bring it to the notice of the team, talk to the practitioner-in-charge, or come back later. Some issues run very deep and other consultants may need to assist the patient.

Some means of introducing spirituality into clinical practice

1. Include a spiritual history at the first encounter

It is an advantage to document spirituality as part of the history of the illness. This allows us not to have to ask the same questions repeatedly and allows your colleagues to refer to your notes as care for the patient continues. There are several formats you can use. I keep the key issues in mind by using the **HOPE** questionnaire.[7] Different approaches are provided by Puchalski and Ferrell.[8]

H **Sources of hope, strength, comfort, meaning, peace, love and connection**
eg. How do you gain hope and comfort during your illness?

O **The role of organised religion for the patient**
eg. Does worship have a place in your or your family's way of life?

P **Personal spirituality and practices**
eg. Do you have any spiritual beliefs or practices that are important to you?

E **Effects on medical care and end-of-life decisions**
e.g. Would your personal beliefs affect your management if there was a health crisis?

2. Introduce spiritual issues at an appropriate time in the conversation by beginning like this:

'We know that many people have spiritual or religious beliefs that influence their understanding of their illness and their preferred management. Would you like to tell me about any beliefs or practices that you may have, that we might keep in mind as we plan your care?' If the patient responds affirmatively, follow-up questions can be used to elicit further information. If the patient responds negatively, move on with the interview, but bear in mind they may want to approach the topic later.[9]

Conclusion

For some Christians, this process outlined above may seem indirect, but having a method for all patients will help you get to know the basic spirituality of all your patients. This can lead to amazing opportunities to assist patients in their spiritual journey and enhance overall patient care.

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Sarah Foot looks at the importance of being part of a local fellowship as a Junior Doctor

THE BODY OF CHRISTIAN DOCTORS

Being a junior doctor can be lonely at times. Switching rotations every four to six months, changing hospitals annually and then moving as you find training vacancies means it can be hard not to feel alone – not to mention the difficulty getting to church between on calls and visits home, and the disconnect you might feel because no one at church really understands your job. How can we connect with other Christian doctors?

God calls us to be in community with each other, from the beginning of Genesis when Adam is given Eve[1] to the growing church in Acts.[2] When we are together as one body we are strong and help grow the body of Christ.[3,4] The more we work together, the more support we have to overcome obstacles in our Christian working life.

Some reading this may be part of an active local group, meeting regularly and feeling support from their fellow Christian doctors. For others you might feel like the only Christian in your hospital. I'm blessed at this time to be part of a local group. However, I have previously experienced the frustration and disappointment of failing to find fellowship.

God's majestic presence

Before anything else rejoice in time with God and delight in knowing he is with you in your workplace.[5] On a busy day I find the commute to work, be it on the train, walking or driving, a chance to listen to worship music and talk to God (admittedly in my head on my packed commuter train!). Hurrying along the hospital corridor as I head to an arrest, it is a great comfort to know Jesus is taking those steps with me. These small moments help me to be prepared to look for fellowship opportunities with others.

Getting started

I moved to my current hospital six months ago, the smallest of the hospitals I've worked in, yet the one where I have been blessed with fellowship from colleagues. It started with the simple step of wearing a CMF lanyard. It only has *www.cmf.org.uk* on it, which has never attracted attention from non-CMF members. However, the lanyard helped me to meet other Christian doctors: they struck up conversations with me. These were colleagues from other departments, whom I would not have found were it not for my lanyard.

From these encounters I was invited to the local CMF group; unknown to me an active group meeting every couple of months already existed, almost on my doorstep. It inspired me to start a prayer group at our hospital. As I write this the group is small (admittedly only three of us) but I find strength in knowing God is with us. It is a fantastic way to start the day, and really does need only two of you.

Utilising CMF

Another useful resource is to keep your details up-to-date with CMF. I have previously contacted CMF to ask if there was anyone listed as living or working near me. Fellowship is closer than you think! CMF also has the online link system, and I urge you if you read this and you are settled in an area, to offer to be an area or hospital link. In my first hospital I met with the link consultant, a scary prospect as an FY1 starting out, but it's great to know a senior doctor is keeping an eye on you. It was a great disappointment to discover my future hospitals did not have a named link. Please also post on the Junior Doctors' Facebook group. You may find another junior working nearby or even an established group. At the very least, others can pray for opportunities for fellow Christian doctors to find you.

As a member of the Junior Doctors' Committee I know we want to support junior doctors in staying connected. At university there is often a well-established group, with support from local consultants and GPs. It can be much harder as a junior doctor to find this network. At the Junior Doctors' Conference in October last year we introduced a 'Be Brave: encouragements from the front line' session, an opportunity for people to give a short testimony of something encouraging at work that God has done. Part of this was encouraging stories from local groups, some had started up from only two juniors deciding to meet. It proved to be very inspiring, and we shall certainly be making it a permanent fixture at future conferences.

In addition, we have two years' experience of running speciality and regional tables during meals at the conference. Another popular addition, this is an opportunity to meet with those in your local area or speciality. It is a surprisingly difficult logistical exercise, and one we are getting better at, but it's an excellent networking opportunity.

If connections locally are proving difficult do not forget about the national CMF body. Through volunteering such as through the Deep:ER programme or helping set up a Catalyst Team you will not only serve but also grow. Alternatively, attend a day conference. It can be daunting attending as a junior, but it is a valuable chance to meet senior colleagues who might mentor you in your working life.

It's not always easy finding other Christian medics at work but forming a support network of Christian doctors is crucial in our increasingly hostile world. Pray for opportunities to connect with others. Be brave, listen for those clues that a colleague may be a Christian and don't be afraid to tell others what you did on Sunday. Utilise CMF – post on the Facebook page, use the link system or contact the Junior Doctors' Committee for ideas and support. I would love you to come to the Junior Doctors' Conference in October (25-27) and to hear more inspiring stories of juniors connecting and reshaping their workplaces. Most importantly: Do not give up meeting together, but encourage one another.[6]

***Sarah Foot** is a CT1 in Core Medicine at Newham University Hospital, London*

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Gordon Macdonald looks at how to address the spiritual needs of patients in general practice

PRIMARY CARE CHAPLAINCY

key points

- Most people we care for are aware of a spiritual/existential aspect of their health problems, but do not always know how to articulate it.
- Likewise, Christians working in primary care know how spiritual issues affect health, but there are not always clear pathways to address these needs appropriately in the community setting.
- Primary care chaplaincy is one approach that is having an impact, facilitating a more whole person model of care, and with a growing evidence base to support its wider implementation.

Most patients accept they are more than their bodies, that they have an inner part of their life. They function as 'dualist interactionists', experiencing a fusion of body and soul, as opposed to the 'ghost in the machine' described by Ryle.[1] Many are directly aware of the bi-directional relationship between their physical health and their inner well-being. While they may not have articulated such thoughts, once highlighted they are often accepted as self-evident.

It is not uncommon in general practice to encounter patients who, through a complex interplay of physical disease, multimorbidity and functional decline, experience significant social isolation. Such patients know all too well the results that each of these physical 'losses' have on their inner life, with many living with loss of well-being or mental health issues. Conversely, doctors frequently see patients who, through traumas of their inner life or soul, present with physical manifestations such as hypertension, cutaneous reactions, headache or gastrointestinal symptoms to name but a few.

We should not be surprised by this, as Scripture has long since spoken of these truths. There are several examples of how the physical affects the spiritual. The story of Bartimaeus highlights how physical affliction can remove autonomy, diminish dignity and compromise an individual's deepest inner needs of security and purpose.[2] In Luke's Gospel, we see how a sense of identity and community was lost for the man with leprosy through his exclusion.[3] However, the greatest impact of the physical illness, in these stories was the individual's separation from public worship.

We instinctively agree with the psalmist as he describes the effect of unconfessed sin on his physical state.[4] We read with encouragement of our physical revival as we wait on the Lord.[5] Finally, as believers we acknowledge with Paul the inevitability of physical decline and the supremacy of Christ and his work of inner renewal.[6]

Primary care chaplaincy is one way to speak these truths to patients. 'Davie' is a case in point. A man in his 60s, he has served time for murder but now lives alone. His wife supported him and brought up their children. Sadly, she died ten years ago leaving Davie devastated with guilt – she was no longer there and no longer able to say she forgave him. He presented to me with anger, loss of well-being (as opposed to depression) and was increasingly nihilistic and isolated. His physical symptoms of pain were consequently magnified. We spoke of his deepest inner needs, his need for security and forgiveness and that these may not be met in the biomedical paradigm. He was referred to see our practice chaplain to talk about these spiritual needs and he continues to receive support.

Primary care chaplaincy (in a soundbite) is 'a talking therapy, provided by chaplains in general practice, with the aim of helping people find meaning for their deepest inner needs, in the midst

of suffering and to provide spiritual direction.'

We started offering a chaplaincy service in our surgery in 2008 and have provided over 1,600 appointments with nearly 10% of the practice list having attended at some point. Our model of chaplaincy is based on a fusion of Maslow's hierarchy of needs and Hanlon's 'modern maladies'.[7,8] We have summarised Maslow's peak needs as being those deepest inner needs of significance, security and self-esteem and ultimately transcendence. We have found these three 'S's (of significance, security and self-esteem) to be a helpful way of identifying 'cues' within a consultation and opening up a pre-chaplaincy conversation that facilitates a referral. We also find them a useful *aide memoire* and way of promoting understanding amongst colleagues, trainees and undergraduates. In practice, these three 'S's are frequently evidenced by one of Hanlon's modern maladies.

Hanlon describes how we have moved through several waves of public health – starting with the great public works (such as the clean water supply) through germ theory and its application, on through social reform and its impact on health, and then to the risk factor theory of disease and consequent control of such risk. Through each of these waves, Hanlon points out that the human condition has been increasingly dichotomised with body and soul being separated and the importance of the soul, of consciousness, of aesthetic and of individual value being eroded. He argues that the current prevailing philosophical societal values of reductionism, individualism, consumerism and economism have fuelled this dichotomy and created the 'crisis of modernity' with resulting modern maladies. These modern illnesses are defined as loss of well-being (as distinct from depression), obesity, addictive behaviours and depression or anxiety. If we pause to think, it is clear how such prevailing philosophies could result in such maladies; if for example I derive comfort from what I consume, it can be seen how obesity and addiction develop. If beauty, choice or community are no longer possibilities, it is evident how well-being could be affected. Such modern maladies can either function as an independent long-term condition or as a consequence of the other long-term conditions we so frequently face. As clinicians, we use each of these maladies as a marker highlighting the unmet needs of significance, security or self-esteem and of the potential benefit of a chaplaincy referral.

Chaplaincy appointments last up to one hour and provide patients with a rapidly accessible well-being / spiritual care service that meets the ideals of continuous, coordinated and comprehensive care, increasingly required in our primary care teams.[9] Patients, as we know, are complex and often require multiple appointments and multiple 'interventions'. Key interventions such as listening with generosity while being a 'compassionate presence'. Henri Nouwen, psychologist and Catholic priest, spoke of this 'compassionate presence', which emanates from a 'wounded healer'. Such a wounded healer is a self-aware practitioner, who is consequently non-judgemental and can provide not merely empathy, but rather overflows with the love they have received. Surely these are key attributes not only of our chaplains, but also of the resilient practitioners we are all encouraged to be.

Thankfulness is also helpful. What are the signs of life for which patients can be grateful? We have found that practical help can open up the way for deeper connections and input. So frequently the advice given is very practical, on problem-solving and helping patients understand the consequences of positive and negative actions. Fundamentally though, chaplaincy is a place where spiritual direction is available; a search for meaning, particularly in the midst of suffering; a search for the sacred and a pointing beyond one's self to a transcendent other. Prayer is frequently accepted as part of this journey.

As with any new service, confidence grows as evidence of efficacy accumulates. We have been able to publish some evidence that highlights the place of primary care chaplaincy. We have shown that patients who attend chaplaincy (as the sole therapy) have an improvement in well-being that is comparable to that of antidepressants.[10,11] A follow-up study has shown a reduction in GP appointment utilisation among those attending chaplaincy.[12] This study also highlighted that chaplaincy was responsive to a wide variety of presenting symptoms including 'loss of well-being'.[12] This 'loss of well-being' is related to the undifferentiated presentations we regularly need to respond to in general medicine. So it is helpful to see how chaplaincy is beneficial for this group of patients. Finally, chaplaincy was also seen to be a useful intervention for those with multimorbidity, a presentation now so common in primary care.[12]

Whilst these results are encouraging it is the narrative feedback that remains most important – what patients tell us. 'It gives me great comfort'; 'I can cope better with what's going on'; 'It re-affirmed I have not failed God.' These quotes point to so many wonderful stories of healing and restoration that confirm this model of whole person care.

Our experience is that like Bartimaeus or the person with leprosy; many patients' ultimate suffering is not their physical decline but rather their spiritual isolation from God. We see in 1 Kings 19 that Elijah's restoration was part physical provision and part spiritual encounter. Our hope is that chaplaincy, when embedded within primary care, allows physical and spiritual care to happen concurrently. Our desire is to see this service replicated in other surgeries, and ideally supported by the local church. It is recognised that chaplaincy must work within NHS spiritual care guidelines, but it seems clear that as we walk this line, we are well placed to share God's common grace which points to his goodness and restoring power.[13,14]

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Many patients' ultimate suffering is not their physical decline but rather their spiritual isolation from God.

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Steve Fouch looks at an individual story of how a clinical error was dealt with, and at the lessons learnt

YOU ARE NOT YOUR MISTAKE

COMPASSIONATE RESPONSES TO CLINICAL ERRORS

key points

- Clinical errors happen to almost all doctors and nurses at some point in our careers. How those errors are handled by managers and colleagues has a huge impact on the well being and career of the person who has made the error.
- Workplace and team culture is the main predictor of how clinical errors are handled; however, too often in the NHS, that team/workplace culture is toxic and highly damaging.
- The author looks at constructive ways of responding and at the roles of self-care, spiritual maturity and good clinical leadership.

We all face them. Situations when fatigue, overload or simply a momentary lapse of concentration or judgment lead us to do or say the wrong thing in a clinical situation. Most of the time these are minor mistakes that have no serious consequences, but we often live in fear of the clinical error that may harm or even kill a patient or end a career.

Much more difficult though can be the way our colleagues and those in authority treat us when we are dealing with the consequences of such errors.

Jemima has experienced this reality twice. A paediatric staff nurse with many years' experience, she made a drug error on a paediatric ward and was initially taken through a capability procedure, being supervised on all drug administrations by a senior member of staff. However, the Trust then decided to take her to a disciplinary hearing.

Though she was eventually reinstated, her colleagues ostracised her and she no longer felt like an accepted and valued member of her previously close-knit team. She decided to leave her job.

Five years later, in a new post at another Trust, she had established herself as a competent nurse with her colleagues but was still suffering stress, anxiety and self-doubt as a result of her error. On one shift she found herself having to undertake a procedure that no one on her unit had taught her how to do and with no supervision immediately available. Again, she was suspended and taken to a disciplinary.

This time she lost her job. In the lead up to this, and during the subsequent tribunal, it became apparent that she had been bullied and intimidated by senior members of the team and had been under considerable emotional stress as a result. Regardless, and despite further evidence from members of the medical team about the quality of her nursing care, she lost her job.

While she accepts her errors were her fault, the bullying and lack of support and training from her seniors were significant contributing factors. But worse than this was that her colleagues, including some other Christian nurses on her unit, totally cut her off. The junior doctors in the unit were highly supportive, but as soon as she was suspended facing disciplinary action, no one would return her calls or even acknowledge her presence.

Shocked by this, she began to talk to others who had also been through a disciplinary procedure, both nurses and doctors. What became apparent was that her experiences, both of bullying and shunning by colleagues, were not unique. She has subsequently set up a support group for people who have been through this process. The group exists as an online forum called 'You Are Not Your Mistake'.

She has consistently found that doctors support one another much more and much better than nurses.

Why is this the case? In Jemima's experience, nurses tend to be more passive and tend not take a leadership role unless specifically given it, while doctors tend to assume leadership roles more readily. This inclines nurses towards passivity and outwardly accepting the status quo, while moaning behind the scenes and behind each other's backs.

Fear is also a factor. Being seen to be associated with someone who is facing professional disciplinary action risks guilt by association. Everyone is busy watching their own back and ensuring that their own status is secure rather than supporting their colleagues, for fear it will harm them.

Moreover, the NMC is much more likely to bring nurses to competency hearings than the GMC is to bring doctors, so the fear factor can be a lot stronger for nurses.

'I tell you, use worldly wealth to gain friends for yourselves, so that when it is gone, you will be welcomed into eternal dwellings' (Luke 16:9).

From this verse Jemima felt that God was telling her she would lose her job, but that this was the best course. It encouraged her to set things right with her colleagues before she left. She subsequently spoke to both her managers and colleagues, including her Christian friends. One of the issues they raised was that they felt she had become very negative and not like her old self. She realised that the process had changed her – making a positive, confident and capable person into someone negative and lacking in self-confidence. She felt that the culture of the ward as well as the disciplinary process had contributed to this.

Overcoming the leadership deficit

A good leader recognises the skills and the weaknesses in their colleagues and seeks to encourage people's strengths and the sharing of skills between team members. They support and supervise in areas of weakness, getting those stronger in that area of practice to teach those who are weaker. This is not just good management; it also requires a degree of pastoral care. It is about concern for team members as people, not just as co-workers or subordinates. It means being willing to gently but firmly confront errors and problems, but in a constructive manner with the aim to build up and develop, rather than criticise and tear down.

This made Jemima realise that workplace culture shapes us as professionals and that again requires good leadership. But that leadership is not just for the senior staff member, it is taken on by all staff who assume appropriate responsibility for their team and themselves, regardless of who is in charge.

It is about being proactive in building a team rather than waiting on someone else to lead. And the core quality needed by such leaders is compassion – not just for patients, but for colleagues. It is this that shapes culture, which shapes the team that gives care. It is about catching people on a negative pathway before they tip over the edge into a more serious level of incapability. Burnout happens when staff not only stop caring but are no longer bothered by the fact that they do not care. An uncaring leadership team accelerates this process; a compassionate leader will anticipate and help prevent such a downward spiral.

Jemima learnt through this process that her identity and security cannot rest in her work or her professional status – it has to rest on Christ. We are not our profession, we are not our mistakes – if we let these define us, we are missing out on who we really are as followers of Jesus.

She also realised that forgiveness was key. Owning up to her own errors and accepting responsibility was the first step. But she also had to forgive those who let her down or ostracised her. In doing this, hard and painful though it was, she was able to let herself and her former colleagues move on.

More widely than our personal spiritual responses, we need to recognise that our professions and the NHS as a whole need some fundamental, cultural changes.

First, as professionals we need to focus on and make space for self-care; rest, spiritual refreshment, and being willing to seek help. A real weakness faced by doctors and nurses alike is that we find this really hard to do. We need to care for ourselves before we can really care for our patients and our colleagues, but so often we put ourselves last – to the detriment of all.

Second, there needs to be an emphasis on developing real leaders. Not managers, but nurses and doctors who lead out of a biblical sense of serving their colleagues and patients, bringing the best out in every team member. Compassion and vision are key qualities.

Finally, we need to be building community – teams that look after one another and know what they are there to do. Fear, self-interest and self-preservation are not good motivators. As Christians, we also need to be building a spiritual community in our workplaces – praying together as well as working together. Workplace fellowships are a vital part of building a good workplace culture.

As Christians we should be at the forefront of changing NHS culture from the inside. We need to grasp a biblical model of Christian leadership for our workplaces, leading by example. We also need to care for ourselves by nurturing our spiritual lives with our church families.

Jemima has moved on to a new role now, but her passion is to see more support and care for one another among the health professions, and in particular to see Christians leading and encouraging others by example.

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25-30%
of NHS staff say that they have experienced bullying from colleagues and managers at some point

10%
have experienced discrimination in the workplace

UP TO **1/3**
of those who experience bullying in the NHS have had to leave their jobs

IN **2015-16**
the Nursing and Midwifery Council received
5,415
fitness to practice referrals

960
of those cases concluded at a hearing, with
809
resulting with a sanction against the complainee

From NHS England staff survey 2016

Evelyn Sharpe explores the ways we can build resilience in our spiritual, work and personal lives

RESILIENCE

key points

- The ability to recover from setback and trauma and the ability to persist in the face of stress and opposition are the key elements of resilience.
- We need to work at maintaining our own resilience – mentally, physically, relationally and spiritually.
- Ultimately, resilience is not our goal, but to grow spiritually in our relationship with God.

'But we have this treasure in jars of clay to show that this all-surpassing power is from God and not from us. We are hard pressed on every side, but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed.' [1]

My favourite piece of resilience research [2] used the number of teeth retained by adults as a marker of resilience in a socially deprived, inner city community. Good dental health was an indication of parenting that had paid attention to children's general health and diet, which in turn was linked to family stability, employment, adequate housing and with belonging to a faith group. This study encapsulates many of the factors that influence resilience.

What is resilience?

Resilience was originally an engineering term denoting the ability of an object to spring back into shape. It was later appropriated by psychologists to refer to the human capacity to recover from difficulties.

It has two main elements: *recovery*, which is the ability to return to normal following stress and *sustainability*, which is the ability to keep going under stress. Rather than the more traditional medical method of trying to estimate risk, assessment of resilience looks at what enables people to cope when they have illness or encounter other potentially life-altering events and situations.

As a junior doctor on a general medical rotation, I found it fascinating to see how patients and their families reacted in different ways to apparently similar conditions and diagnoses. It was one of the reasons I moved into psychiatry.

When thinking about resilience from a Christian perspective, it is important to remember those words of Paul to the Corinthian church. When we know that trials and difficulties are normal for the Christian life and that God uses them for our good and his glory, we will not expect to be unaffected by stress or to always come through it unchanged. However, understanding what modern science shows us about human resilience can also help us to live lives worthy of God's calling.

Are children naturally resilient?

My interest in resilience came from studying children coming from very difficult and traumatic circumstances and finding that there were some who coped unexpectedly well. This 'ordinary magic', as Ann Masten [3] described it, is not automatic but depends to a large extent on good relational bonds in early life with at least one caring adult. The child can then develop the ability to regulate their own emotions and learn helpful coping strategies. The functioning of the hypothalamic pituitary axis and other brain processes involved in reactions to stress are influenced by early life experiences. Although there is always the possibility of changes in these processes because of the wonderful plasticity of the brain, they do exert significant influence on how a person reacts to life's stresses.

Sometimes the mechanisms children find to enable them to keep going when life is hard prove less helpful in later life. An extreme example is when dissociation (mentally shutting off from present reality) is a refuge from the emotional and physical pain of abuse, but in adulthood it prevents healthy processing of distress. Childhood abuse of any kind, including

bullying, affects resilience and some ways of trying to relieve emotional distress such as self-harm and substance misuse (think of street children, many of whom use glue or other solvents) bring their own dangers and cause long-term damage to resilience.

Using our brains

Resilience does not require extraordinary intelligence, but simply 'a human brain in good working order and some knowledge about what is going on and what to do'.[4] In the long-term, cognitive ability may be affected by brain damage or disease, in the short-term cognitive processing can be impaired by lack of sleep, alcohol and other drugs, illness etc, so that the capacity for handling stressful situations is reduced. Resilience is a dynamic concept, not a superhuman power, and there are many circumstances that make it difficult to 'think straight'; it is important to be aware of our own vulnerabilities and not to expect to function effectively regardless of our mental state.

Normal cognitive development allows the mastery of skills, which is an important motivation in life from childhood onwards. If mastery is denied or hindered by neglect or adversity, then the sense of agency is limited and a sense of helplessness may prevail when trouble comes. This was demonstrated in studies of children raised in orphanages where they received physical care but no emotional nurture or stimulation; many remained apathetic and had great difficulty learning to function independently even when care improved. Michael Marmot's Whitehall studies showed an increased cardiovascular risk, not as predicted among those with the top jobs, but among the lower levels of civil servants. One of the theories to explain this, which is supported by other studies (though not all), was the discrepancy such workers experienced between responsibility to be productive and a perceived lack of agency, a sense of being able to affect things or to bring about change. Helen Keller, who was born blind and deaf, but with the help of an inventive and devoted governess went on to become a world-renowned speaker and writer said, 'A happy life consists not in the absence but in the mastery of hardships.'[5]

Working to maintain cognitive fitness is helpful to maintaining resilience. Continuing to learn, to develop new interests and to give time for reflection and to pray, can all help. Learning new things may get harder as we age, but the ability to see patterns, and to quickly identify solutions because of experience, may emerge as a skill to be drawn on and enjoyed. Achieving mastery ourselves may fade as a motivation but enabling others to master the necessary skills for them to progress can replace it.

The importance of purpose

To be resilient is to be motivated, to have purpose. Alim et al[6] concluded in their study of a high-risk population that 'Purpose in life is a key factor associated with resilience.' Viktor Frankl, a psychiatrist and concentration camp survivor, called the book of his experiences, *Man's Search for Meaning* because 'Life holds a potential meaning under any conditions even the most miserable ones.'[7] Those prisoners who lost their sense of purpose weakened and died very quickly, whereas those who retained hope tended to survive the longest. A recent *BMJ* editorial[8] was about hope as a therapeutic tool; patients look for hope as well as for understanding of their illness and likely outcomes whenever they see their doctor.

Our hope is in the Lord, and that should help to sustain us in difficult times. Even when we may not be able to fully share what we believe, we can impart some sense of true hope to our colleagues and patients when they express their underlying fears and concerns.

As the writer of Ecclesiastes insists, life without God is ultimately meaningless; in faithful obedience to him we find our chief end and purpose.[9]

Relationships matter too – with others and with God

Hope does not emerge from a vacuum. It is embedded in relationship. The importance of relationship for resilience has been noted in all the major reviews. Not only in the early years of development, but throughout life supportive relationships are vital. As those with religious faith tend to have more social support, some have seen this as the explanation for religion emerging as a potent positive influence on resilience. However, very often religion is associated with the active confrontation of problems rather than denial and avoidance. There is also the sense of meaningfulness given to life and even to adversity which comes from belief in God. As Glynn Harrison wrote in a recent *Triple Helix* article[10] 'A spirit of thankfulness acknowledges the sovereignty of God and asserts the dependency of his creatures. It positions grace at the very centre of our spiritual journey.' Furthermore, 'Psychologists are beginning to uncover how cultivating gratitude benefits mental health and well-being.'[11] Several studies have shown the benefits of being grateful, including increasing stress resistance.

So, is resilience the main goal?

The Bible tells us of many people who faced significant hardship and loss. The emphasis is not on how well they coped, (though we might well think of them as resilient) but how they coped as they trusted God and saw God's faithfulness to them.

Recognising the sovereignty of God and his purpose to make us for the praise of his glory[12] as individuals, but also as a community of his people, Christians will not see resilience itself as the ultimate goal, but spiritual growth as we 'make it our goal to please him'.[13]

'To him who is able to keep you from stumbling and to present you before his glorious presence without fault and with great joy – to the only God our Saviour be glory, majesty, power and authority, through Jesus Christ our Lord, before all ages, now and forevermore! Amen.'[14]

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Christians will not see resilience itself as the ultimate goal, but spiritual growth as we 'make it our goal to please him'.

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Peter Evans shares his reflections on what makes for a good marriage

MARRIAGE AS A MEDIC

key points

- God ordained marriage as a good thing – bringing a man and a woman together to form a new unit or team. It thus reveals something of the nature of God and his relationship with his church.
- Because of this, our choice of marriage partner is very important, and not to be left just to feelings or circumstance.
- The author looks at the challenges and practical problems faced by married medics and at how we juggle career, church and marriage/family.

In my speech at our wedding in 1992, I quoted Wayne from the film *Wayne's World,* who made the observation to his friend Garth that 'Marriage is a punishment for shoplifting in some countries!'

I'm not sure what my new wife made of that, but I'm probably forgiven now. It does reveal something of the attitude that people have toward marriage though, and there are many more erudite expressions of this.

Chekov famously stated that 'if you are afraid of loneliness, don't marry', and, even more sadly, Woody Allen opined that 'Marriage is the death of hope!'

The statistics from this country demonstrate how this thinking has permeated our whole society – recent figures show 111,000 divorces per annum in the UK, and more and more people are choosing to see marriage as an outdated institution, cohabiting, or expecting to change 'partners' as their lives and circumstances change. At the same time most people long for the security of marriage and the failure of their own causes immense heartbreak and hurt.

So what is marriage? Who came up with the idea, and what can we do to make it work – and what about medics?

It is often said that the answer to any question in Sunday School or in a children's talk is either 'God' or 'Jesus' and in a way that's a profound comment on the answer to most questions about life. In the case of marriage though, the answer to my first question ***is*** 'God'.

Marriage was designed and planned by God for his created people. He saw that it was not good for man to be alone and created a person the same but different to be with him. He then explained marriage. God had made a suitable helper for man, and we are told 'that is why a man leaves his father and mother and is united to his wife and they become one flesh'. This is the essence of marriage – a man and a woman leaving their parents to become a new unit – in the older language 'leaving and cleaving'.

Marriage is therefore a *creation* ordinance – that is, a mandate God gave in creation, to reveal something of what it means to be made in the image of God, and something of his glory. It is a decree (along with working, amongst others...) that was planned and ordained by God, right at the very beginning, for all people. It predates the fall and is therefore not just for Christians or for those who acknowledge God – it is an ordinance for all people.

God's plans and glory are demonstrated in marriage in many ways, and there are examples throughout Scripture of times when God used marriage in an extreme way to reveal himself and his purposes to his people (think for example of Hosea), or times when his people, through marriage, blew it – again, and again, with polygamy, adultery and intermarriage revealing some of the catastrophic outcomes of rebelling against God's will and desire.

Ultimately, marriage is also an amazing, beautiful

picture of the relationship between Christ and his bride – the church, the gathered people of God for whom he is coming and who should be excitedly, joyfully preparing for the great wedding day.

With marriage being such a precious gift and example from God, it is hardly surprising that many would try to undermine, devalue, change or attack it, and much has been written about this recently.

However, on a practical level, how do we as people – and as medics – work this out and benefit from marriage in more of the way God intended?

Well, first we must acknowledge that things go wrong. We live in a fallen world; we are all a wretched bunch, saved by grace but still with our sinful natures. For all sorts of reasons, marriage, if we are called to it at all, can go horribly awry. Many wonderful, God-loving, God-fearing people have been hurt and destroyed by marriages that have broken down. It is crucial that within the church the broken and the hurting find love, acceptance and restoration and are never made to feel less worthy or condemned – that is ***not*** God's way. One of my favourite Christian singers, Don Francisco talks about this in his live concert and observe that when we, the 'smug married' (a Bridget Jones quote, not Don!) judge people we become like the Pharisees. God is the God of grace, forgiveness and hope, and we need to demonstrate this in our churches.

Medics in particular face huge pressures – often described as being 'married to the job' – we often make no time for our spouses, and are constantly busy. We work closely with others – often doctors or nurses of the opposite sex who support us and understand, whereas when we arrive home exhausted we may find no understanding or sympathy. Parents may have opinions about what we do or don't do right, and things happen – children, exhaustion, bereavement, exhaustion, family illness – and oh yes, did I mention exhaustion?

So for those who are contemplating marriage, or who are married, here are a few key, practical ways to protect your marriage.

1. Be careful who you marry

People often tell you that you can see what your wife/husband will be like in 30 years by looking at their parents. It's not always a comforting thought! However, if you are contemplating marriage as a Christian, the spiritual parentage of your spouse is vitally important. Is your 'other' a Christian? The Bible is clear that believers are children of God. If you are a child of God, but the person you are involved with is not, then your parentage is incompatible. Biblically, there are only people who are co-heirs with Christ or people dead in their sins and transgressions. Now this is not always easy to see, especially when the non-Christian is utterly lovely, kind, generous and gracious, and all the Christians around you are frankly unpleasant. Nevertheless it is true, and the Bible explains that we shouldn't be yoked with unbelievers, simply because we have nothing in common where/when it matters.

2. Leave and cleave

Andrew Fergusson spoke on this at our wedding and we feel it should be a message for all marriages. You may come from a wonderful, amazing, remarkable home, where you tell mum everything and ask dad for advice about all your major life decisions (or vice versa), but when you marry a person, the one you discuss things with, decide things with and tell everything to is your spouse. You have left home, you are a new unit, and whilst you must care for your parents, you must be clear that you have left. You are a new body together.

3. Be more like Jesus

'If only...' I hear you say! But we should aim to be more like Jesus if we want his plan – our marriage – to work. What do I mean to be like Jesus in this context? Well develop a servant heart and mentality. Much has been written about passages such as the one in Ephesians on wives and husbands – but the bottom line is – be like Jesus in your marriage. Most of the time, in a non-abusive relationship, it doesn't ultimately matter who is right – what does matter is that we put the needs of our spouse above our own, and put our expectations under those of our spouse. Read Philippians chapter 2 and consider using the chapter as a marriage model, quite apart from anything else. And those temptations, that person at work? Run from them – recognise the risk, face up to it and get out of the situation.

4. Keep close to God

It sounds obvious, but the old analogy of the traffic cone is true – the further you go from God (the top of the cone) the further you go from each other (running round the circumference of the cone). Make church a priority, and missing (except clearly for reasons of work, illness etc) a 'never' event. Read God's word – it doesn't have to be together in a cosy Bible study for two – just read it! And pray. Work on your relationship with God. Much is made of 'date nights' and 'me time', the gym and holidays, and all these are fine and may or may not help you, but the fundamental core issue is keeping close to God and living in obedience to him.

I hope this helps. I now have the difficulty of showing this article to my wife of nearly 25 years. I fear she won't recognise me in much that I've written. But she loves me, and will forgive me and help me to grow. I can testify that having someone who knows all my faults and failings, but loves me unconditionally anyway is just incredible and gives great joy. And that's my wife as well as my Saviour!

Martin Luther said, 'There is no more lovely, friendly or charming relationship, communion or company, than a good marriage'.

I hope Wayne found that out!

Peter Evans *is a General Practitioner in Merseyside*

Marriage is therefore a creation ordinance - that is, a mandate God gave in creation, to reveal something of what it means to be made in the image of God, and something of His glory.

David Cranston shares his experiences of caring for the whole person

PATIENTS ARE PEOPLE TOO

key points

- Having time to interact meaningfully with patients is a big challenge in the clinical setting.
- Taking time to go deeper and wider in our interactions helps us go deeper into the needs of our patients and to see them as rounded human beings, not just clinical problems.
- This attention to the wider humanity of our patients helps us improve our clinical care and support.

A week before writing this article, I was sitting in my urology outpatient clinic with a visiting professor from Japan, when a 93-year-old gentleman came in with his daughter. I debated about whether or not I should ask what is normally my first question to a man over 90, after introducing myself to him, and then, as I had got to know my Japanese friend well decided I would.

'What did you do in the war?' I asked.

He replied that he was a submariner and was involved in protecting the North Atlantic and Arctic convoys. My Japanese friend did not mind at all as 'we are all friends now'. We then proceeded to have a most interesting conversation about what it was like to be a submariner in the Second World War, and the hardships endured not only by him but, by the Arctic convoys they were protecting, where other patients of mine served. On those ships, the ice had to be knocked off the superstructure in temperatures well below zero to prevent the ships capsizing under the weight, and life jackets were often not worn as the likelihood of being rescued if torpedoed was minimal and unconsciousness and death came much faster with no life jacket.

> Patients are people too, and one day all doctors will become patients. Woe betide the doctor who lets humanity slip out of medicine.

One cannot have that type of conversation with every patient in a busy clinic, but on occasions one can, especially, as in his case, it was a follow-up appointment made by a junior and he was symptom free from the urological point of view.

A week later, I received a letter from him saying it was the most pleasant consultation he had ever had in hospital. He enclosed a copy of a handwritten letter sent to his mother by King George V in 1918, on the release of his father who had been a prisoner of war having been captured on the Messines Ridge at Ypres in 1917.

Patients are people too, and one day all doctors will become patients. Woe betide the doctor who lets humanity slip out of medicine. In the current practice of medicine, it is all too easy to look at computers, charts and scans and ignore the patient.

Sir William Osler was a Canadian who trained at McGill University and subsequently became one of the four founding fathers of the Johns Hopkins University and ended his life as Regius Professor of Medicine in Oxford. When he died in 1919, *The Lancet* described him as 'The greatest personality in the medical world at this time.' He was the man who took students to the bedside to learn from the patients and speak to the patients and demonstrated that compassionate medical care and science were not only compatible, but both were necessary, and that careful clinical observation was essential to diagnosis. 'If you listen to the patient he will tell you the diagnosis'. He brought science into medical education and commanded enormous admiration and respect amongst colleagues, students and patients.

Osler never forgot the patient and we would do well to learn from him. He is well known for many quotations but one of the most important is that 'It is more important to know about the patient who has the disease than the disease that has the patient'.

Multidisciplinary meetings have now sprung up around the country where patients' problems are discussed by a group of physicians, surgeons, oncologists, radiotherapists, radiologists, and pathologists and plans for treatment drawn up. In these meetings the most important person, the patient, is not present. In many settings, especially in the management of prostate cancer one ends up with the conclusion 'All options open; discuss with the patient'. While it may not be appropriate for the patient to be in these meetings especially as many different patients will be discussed, it is important for all present to realise that the most important person is missing.

As doctors, we are not only clinicians and teachers, but we are also role models for those around us. When we teach at the bedside or in clinic, we are watched and observed as to how we treat our patients and our staff. It gives insight into our values in life, our goals and beliefs. Our Christian witness in words will be nullified, if our Christian witness in actions do not match those words.

William Osler had no greater accolade than his reputation among the clinical students who said that, 'If you want to see the chief at his best, watch him as he passes the bedside of some poor old soul with a chronic and hopeless malady, as they always get his best'. Would that that was true of all of us who are in the so called 'caring professions' today. One day we too will be in the bed rather than standing at the foot of it.

One of my former research registrars, now Team Rector of Chipping Norton was recently asked to speak in China at a medical conference on his transition from doctor to priest. He spoke about the great physician, a term well recognised in Chinese medicine. The Greatest Physician of all time chose twelve disciples to be with him in his three years of ministry. Much of the time his disciples lived with him, travelled with him, ate with him, and talked with him. They would have learned from his actions as much as his words. They would have seen how he used his time. They would have seen how when he was stressed, he prayed. He loved to pray. Those three years of his ministry were hectic years, teaching, healing, preaching; with individuals, with friends, with disciples, with crowds and with enemies. The less opportunity he had to pray, the more imperative it was for him to maintain his relationship with the Father. The tighter the tension, the more time was spent in his Father's presence. It is difficult to believe that he went up into the hills determined to pray all night. Rather, as he prayed, he was lost to time in his Father's presence, and scarcely noticed as the sun broke over the hills to announce the dawn. His disciples would have seen him come back refreshed after his time of communion with his Father.

We note how he treated those to whom he ministered. He listened attentively to Jairus and many other individuals, not being distracted by the crowd around him or looking over their shoulder to see who else was more important or more interesting. He offered unconditional love to those in need. He refused to be judgemental to the woman caught in adultery, but did look forwards rather than backwards, to a better future for her and to a change of life and lifestyle. He identified obstacles to spiritual growth in the Scribes and Pharisees, as well as to the rich young ruler to whom money and possessions were very important. He bore patiently with laziness, ignorance, fear and failure, and never gave up on his disciples. He challenged, confronted and corrected. He often operated with a lightness of touch, but could be forceful when the need arose. He provides an excellent model to all those in the so called 'caring professions'.

So, as we go about our daily work on the wards, in the outpatient clinic, in the operating theatre, GP surgery, or in interactions with hospital staff, we need to remember that every patient we look after and every staff member or colleague with whom we interact are people for whom Christ died.

Professor David Cranston *works at the Nuffield Department of Surgical Sciences at the University of Oxford*

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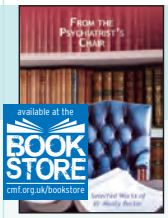


From the Psychiatrist's Chair

Selected works of Dr Monty Barker

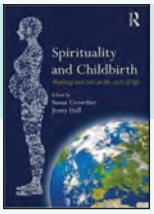
Monty Barker

- Words by Design, 2018, £12.50, 220pp, ISBN: 9781909075672
- Reviewed by **Peter May**, a retired GP in Southampton

In 1970, medical students from the Royal Free Hospital School of Medicine were allowed just one month for an elective period. I chose psychiatry. Dr Monty Barker was the newly appointed consultant at Bristol and was already being recommended by other students. Sorting out the spiritual from the mental, and feelings from hard facts seemed to be his prime concern for a Christian doctor. Monty became a close friend and mentor until his death in 2015.

Widely read, he was a gifted teacher deeply interested in history, behaviour and culture. He taught theological students in England and Paris. In the 1980s, I would invite him to give lectures to lay audiences in Southampton, knowing many would come to hear him. After retirement, he spent much of his time teaching in India, ably supported by his wife Rosemary. Sadly, he wrote very little and we are indebted to his editors for assembling this collection from Monty's lecture notes.

In a rapidly changing world, the hot topics today are so different from a generation ago. There is nothing here about recreational drugs, transgender identities, eating disorders, knife crime or 'conversion therapy'. But there is plenty of wisdom about marriage, parenting, teenagers, bereavement, burnout and sleep disorders. There is also much about cross-cultural mission, the call to ministry and most importantly, pastoral care.



Spirituality and Childbirth

Meaning and care at the start of life

Edited by Susan Crowther and Jenny Hall

- Routledge, 2017, £28.79, 222pp, ISBN: 9781138229402
- Reviewed by **Mary Hopper**, retired lecturer in midwifery at Oxford Brookes University

A midwife is asked how she sees spiritual care being achieved in her practice area, she replies 'I'm not sure. We call the chaplain if there's a problem and it's fine if people want time to pray after the birth of their child. Is that the right answer? There's no time for anything much'

Anyone associated with childbearing and parenting, can only benefit from the wealth of information found in this book. It sets out to question the art and meaning of childbirth by considering spirituality from a variety of perspectives.

Edited by two long standing midwifery academics, they draw upon a vast array of evidence and practice offered by experts from different fields. Throughout the text, there is a linking of theory to practice for current practitioners on how to achieve the optimum outcome for mother and baby when there is a shortage of staff or beds, limited resources or a high-tech environment.

Every aspect of the birthing experience is covered – from the moment of conception through to parenting. Exploring the spiritual impact of pregnancy and birth on parents and those around. It addresses both positive and negative outcomes.

The book suggests we reconsider how we 'hold the sacred space' during pregnancy, labour and birth and reshape practice, while listening to our own, inner spiritual voice.

Perfectly Human

Nine months with Cerian

Sarah C Williams

- Plough Publishing House, 2019, free, 160pp, ISBN: 9780874866698
- Reviewed by **Steve Fouch**, CMF Head of Communications

It was no longer primarily a matter of abstract ethical principle but rather the gentle imperative of love.' When Sarah and Paul Williams are given the devastating news that their unborn child has a rare and lethal form of dwarfism, they are faced with the heartbreaking choice of whether to abort or continue with the pregnancy. Williams shows how much pressure to terminate a pregnancy can be put upon parents faced with such a diagnosis, and the real opposition from the medical professions and wider society that come against those who choose a different path.

As Christians, the Williamses chose to go ahead with the pregnancy, and to welcome the daughter they named *Cerian* (Welsh for 'beloved'), however fleetingly. Williams' account does not shy away from the real heartache, pain and anger that she and her family went through in making this choice. It also shows the power of God's grace and love to transform her family, friends and colleagues through this difficult time.

Furthermore, in the process, she also reflects on the nature of our humanity, what it means to love and be loved by God, family and friends, and embeds her painful story in a much wider context.

This book helps earth in personal experience some of our most profound contemporary ethical and spiritual debates, about what it means to be a human being.

Transformed

A brief biblical and pastoral introduction to understanding transgender in a changing culture

Peter Lynas

- Evangelical Alliance, 2018, available to download: *bit.ly/2u4rytB*, 35pp
- Reviewed by **Katharine Townsend**, a GP in East Anglia

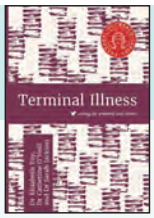
Transformed is a superb online resource summarising the main issues for churches and Christian organisations in relation to people who identify as transgender. It encourages and equips them to be ready for and warmly welcoming to transgender people and their questions of faith and identity.

Written compassionately, it covers the philosophical thinking and cultural trends that have led to the rapid rise of this phenomenon. It speaks of the pain and isolation felt by so many transgender people, and of their mental health and suicide rates. It has a section on medical treatments possible with a sound grasp of the poverty of scientific evidence to support hormonal and surgical options.

An excellent overview of a biblical understanding of gender, human identity, sex and the importance of the body, followed by a section on the present day (but rapidly changing) legal situation, and the impact on education and freedom of speech.

However, especially useful is the pastoral advice for organisations supporting transgender people. Recognising the possible tension between a theological/ideological response and a personal/pastoral response, its suggestions are helpful and practical – combining grace, truth and love.

It is short but surprisingly in-depth. It has helpful links to resources for further information.



Terminal Illness

Caring for yourself and others
Elizabeth Toy, Catherine O'Neill, Sarah Jackson

- Redemptorist Publications, 2018, £4.95 53pp ISBN: 9780852315217
- Reviewed by **Claire Stark-Toller**, consultant in palliative medicine at Countess Mountbatten Hospice, Southampton

Written for people facing life-limiting illness and their carers, this short booklet is written by three doctors and aims to provide a practical resource for Christians, particularly from Anglican and Catholic traditions.

It is divided into three sections: *Terminal Illness: a definition*, *For the person affected*, and *For those who care* and finishes with prayers and further reading. Written in simple and clear language, the first section explains medical terminology and the process of diagnosis. It raises practical and useful issues eg. holidays and clinical trials and explains legal aspects such as 'Lasting Power of Attorney'. There follows a gentle and sensitive discussion about prognosis, what dying is like, what to expect as life ends, and a brief overview on grief.

Focusing on the affected person, the second section explores themes including preparing for dying, hope and dying well. It provides a wise and approachable overview, recognising complexity and suffering without excessive emotion. The next section, written for the carer, acknowledges the pain of loss and explores the meaning of healing. It examines practical matters eg. planning for the future and finding help. Each section is illustrated by real life stories. The final part comprises a section of mostly Christian prayers and Scripture around the themes of God's presence and dying.

Other than the section on prayers, the content is practical rather than faith-based, although rays of Christian faith and hope shine throughout. This booklet can be given to and read by those with and without faith. It would be most useful for carers and those facing a life-limiting illness, who value reading and the opportunity to reflectively prepare.

The Image of God, Personhood and the Embryo

Calum MacKellar

- SCM Press, 2017, £35.00, 265pp, ISBN: 9780334055211
- Reviewed by **Trevor Stammers**, Reader in Bioethics, St Mary's University, Twickenham

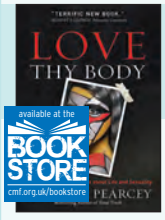
This is the most comprehensive defence I have ever read of the view that the human embryo is a person from the completion of fertilisation. Sceptics and the already persuaded alike will find plenty to consider here and the book's clear Christological emphasis is faith inspiring, even if one cannot agree with all the book's conclusions.

It is a scholarly work with hundreds of references, divided into two unequal parts. The first (shorter) section looks at historical and contemporary perspectives on the moral status of the embryo, the meaning of the *imago dei* and what it means to be a person.

The five chapters comprising the bulk of the book explore the embryo in relation to creation and incarnation and then substantive, relational and functional aspects of the embryo are examined to determine its status. TF Torrance is quoted in relation to the incarnation: 'Christians came to regard the unborn fetus in a new light, sanctified by the Lord Jesus as an embryonic person' (p143).

The chapter on functional definitions of personhood critiques the much-embraced gradualist approach championed by Peter Singer and others and there is a very helpful section providing counterarguments to all the standard objections raised against fetal personhood such as twinning, recombination, molar pregnancies and high rates of spontaneous miscarriage.

A wide range of sources from Calvin to Pope Francis are cited, but Christ is the central focus of this book which deserves a wide readership, in spite of the publisher's hefty price tag.



Love thy Body

Answering hard questions about life and sexuality
Nancy Pearcey

- Baker Books, 2018, £12, 336pp, ISBN: 9780801075728
- Reviewed by **John Greenall**, CMF National Field Director

We have a new category of an individual: the human 'non-person'. So argues Nancy Pearcey in a compelling new book following on from her bestseller *Total Truth*.

Drawing heavily on the work of Francis Schaeffer, Pearcey argues that the right way to treat people depends on what we think it means to be human. In the modern age, people have concluded that morality does not qualify as objective truth – it consists merely of personal feelings and preferences. Pearcey traces the origins of these views through Plato and a Cartesian Dualism which today shapes secular views on issues such as sexual orientation, euthanasia, abortion and transgenderism.

Pearcey argues that we have relegated the body to a 'fact realm', lower story and elevated the person to a 'values' realm, upper story. Take transgenderism: 'I'm not my body – I am a spiritual being' is a claim that the real person resides in the mind, spirit, will and feelings rather than in a physical body. Instead of 'hating our bodies', Pearcey contends that they give us a clue to our personal identity, our purpose as human beings and provide rational grounds for our moral decisions. She warns of the trajectory of such dehumanising world views – that whoever has most power (ultimately the State) will decide who qualifies as a person. She urges Christians to resist a privatised, other-worldly spirituality and to defend a high view of the human body as Christians did in similar cultures before us.

As healthcare professionals, we should be at the front and centre of this apologetic. That is why it is my book of the year and a veritable must-read.

eutychus

Second HIV patient 'cured' in London

Excitement buzzed around the media in early March as the story of the so-called 'London Patient' broke. Apparently 'cured' from HIV, and only the second patient ever claimed to have been, the actual circumstances of the 'cure' turn out to be somewhat singular. Treated for HIV-related Hodgkin's lymphoma by a blood stem cell transplant, drugs were first used to kill off the patient's bone marrow, before transfusing new stem cells from a donor who had a hereditary immunity to HIV. While such drastic treatment is not a viable cure for most, it does point to the possibility of gene editing HIV-resistant blood stem cells, as a potential future treatment. *The Economist* 7 March 2019 *econ.st/2VWrnMP*

NHS has 'no chance of training enough staff'

Significant recruitment shortfalls for GPs, nurses and midwives are hardly headlines any more. Even the recent announcement of 3,000 more midwifery training places only raised a slight 'meh' from professional bodies (*bbc.in/2uhE09k*). Now a joint report from Nuffield and King's Fund suggests that however many training places we offer, and however much overseas recruitment we undertake, the UK is at crisis point for finding enough clinical staff. The situation may be irreparable. New measures may be no more a long-term solution than a Dutch boy's finger plugging a leaky dyke. *BBC News* 21 March 2019 *bbc.in/2ukJFvu*

Ebola makes an unwelcome comeback

The Democratic Republic of Congo (DRC) declared their tenth outbreak of Ebola in 40 years on 1 August 2018. Largely unreported in the Western media, the outbreak is centred in the northeast of the country, which is still a conflict zone, further complicating the spread and the response of health authorities. With the number of confirmed cases passing 800 and nearly 490 confirmed deaths, it is now by far the country's largest-ever Ebola outbreak. It is also the second-biggest Ebola epidemic ever recorded, behind the West African outbreak of 2014-2016. The latest news shows that the virus has now spread to the city of Bunia, home to nearly a million people. Despite strong national and NGO input, the global response has yet to get into gear, suggesting the lessons of the West Africa outbreak have still to be learned. *Deutsche Welle* 21 March 2019 *bit.ly/2uls2vn*

Could platypus milk solve antibiotic resistance?

Multi-drug resistant micro-organisms are a looming health threat that has mobilised the global community. It now seems that one of the most quirky of God's creatures, the duck-billed platypus, may have the answer. A monotreme that lays eggs, has poisonous feet and suckles its young, the platypus is one of the most unique species in creation. It turns out that its milk also contains a strong and effective anti-bacterial agent that may be a launch pad for the creation of a new generation of antibiotics. Nothing is ever wasted in God's economy it would seem, not even platypus milk. *BBC News* 13 March 2019 *bbc.in/2uiKSmM*

Controversy around testosterone and female athletes

The International Association of Athletics Federations (IAAF) was due to propose new rules stipulating that female athletes with circulating testosterone levels of 5nmol/L or higher, and whose bodies respond to such sex hormones, must lower their testosterone levels to compete in women's track events from 400m to 1 mile. However, two academics writing in the *BMJ* have argued that this is 'unscientific', arguing that circulating testosterone alone is not enough to determine competitive advantage and testing for testosterone sensitivity is all but impossible. South African athlete Caster Semenya, who has hyperandrogenism, is taking the IAAF to court over its proposed rules. The outcome of her case will have controversial impacts on the ability of both transgender women and female athletes who have naturally high testosterone to compete in women's competitions. *The Guardian* 21 March 2019 *bit.ly/2uky3bL*

Has euthanasia gone too far in Holland?

Christopher de Bellaigue's long-read article on Dutch euthanasia laws has created quite a stir. Revealing the uses and a growing number of abuses of the 2002 legislation, it illustrated not just the dangers of legalising euthanasia, but also why so many doctors and activists are still so positive about medical killing. His conclusion, depressingly, is that the law is now irrevocable. Furthermore, moves are now afoot to bring in a 'completed life' pill to facilitate suicide in those who feel their life has come to its 'completion'. The Netherlands has become an object lesson of what horrors lie within the Pandora's Box of assisted suicide. *The Guardian* 18 January 2019 *bit.ly/2ulUyNG*

Opioid drugs more likely to be prescribed in poorer areas

GPs in poor communities are more likely to prescribe opioids for common chronic pain such as lower back and arthritic pain, despite their poor efficacy and long-term side effects. Lack of time, resources and social capital are all cited as reasons why socioeconomically deprived areas show such prescribing patterns. Social prescribing and other pain relief measures are more common for middle-class patients in less deprived communities and are often more effective. Whole person care is apparently more available to the wealthy than the poor. *University of Manchester News* 19 January 2019 *bit.ly/2utHYfr*

The Isle of Man has become the first place in the British Isles to decriminalise abortion

For many years the Isle of Man (a self-governing region of the British Isles) had strict laws restricting abortion. New legislation agreed by the House of Keys (the elected chamber of the Manx Tynwald) in January, allows a woman to request an abortion for any reason up to 14 weeks of pregnancy. This is the first time abortion on demand has formally been legalised in the UK. Abortion up to 24 weeks will be allowed under widely interpretable 'health' and 'social' grounds. Prospects for changing the laws in Northern Ireland and England look worryingly close as a result. *The Daily Telegraph* 15 January 2019 *bit.ly/2Figs9F*

Ruth Butlin considers the distractions of possessions

DO NOT BE BURDENED BY POSSESSIONS

At a drop-in centre for refugees and asylum seekers, I deposited my few things (which were in a plastic carrier bag) in the back room, as instructed, and went to observe the work. Drinks were available free of charge, and clients could help themselves from a table bearing food donated by a local supermarket. Another table was loaded with toiletries and second-hand, but good-quality clothing – those who needed anything could help themselves. Technical advice on immigration matters was available from an expert, and English languages classes were on offer. Everyone received a friendly welcome and the children were invited to play with toys.

When we packed up and prepared to leave, I could not find my bag of things. It took about 20 minutes to locate them: they had accidently been put into the box of donated things remaining for redistribution next week! During that 20 minutes I was very anxious and let it be seen. On the way home, I felt ashamed as I reconsidered my response.

Had my bag not been found, I would have lost a raincoat, a new pair of tights, a shopping list, a bus pass (due to expire in 3 months' time), and an old carrier bag. Not much. My house key was still in my pocket, along with a small amount of cash, enough for the bus fare to get home. Even on that cold day (dressed as I was in a jumper) I would not have come to much harm walking for ten minutes through the High Street, then covering a five-mile journey on a bus.

Some of those people I met at the drop-in centre had lost *everything*. Not just clothes and household goods, but savings, treasured mementos, documents proving who they were and how they were qualified, and what is more, relatives and friends (some obliged to stay behind and some who had died). Some of those people had started off with much less than I had at home, and now had practically nothing. Why was I worried about losing a few possessions, which I could easily replace?

Jesus told his disciples on one trip not to carry extra money or a spare coat,[1] but they carried the Good News. *Nothing* else should be carried if it interferes with our ability to serve. Do not be anxious about possessions.[2] Lord forgive me for overvaluing my things. Give me grace to hold lightly whatever you have given me, ever ready to share it with others.[3]

Let us travel light as we follow him.

***Ruth Butlin** is a retired GP*

references

1. Matthew 10: 9-10
2. Matthew 6:25, 28a
3. Matthew 10: 8b

WRITE

ETHICS

GO OVERSEAS

APOLOGETICS

SPEAK

LEAD

FAITH : MEDICINE : LIFE

Deep:ER

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