summer 2019

for today's Christian doctor

triple helix

surrogacy

CMF @ 70, life and death in the hands of God, serving through mission hospitals, juniors' forum, shift work and the local church, bringing healthcare to the feet of Jesus

ISSN 1460-2253

Triple Helix is the journal of the
Christian Medical Fellowship

A company limited by guarantee
Registered in England no. 6949436
Registered Charity no. 1131658
Registered office: 6 Marshalsea Road, London SE1 1HL

Tel 020 7234 9660
Email info@cmf.org.uk
Web www.cmf.org.uk

President John Wyatt MD FRCPCH
Chair Maggy Spence MB MRCGP
Treasurer Philip Taylor MA (Oxon)
Chief Executive Mark Pickering MBBS MRCGP

Subscriptions
Triple Helix is sent to all members of CMF as part of the benefits of membership.

Contributions
The editor welcomes original contributions, which have both Christian and medical content. Advice for preparation is available on request.

Authors have reasonable freedom of expression of opinion in so far as their material is consonant with the Christian faith as recorded in the Bible. Views expressed are not necessarily those of the publishers.

Managing Editor Steve Fouch
Editorial Assistant Oluwatosin Oyeniyi

Editorial Board
Ruth Butlin, Cheryl Chin, Sarah Germain, Colleen McGregor, Jason Roach, Alice Smith, David Smithard, Claire Stark Toller, Sheldon Zhang

Design S2 Design & Advertising Ltd 020 8771 9108
Print Partridge & Print Ltd

CMF
Christian Medical Fellowship

No. 75 Summer 2019

contents

Age of anxiety

'You will hear of wars and rumours of wars, but see to it that you are not alarmed. Such things must happen, but the end is still to come.'

On my bookshelf in the '90s was a volume of poetry entitled *The Age of Anxiety*. It contained a series of poems (of varying quality) on the worries of the decade – AIDS, climate change, terrorism, economic instability and war.

The title of that anthology came from WH Auden's epic 1947 poem [1] exploring the anxieties of post-war America and Britain.

The anxieties of these poets ring very familiarly today. The re-appearance of despotism and populist revolts against the established, liberal order; the uncertain path to Brexit and its aftermath; global terrorism from multiple ideologies; all challenge our sense of political security (for good and ill).

In medicine, we face genetic engineering, the push to liberalise abortion and euthanasia laws, new epidemics of Ebola and virulent influenza, the rising tide of non-communicable diseases, the financial strains on the NHS and the crisis in our care system. All raise anxieties about the future of healthcare.

The changing cultural and spiritual landscape adds to this insecurity, where what was unthinkable less than a decade ago is now normalised. It is a time where dissension is increasingly stifled by the opprobrium of the Twitterati. The cusp of the '20s would seem to be another age of anxiety.

Well, that is how the press often portray it. The Christian press is no exception to that, and hands on heart, we have been guilty of that in *Triple Helix* as well.

But let's stop for a moment and consider. Reading in the books of Samuel and Kings recently, I found it hard not to notice the anxieties of the people of Israel, facing occupation and oppression from the Ammonites, Moabites, Philistines and others. Where was God when they needed him? Why was it that the Torah demanded a way of life so at odds with the cultures around them? Surely, it would be easier just to go along with the ways of the surrounding nations?

Or take Elijah, alone in the wilderness and despairing after his apparent victory against the prophets of Baal on Mount Carmel was quickly reversed, and he had to flee for his life. Why had God led him into such a situation? Surely, it would have been easier to keep his head down and not challenge the political and religious establishments of his day? [2]

Every age it would seem is an age of anxiety. It is the human condition – a result of the fall. Every age joins with the cry of the prophets and psalmists in asking where God is in the midst of everything that is happening around us. One of our besetting sins is to be cowed by this anxiety, or to believe this fear is unique to our time and society and to lose hope.

The other sins society falls into are either the naïve 'we've never had it so good' optimism of a Steven Pinker, or the nostalgic delusion that if only we went back to the way things used to be, all would be better. A fourth error is simply to bury our heads in the sand of Netflix binge watching, anaesthetising ourselves with entertainment.

Jesus calls us to something quite different. In his long discourse about the destruction of the Temple and the coming persecution of believers, [3] he counselled the disciples *'You will hear of wars and rumours of wars, but see to it that you are not alarmed. Such things must happen, but the end is still to come.'* (Matthew 24:6)

When you read through Matthew 24, the list of anxieties and trials before the early church could have been written today. Jesus warned them to be prepared for this, but also to hope, because this is all part of the coming of the kingdom of God. We are told not to fear or to be anxious because God is still in control. And the kingdom of God is, for now at least, at work in quietly powerful ways, in the lives and witness of his people around the world.

Israel lived through its age of anxiety, guided by the judges and the prophets until David as king re-united the nation and brought peace (albeit only for a couple generations). Elijah encountered God during his exile and was given reasons to trust in a better future. We also wait; not passively, but actively engaging with the world. We may feel powerless to change the things going on around us, but we serve a God who has the power to do anything.

Change is coming thick and fast, but God is at work in the midst of it. I hope that some of the stories and reflections in this edition of *Triple Helix* might encourage you to see something of how God is working. His invitation is for us to join with him, bringing his good news of salvation and hope to an anxious and hurting world.

Steve Fouch *is CMF Head of Communications*

references

1. Auden WH. The Age of Anxiety: A Baroque Eclogue. New York: Random House, 1947
2. 1 Kings 18-19
3. Matthew 24

news reviews

Mumsnet encourage nurses to return to work

Only scratching the surface of the real need

Review by **Pippa Peppiatt**
CMF Head of Nursing

At the start of June, Health Education England (HEE) launched a return to practice campaign with Mumsnet.[1]

The aim is to recruit at least 1,000 returning nurses into adult, child, mental health and learning disability nursing per year, and at least 100 returning nurses into general practice by March 2020. For returning nurses, support available includes mentors and tutors, alongside £500 worth of financial support to help with travel, childcare and book costs. Mumsnet[2] will help to promote the marketing campaign and showcase video stories from nurses who have returned to the profession.

A good and creative idea, it will hopefully help some nurses return to practice. But tempting nurses to return after maternity breaks won't fix retention issues.

With one in nine nursing posts unfilled – that's nearly 40,000 nursing vacancies in the UK – the consequent lack of nursing staff is having a big impact on both patient safety and the stress and mental health of nurses.[3]

Recent conversations with CMF nurses brought to light members barely hanging in there at work, and who are constantly concerned that they will make a serious mistake (and possibly lose their PIN number, in a quick–to-blame nursing culture), due to time and resource pressure. These CMF members are trying to do the best job they can, but need support. CMF can't solve hospital staffing issues, but can offer informed advice, care, compassion and prayer.

Low staff levels and unfilled posts are obviously not confined just to nurses and affect all healthcare professionals. We need better retention, support, and working conditions for all NHS staff.

In May this year, the Royal College of Nursing Congress called for the government to introduce a safe staffing level legislation[4], which Wales introduced in 2016 (the first country in Europe to do so) and which has recently been passed by the Scottish government.[5] At present, nurse staffing levels are set locally by individual health providers and there is currently no compliance regime or compulsion for providers to adhere to these levels. Safe staffing level legislation would mean an obligation for health boards and trusts to ensure there are sufficient nurse staffing levels, and the skill mix to meet the needs of patients receiving care.

Obviously, this doesn't answer the question of funding, increasing demand, and the recruitment of new nurses, but at least it would be a first step in creating a safer and less stressful environment for our nurses to work in. Who knows, they may even stay.

references

1. Launder M. HEE launches return to practice campaign with Mumsnet. *Nursing in Practice* 5 June 2019. *bit.ly/2QQi3cb*
2. We are returning nurses. *Mumsnet*. *bit.ly/2Wg2fAx*
3. Mitchell G. Mid Staffs lessons being lost, as review finds progress on safe nurse staffing not sustained. *Nursing Times* 16 April 2019. *bit.ly/2XxKeyY*
4. Mitchell G. Nurses sign giant letter to Hancock calling for safe staffing law. *Nursing Times* 24 May 2019. *bit.ly/2Wmitb3*
5. RCN Safe Staffing Campaign. *bit.ly/2yOvEpT*

Eugenics

The idea that never went away

Review by **Kelly Hibbert**, a junior doctor and a Deep:ER Fellow with the CMF Public Policy team

In 2016, the State of Indiana passed the 'Sex Selective and Disability Abortion Ban'. This would have prohibited any abortion based solely on race, gender or disability. Following opposition from pro-abortion groups, a federal district court blocked enforcement of the law, declaring it unconstitutional. The State of Indiana appealed to the Supreme Court, which declined to overrule the decision.

The failure in May 2019 to reconsider this judgement prompted Justice Clarence Thomas to write a lengthy response[1], in which he states that laws such as this '*promote a State's compelling interest in preventing abortion from becoming a tool of modern-day eugenics*'.[2]

We recoil at the mention of 'eugenics'. It conjures up images of the Nazi regime; the discrimination and genocide of those viewed as 'inferior'. However, it was well-established prior to the Second World War. Thomas describes the American eugenics movement of the early 20th century as a 'full-fledged intellectual craze'. Many states in America employed birth control for eugenic purposes. Between 1907 and 1983, more than 60,000 individuals perceived to be 'dysgenic' were involuntarily sterilised. In *Buck v. Bell* (1927), the US Supreme Court declared '*It is better for all the world, if... society can prevent those who are manifestly unfit from continuing their kind.*'[3]

Thomas highlights that '*abortion is an act rife with the potential for eugenic manipulation*'. The founder of Planned Parenthood, Margaret Sanger, whilst opposing abortion, believed that '*Birth control... is really the greatest and most truly eugenic method*' of '*human generation*'. Her campaign to target birth control in black communities fed into race-based eugenics. Future Planned Parenthood president, Alan Guttmacher, sanctioned carrying out abortions for eugenic purposes, saying '*...it should be permissible to abort any pregnancy in which there is a strong probability of an abnormal or malformed infant.*' A recent CMF blog explores the strong eugenic and racist opinions held by Marie Stopes[4], whose life heavily shapes the work of her namesake organisation today.[5]

Nowadays, we see the effect of selective abortion on population demographics. A recent study carried out across 90 countries found that globally, 23 million baby girls are missing as a '*direct consequence of sex-selective abortion*', mostly in mainland China and India.[6] In Iceland, almost all children with a prenatal diagnosis of Down syndrome are aborted.[7] A topical CMF blog explores the ethical difficulties raised by non-invasive prenatal testing (NIPT).[8] The link between abortion and eugenics is too often brushed under the carpet, as though it is unfeasible that eugenics could be permitted today. However, the ongoing US debate shows us that despite appearances, eugenics has never gone away.

references

1. Thomas C. SCOTUS judge links abortion and eugenics. *Mercatornet* 30 May 2019. *bit.ly/2F61dBb*
2. Supreme Court of the United States. Box v. Planned Parenthood 2019. *bit.ly/2XBmOJ3*
3. Legal Information Institute. Buck v. Bell 1927. *bit.ly/2F7OrlL*
4. Taylor P. Marie Stopes: history erases ugly facts to create a mythical feminist hero. *CMF Blogs* 7 May 2019. *cmf.li/2WEyRnD*
5. Marie Stopes International. Our history. *bit.ly/2MThEHg*
6. Gennarini S. Study Finds 23 Million Females are Missing Due to Sex-Selective Abortion. *Center for family and human rights* 2 May 2019. *bit.ly/2lbmpb2*
7. Quinones J, Lajka A. 'What kind of society do you want to live in?': Inside the country where Down syndrome is disappearing. CBS News 14 August 2017. *cbsn.ws/2wh4zO5*
8. Prenatal Screening and Down Syndrome – million-dollar ethics. *CMF Blogs* 1 May 2019. *bit.ly/2H7EepE*

What next?

Withdrawal of Clinically Assisted Nutrition and Hydration

Review by **Rick Thomas**
CMF Public Policy Researcher

The Supreme Court has ruled[1] that clinically-assisted nutrition and hydration (CANH) may be withdrawn from patients in prolonged disorders of consciousness (PDOC) without court approval, where the family and the clinicians agree it would be in the 'best interests' of the patient and the legal requirements of the 2005 Mental Capacity Act (MCA)[2] have been followed. This will apply to:

- Patients with progressive neurodegenerative conditions (eg. Parkinson's or Huntington's disease).
- Patients with multiple comorbidities and/or frailty that are likely to shorten life expectancy, or who have suffered a brain injury (eg. a catastrophic stroke).
- Previously healthy patients with PDOC who are in a vegetative state (VS) or minimally conscious state (MCS) following a sudden-onset brain injury (eg. a traumatic brain injury after a road traffic accident).

The British Medical Association and Royal College of Physicians (RCP) have issued joint guidance[3] in response to this ruling.

The guidance addresses some, bu no means all, of the conerns raised. So, how shall we now respond?

CMF is forming a working group of clinicians and lawyers:

- To monitor the effect of the new guidance in practice: how many patients will have their lives ended in this way? How will their deaths be recorded? Will the ruling open the door to 'euthanasia by stealth' for other categories of patient?[4]
- To consider whether 'consensus' between family and clinicians that CANH be withdrawn truly meets the purpose of the MCA in protecting the rights of the incapacitated person. For example, is it within the boundaries of their professional responsibilities, competencies and resources for clinicians to evaluate conflicts of interest between the incapacitated patient and their family?
- To consider whether to press for an amendment to Section 4 of the MCA to provide that decisions to withhold or withdraw CANH from patients who are not at the end of life must be subject to application to the court for a declaration of lawfulness, irrespective of whether family and clinicians are in agreement.

For more information on CANH see *CMF File*: 69, No water, no life.

references

1. An NHS Trust and others (Respondents) v Y [2018] UKSC 46
2. Mental Capacity Act 2005. *bit.ly/2MtLqkx*
3. Clinically-assisted nutrition and hydration (CANH): New guidance to support doctors making decisions about CANH for adults who lack capacity in England and Wales. BMA 24 May 2019. *bit.ly/2C5XSkC*
4. CMF Files. *cmf.li/CMF_Files*

New abortion statistics published

Alarming trends emerge as rates of abortion increase

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

The latest abortion statistics from the year 2018[1] show that abortion numbers have hit a ten-year high, with 205,295 abortions in England and Wales, an increase of 7,762 abortions from the previous year.

A breakdown of the figures shows some particularly disturbing developments. For example, there has been a steady rise in repeat abortions, reaching 78,998 in 2018. This means that 39% of women undergoing abortions had one or more previous abortions, compared to 33% in 2008. For women aged 30 and over having an abortion in 2018, almost half (48%) had previously had one or more abortions.

Can we really just blame this level of repeat abortions on poor contraception advice or lack of availability of contraceptives? It seems that abortion is being used as a form of contraception now. One young woman, who had her first abortion at the age of 18 and then another three by age 22, was interviewed a few years ago about how she felt having several abortions, she said: 'It does get easier, the more you have. I know that sounds really bad but that's how it is... I just think I was really careless...it was down to me, but I should have been more responsible because I've killed a life now, and it wasn't that baby's fault...'[2]

Another trend in the statistics is the sharp increase in abortions carried out using pills – medical abortions. In 2008, 37% of abortions were medical. By 2018, the proportion was 71%. The use of abortion pills is advocated by abortion providers as a safe and simple procedure. However, a large Finnish study of 42,600 women found that women had four times as many serious complications after medical abortions than surgical abortions: 20% compared to 5.6%. Rates of surgery after medical abortion can be up to 33% for later abortions. These are costs borne by hospitals, not abortion clinics.

Abortion providers (with obvious financial and ideological vested interests in increasing numbers of abortions) are now driving campaigns to make obtaining a medical abortion as easy as possible, removing the administration of the abortion pill misoprostol from medical oversight and removing legal restrictions on abortion. This is likely to cause these statistics to get even worse.

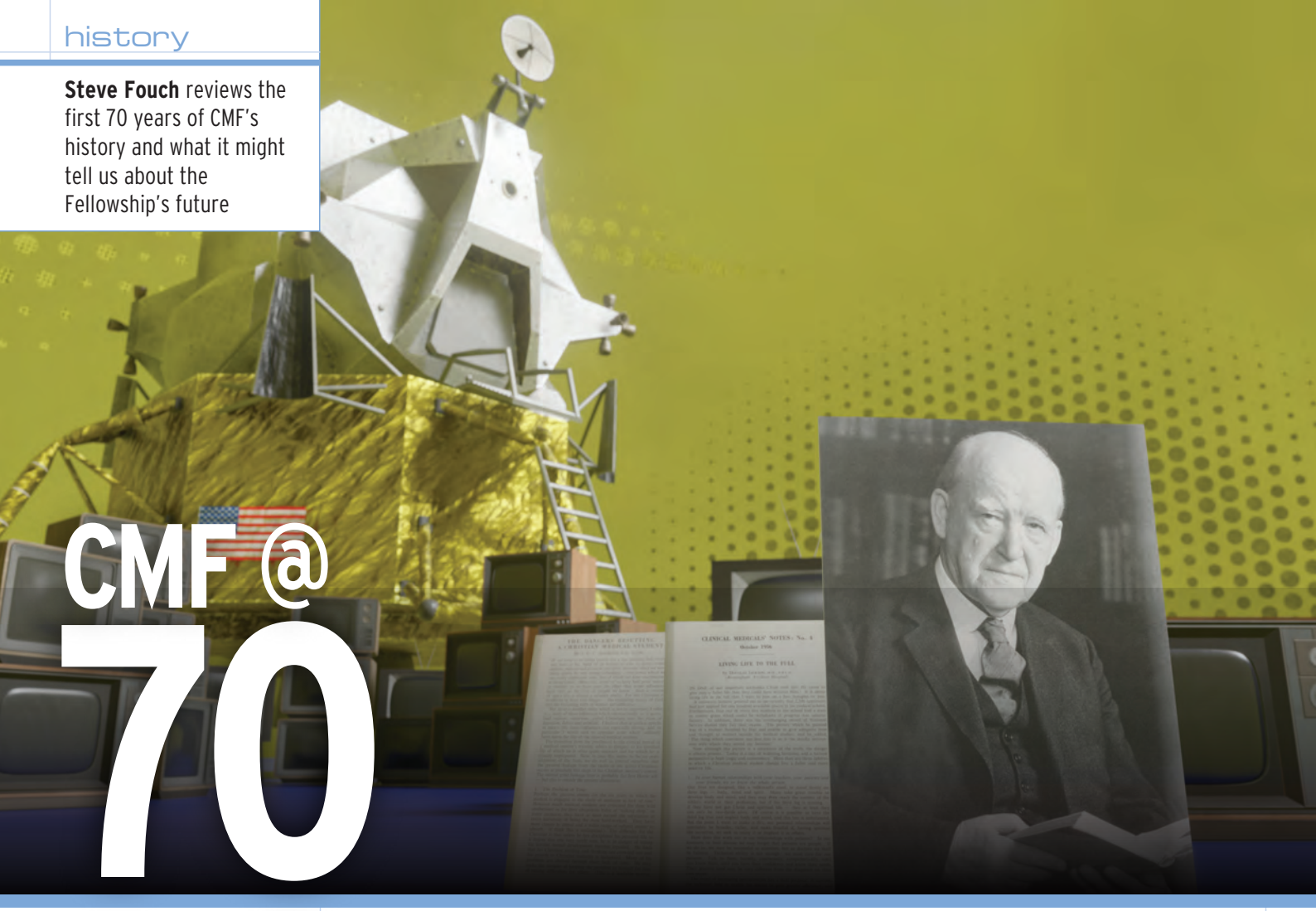
There has also been an increase in disability-selective abortions up to 3,269.[3] This figure includes abortions carried out after 24 weeks gestation; a number that has increased for babies diagnosed with Down's syndrome. This is likely to be partly attributed to the private availability of non-invasive prenatal tests (NIPT) and is a situation that will become worse as the government moves ahead with their proposals to implement NIPT testing into the Fetal Anomaly Screening Programme.

Every one of these abortions represents a failure of our society to protect the lives of babies in the womb and a failure to offer full support to women with unplanned pregnancies.

references

1. Abortion Statistics, England and Wales: 2018. *Department of Health and Social Care* 13 June 2019. bit.ly/2IeC8pM
2. Taylor P. The number of women having several repeat abortions is shockingly high, and increasing. *CMF Blogs* 29 April 2014. cmf.li/2RjULLR
3. Abortion Statistics *Art.cit*

Steve Fouch reviews the first 70 years of CMF's history and what it might tell us about the Fellowship's future



CMF @ 70

key points

- CMF came into being at a time of great social, technological and spiritual change in the UK, to help Christian doctors support one another.
- Over the last few decades, CMF has become more global and multidisciplinary in its ministry and membership.
- The core values and beliefs that shaped the formation of the Fellowship in 1949 lie at the heart of CMF today and as it looks towards the future.

In the aftermath of the Second World War, Britain was reeling from more than half a decade of conflict. Yet in that time, the nation had learned powerfully about how to pull together and support one another. It was perhaps in a desire to hold on to this spirit of mutual solidarity that the post-war government created the National Health Service (NHS) – the first tax funded, government-run, health service in the world.

Many doctors were returning from military service and dealing with the challenges raised by their wartime experiences and the changed country to which they had returned. The Medical Prayer Union, led by Neville Bradley, felt that Christian doctors needed to be more closely connected for mutual, spiritual support.

At the same time, the medical student membership of the Inter-Varsity Fellowship (the forerunner of today's Universities and Colleges Christian Fellowship) was growing fast. Under the leadership of William Melville Capper, the need for a dedicated medical section for IVF was widely recognised.

Less than a year after the NHS was formed, in June 1949 these two groups decided to band together to further connect, support and encourage Christian doctors and medical students in their faith. And so was born the Christian Medical Fellowship. The new organisation recognised early on that its members faced not only the challenges and opportunities of the new healthcare system, but also the advent of new medical technologies that raised many novel, ethical and professional questions.

While the late'40s and early'50s was an era where Christianity was superficially still at the centre of public life, the reality below the surface was that of a society slowly becoming more secular, leaving behind the Christian underpinnings upon which it had been built. Being a Christian doctor in this environment was already creating new problems that CMF wished to help its members address.

It was in this milieu that Douglas Johnson was appointed as CMF's first General Secretary.

The evolving ministry of CMF

Over the next few years, many of the features of CMF that most of us will recognise today began to take shape. In 1950, the first weekend National Conference was held in Bournemouth, with a strong emphasis on Bible teaching, fellowship and discussion on topical medical issues.

In 1951, the first CMF publication, *The Christian Heritage in Medicine* was launched, followed two years later by CMF's first regular publication, *In the Service of Medicine*. Douglas Johnson famously said that getting the publications and student ministries right were essential to the growth and long-term viability of the Fellowship. At the same time, he also focussed on getting local fellowship groups formed to connect and support Christian doctors and medical students. The first in a series of breakfasts at BMA and Royal College conferences were held from 1952.

Douglas Johnson famously said that getting the publications and student ministries right were essential to the growth and long-term viability of the Fellowship

As new medical issues arose, it became increasingly apparent that CMF needed to do some serious thinking to produce well thought through, Christian medical responses. Dr Martin Lloyd Jones came on board to chair a newly formed committee to investigate new medical advances and formulate biblically grounded Christian commentary. This group in time became the Medical Study Group, which continues to this day.

By the '60s, CMF found it had a growing international family of similar fellowships. In 1964, the first International Congress of Christian Physicians (ICCP) was held in the Netherlands, with CMF as a key participant. CMF continued to provide speakers and send delegates to subsequent ICCPs, even hosting one in Oxford in 1966, until the growing network formed itself into the International Christian Medical and Dental Association (ICMDA) at the 1986 Cancun Congress.[1]

The creation of ICMDA was in turn partially responsible for fuelling CMF's vision for supporting its own members serving overseas in mission. In 2004, CMF merged with the Medical Missionary Association and began to be even more engaged with mobilising and equipping Christians in all health professions into world mission.

A growing and broadening fellowship

The increasing secularisation and liberalisation of society in the '60s and '70s led to a growing focus on student ministry through those decades. It was clear that Christian medical students were dealing with new, more secular and often anti-Christian attitudes in the most acute way, in addition to rapid developments in medical science. In 1971, *Nucleus* was launched as a new, regular CMF publication for students. In 1973, Peter May was appointed as the first CMF Travelling Medical Secretary for undergraduates.

The following year, after 25 years as General Secretary, Douglas Johnson stepped down and Keith Sanders took over from him. Keith was an energetic, and very peripatetic General Secretary, travelling the length and breadth of the British Isles, talking to members, churches and student bodies. Under Keith's leadership, the membership tripled to the levels we still see today.

The rate of production of new books, papers and audio resources increased in the '70s and '80s, eventually leading to the creation of the CMF website in the late '90s.

After 16 years of leading CMF, Keith Sanders stepped down in 1990 and Andrew Fergusson took over the reins for the next decade. Andrew brought skills in communications and PR, and a knowledge of bioethics. He also brought in Peter Saunders as his full-time Student Secretary. Andrew and Peter formed a powerful double act that strengthened the student and graduate ministry of CMF. They also brought media awareness and engagement to the Fellowship, speaking out not just to the membership and the church, but to wider society on topical issues.

CMF's flagship magazine went through several changes of name and format over the years from *In the Service of Medicine* to *the Journal of the Christian Medical Fellowship*. Andrew became the first editor of *Triple Helix* when it was launched in 1997 with the aim of reaching a wider audience. Today more than 4,000 copies go out to more than 68 countries around the world, with an equally large readership for the online magazine, which is widely shared on social media.[2]

When Andrew stepped down in 1999, Peter took over the leadership of CMF for the next 19 years of CMF's life, further extending the media and public policy profile of the Fellowship. CMF also developed a much bigger staff team, bought its own building in south London (named Johnson House after CMF's first General Secretary and his son, Alan Johnson who was the Chair of CMF's Board in the early Noughties). CMF also broadened its global ministry still further, becoming more proactive and multidisciplinary in mission resourcing and mobilisation.

In 2013, CMF admitted nurses and midwives to membership, building on eight years of partnership with Christian Nurses and Midwives (CNM) and the Nurses Christian Fellowship International (NCFI). The original Nurses Christian Fellowship (NCF) was both an older and larger fellowship than CMF, but during the '70s and '80s had shrunk, until it had finally closed in 1995. A new nurses' fellowship, CNM, was launched in 2001, but by 2013 it had become clear that the membership of both organisations wanted to work as one body. Today, nurses and midwives are the most rapidly growing part of CMF's membership.

Looking backwards to look forwards

With Mark Pickering, our fifth CEO, only just in post as we celebrate seventy years of CMF, this is a good time to look backwards as well as forwards. CMF has always had at its heart connecting Christians in medicine (and now also nursing and midwifery) to live and speak for Jesus Christ.

The specifics have changed a lot since we were founded and the skills of the people God has raised up have diversified. But Douglas Johnson's belief that student ministry and publications lay at the heart of CMF has not changed, even if the technology with which we communicate and the issues about which we write have changed beyond recognition. Local fellowships and networks are crucial to the life of the Fellowship, though today these are more likely to be organised through WhatsApp or Facebook groups than printed newsletters or telephone calls.

Ultimately, the Lord we serve never changes, and the message of salvation is the same today as it ever was. How we share this message may be changing rapidly, but the gospel stays the same.

We are a Fellowship made up of godly men and women like you, who love Jesus as Lord and Saviour and who want to live out the reality of his kingdom in their day-to-day lives. Thank you for all you bring to CMF.

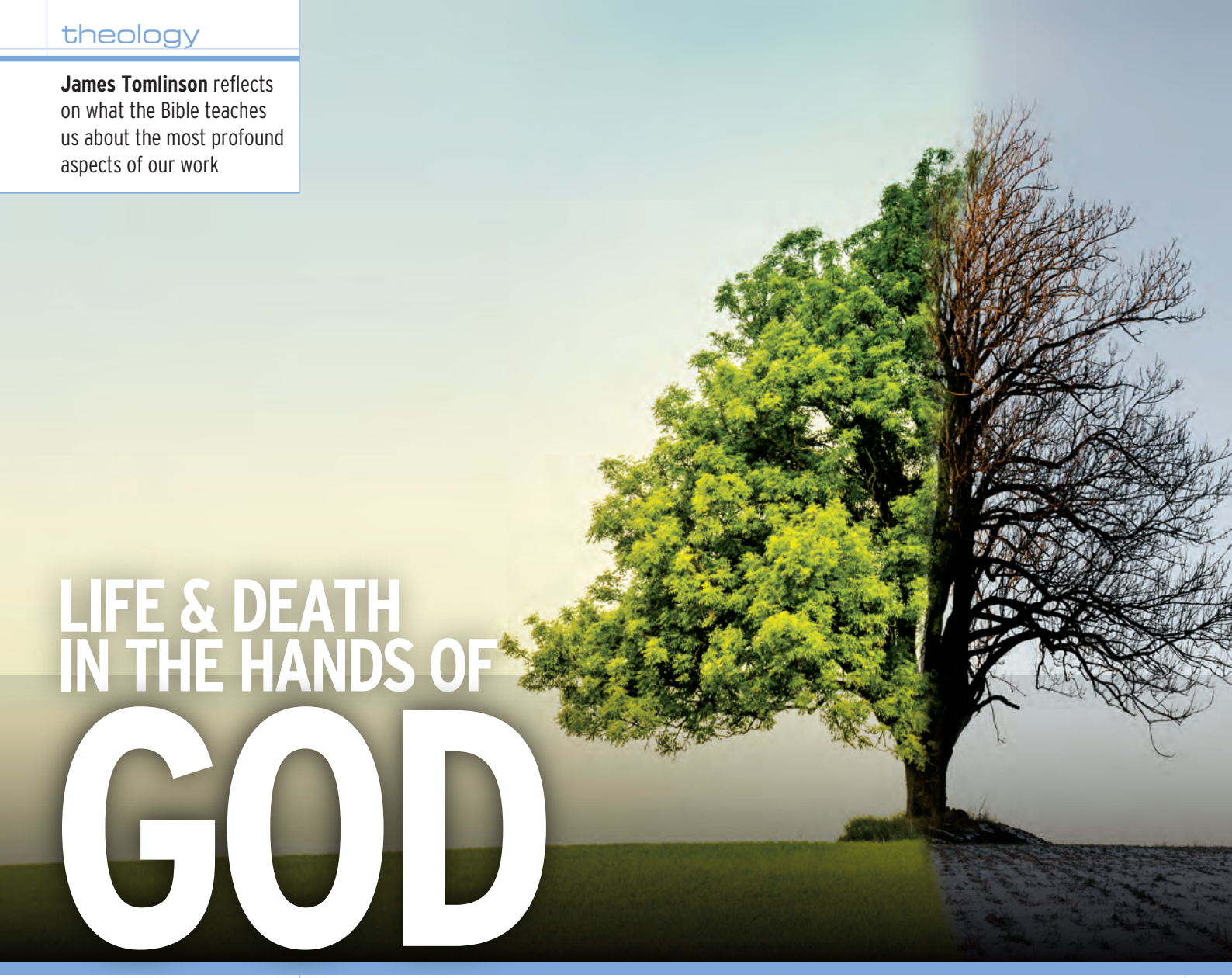
***Steve Fouch** is CMF Head of Communications*

The Lord we serve never changes, and the message of salvation is the same today as it ever was

references

1. ICMDA history *icmda.net/about-us/history*
2. Fergusson A. 20 Years of Triple Helix. *Triple Helix* 2017; Autumn:9 *cmf.li/2JZVq4k*
3. Fouch S. Phoenix from the ashes: A history of CNM. *CNM* 22 February 2009. *bit.ly/2EVuChz*

James Tomlinson reflects on what the Bible teaches us about the most profound aspects of our work



LIFE & DEATH IN THE HANDS OF GOD

key points

- Life and death are not only universal, human experiences, but understanding them is central to our professional practice.
- The Bible has a radical perspective on both life and death and what they mean for us based on our relationship with God through Jesus Christ.
- Understanding what the Bible says about life and death will shape how we practise medicine and nursing and how we live our lives.

Life and death are central to the study and practice of medicine. At the beginning of our studies we are taught the life sciences of embryology, physiology and biochemistry; to consider the workings of the cell and the beginning of human life. As we see patients, we learn how to bring a life into this world and to care for the sick and the dying. Much of our professional lives are dedicated to the preservation of life, the promotion of good and healthy living and postponing death. We deal with life and death on a regular basis. But is our thinking shaped more by our scientific and medical training than through reflection on the Bible?

The God of life

When Paul addressed the men of Athens at the Areopagus he noted that: *'The God who made the world and everything in it is the Lord of heaven and earth and does not live in temples built by human hands. And he is not served by human hands, as if he needed anything. Rather, he himself gives everyone life and breath and everything else. From one man he made all the nations, that they should inhabit the whole earth; and he marked out their appointed times in history and the boundaries of their lands. God did this so that they would seek him and perhaps reach out for him and find him, though he is not far from any one of us. "For in him we live and move and have our being." As some of your own poets have said, "We are his offspring."'* (Acts 17:24-28)

Paul understood that God is the one who created the world. God initiates and sustains life. Without God there simply would be no life.[1] Throughout the Old Testament, Yahweh is described as the living God, the God who speaks and acts. To Moses at the burning bush He declares *'I AM WHO I AM'* (Exodus 3:14). He is the God who simply is; unchanging, eternal and living.

Speaking of Jesus, Paul writes *'The Son is the image of the invisible God, the firstborn over all creation. For in him all things were created: things in heaven and on earth, visible and invisible, whether thrones or powers or rulers or authorities; all things have been created through him and for him. He is before all things, and in him all things hold together.'* (Colossians 1:15-17)

All of us are wholly reliant on Jesus as creator and sustainer. This causes me to consider whether I acknowledge and approach each life with which I connect as being created and daily sustained by God himself? As healthcare professionals, so aware of the biology and mechanics of life, have we lost sight of God's vital involvement in life itself?

Are we thankful for the daily miracle of life – our own and others? As we view life from the perspective of being created and sustained by God, perhaps we must question our actions and assumptions in the way we handle life.

Death the imposter

The Bible has much more to say about life than death; death is an imposter. Death enters our world because of the choice that the first human beings made to disobey God's instructions.[2] In the shadow of death, life becomes momentary and fleeting. This is expressed by the writers of the Psalms and Ecclesiastes.

'*Show me, Lord, my life's end and the number of my days; let me know how fleeting my life is. You have made my days a mere handbreadth; the span of my years is as nothing before you. Everyone is but a breath, even those who seem secure.*' (Psalm 39:4-5)

'*Since no one knows the future, who can tell someone else what is to come? As no one has power over the wind to contain it, so no one has power over the time of their death.*' (Ecclesiastes 8:7-8a)

Life is fragile and precarious. Acknowledging this gives us a choice as to how we live. We can choose to make the most of the limited time we have, or we can live in denial and defiance, accepting the pretence that we and not God are in control of our lives. We can come to the conclusion that life is futile and pointless:

'*Life's but a walking shadow, a poor player,*
That struts and frets his hour upon the stage,
And then is heard no more: it is a tale,
Told by an idiot, full of sound and fury,
Signifying nothing.'[3]

Although written centuries ago, these words still express what many of our colleagues, patients and even we ourselves can feel, especially when faced by untimely death.

Our response to the reality of death affects how we live and treat life. In the words of the preacher: '*Death is the destiny of every man; the living should take this to heart*'. (Ecclesiastes 7:2b)

Bringing spiritual life

When death entered our world, it did so not just in a bodily form but also spiritually and eternally. We yearn for life and see death as the intruder. The prophet Isaiah could therefore look forward to a day where God would defeat death. '*On this mountain he will destroy the shroud that enfolds all peoples, the sheet that covers all nations; he will swallow up death for ever. The Sovereign Lord will wipe away the tears from all faces; he will remove his people's disgrace from all the earth. The Lord has spoken*. (Isaiah 25:7-8)

This hope finds fulfilment in Christ: '*Very truly I tell you, whoever hears my word and believes him who sent me has eternal life and will not be judged but has crossed over from death to life*'. (John 5:24) As Paul puts it, '*For if, by the trespass of the one man [Adam], death reigned through that one man, how much more will those who receive God's abundant provision of grace and of the gift of righteousness reign in life through the one man, Jesus Christ!*' (Romans 5:17) We are transferred from the state of death to the state of life the moment we come and accept Christ as our Lord and Saviour. Even when we die bodily, we remain alive in Christ. For this reason, the New Testament refers to the death of the believer as sleep.[4]

'*Where, O death, is your victory? Where, O death, is your sting?*' (1 Corinthians 15:55)

Much of modern medicine is dedicated to fighting bodily death, both that which is untimely and avoidable and that which comes from the process of decline and age. If we consider many of our colleagues' and patients' attitudes to death, we see a strong thread. Medicine seeks to conquer and delay death – to live as long and as well as we can. It seeks to exert control over death. Thus, through medicine we come to believe that we decide the timing and means of our death. Such thinking underlies calls for the legalisation of assisted suicide and euthanasia.

As those who professionally fight against the effects of decay and death, we should do so expressing care and respect for God's creation. While bodily death must be recognised and even welcomed and certainly not forever put off, it should also not be hastened.

That many of our patients are in a state of spiritual death should cause us to desire their transition to the state of spiritual life. As we practice whole person care and medicine, communicating with permission, gentleness and respect, are we willing to consider and address patients spiritual care needs utilising the wider healthcare team?

That our days are limited can be viewed as a severe mercy, for the reality of bodily death alerts us to the state of spiritual death. It is my observation that the 'wrongness' of death as experienced by patients, their families and carers can be an indicator that they are made for life.

Conclusion

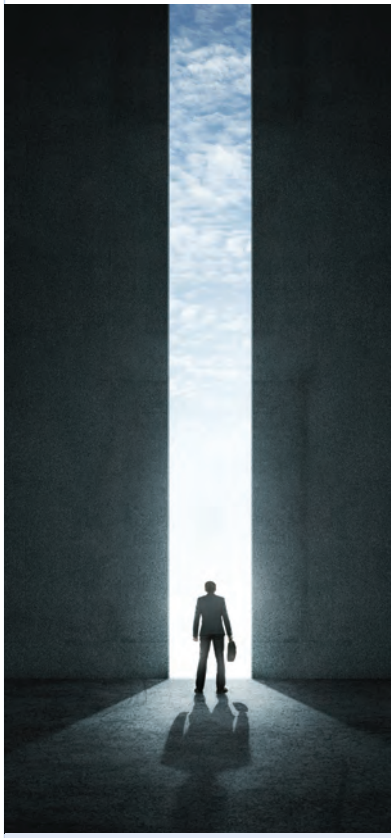
Jesus not only redeemed us but in so doing he took on our humanity – fully God, fully human – paying the ultimate price by laying down his life for us. Our very make up and creation is not rejected by God, but sees its ultimate fulfilment in him.

Life is God's initiative, both in the physical creation of life and the way that he has opened to eternal-life through Jesus. Each human life is of immense value to God. Humanity was created for life – not death. This finds its consummation in Christ's return, when '"*He will wipe every tear from their eyes. There will be no more death*" *or mourning or crying or pain, for the old order of things has passed away*.' (Revelation 21:4)

It is my prayer that as Christians in healthcare, mindful of the predominant thinking of medicine and society, that we study and practice our craft in the light of what God says about life and death.

Life and death are truly in the hands of God.

James Tomlinson *is a practising GP in the West Midlands*



This article is based on a talk given at the KLF (CMF Denmark) National Conference in 2009

references

1. Acts 3: 5
2. Genesis 3
3. Shakespeare W. Macbeth. Act 5, Scene 5
4. Eg. 1 Corinthians 15:51

Nathan Lawrence reflects on his own experiences of cross-cultural mission to ask if it is worth doing

MISSION HOSPITALS: ENDURING WITNESS OR OUTDATED CONCEPT?

key points

- Medical mission is still needed, but does the old-fashioned image of the western Christian doctor or nurse coming to solve problems work?
- Time spent serving long-term in a mission hospital will be spiritually, mentally and professionally taxing, and may lead to disillusionment.
- Spending longer than a few months serving overseas is vital to a shift in perspective to help push through disillusionment and to make a difference serving local Christians.

Anti-malarials? *Check*. Medical French Dictionary? *Check*. *Oxford Handbook of Tropical Medicine*? *Check*. Right then, off to Madagascar.

And so, on the 26 January 2017, I found myself climbing into a small twin-engine Cessna on my way to a town called Mandritsara in the north of Madagascar. I was carrying two huge rucksacks and two huge questions.

First, is working in medical mission something to which I'm suited , that I can thrive in and could or should be considering long-term?

Second, is a mission trip worthwhile?

If you claim to care about either the material suffering or spiritual needs of people overseas (or indeed, both) then what should you do about it? Do you get on a plane and go? Do you do a Master's in Public Health and join the World Health Organization? Or do you work in the NHS and funnel every last penny you can into local Bible schools and medical training?

Is the presence of overseas missionaries and doctors in the developing world a valuable or useful thing in itself?

The answer to the first question became clear fairly quickly: within a few months of starting work at the *Hopitaly Vaovao Mahafaly* (AKA: Good News Hospital) I found myself loving medical mission in the developing world. I loved the mangoes; I loved the team community; I could put up with the bugs; I loved the old red hills around the hospital and I loved the way the place integrated real and vital medical care, with a genuine unashamed proclamation of the gospel every day and in every ward round. Even in the tough times, (let's be honest, being away from home for over a year is tough) I celebrated Christmas Day sheltering from a tropical storm without electricity, while I was sent family photos of mince pies dripping in brandy butter!

It's also beyond hard to spend the whole night running between two dying neonates, who you've resuscitated a total of five times before eventually having to call it a day at 4am.

But the tough times brought me closer to God, closer to the rest of the team (who were always there to patch me up with tea, banana cake, a hug and a prayer), and humbly taught me. God sustained me and did not break me.

So, it became increasingly clear, without wanting to belittle the bumps, challenges and knocks along the way, that by God's grace this was something which more or less agreed with me: a way of life I could survive and maybe even thrive in.

But was it worth it? Should we be even doing mission like this anymore? Is the presence of overseas missionaries and doctors in the developing world a valuable or useful thing in itself? Or is it a necessary evil that would be better done by local evangelists/doctors if only there were the personnel available to do that? My thinking gradually evolved over the 16 months I spent at HVM.

Disillusionment

At six months in, I was pretty much convinced that it was pointless: I was just so useless. Initially I'd thought this was just the language barrier. I spoke good French thanks to having done it for A-level, but as only five per cent of patients speak French I became reliant on either my halting attempts at Malagasy or the nurses' translation, a task they performed with a range of ability, accuracy, enthusiasm, and frustration. It had reduced me to a machine asking yes/no questions. I felt almost totally unable to capture any of the human elements of people's stories that makes medicine an art, much less effectively communicate any real sympathy, compassion or love, and still less, to explain anything at all of Jesus's love for the people I was seeing. I was useless, in fact probably worse than useless. I was a burden on the nurses. I kept thinking, 'if only I knew more Malagasy I could do some good here'.

By month six, it had become increasingly clear to me that it wasn't even that. Even if I woke up tomorrow speaking perfect Malagasy, I would be at best a mediocre communicator of the gospel in this town. My life experience was so far removed from what my patients were going through and how they had grown up. Trying to explain the gospel in ways they would understand, or even express my own compassion in culturally relevant ways would take years to learn. Even then, with years of hard study, I would never have lived through a failed rice harvest that claimed two of my children; I would never have grown up in a world without electricity, and I cannot become Malagasy – even if I make every effort I will still be a *vazaha* (a European foreigner) and that alone would make the truths I'm trying to explain about Jesus seem strange and alien. Surely, a Malagasy doctor with my skills and convictions would do a much, much better job?

Perspective shift

While much of this was still true by month twelve, my perspective had begun to shift. I'd seen the gospel advance because missionaries were working with the Malagasy church in ways that perhaps wouldn't have happened if either had been working alone. I think in particular of a few young guys who got involved with the youth group at church after they'd initially befriended us in an effort to improve their English.

I'd seen a group of patients staring in confused fascination at my attempts to do a gospel talk in pre-school-level Malagasy, suddenly come alive with understanding as the nurse translated my clumsy sentences into an actual fluent explanation, adding her own illustrations along the way. And I'd seen in the welcome and warmth of the village churches in particular, the special sweetness that being one body, united as brothers and sisters in Christ has when you've started from so very far apart.

I'm not saying this is the final word on this, nor that my thinking is complete. I still feel the weight of the argument that this may not be the best way to make the biggest impact, but I am convinced serving on the front line in a mission hospital isn't useless, futile or harmful. Convinced enough that come August, God-willing, I will be going back.

Two tips for investigating mission work:

1. **Go and see**. Working out what does or doesn't help, whether this is a good use of your life and gifts is really hard to do from a sofa in East Anglia!

2. **Go for as long as possible.** While a short-term mission trip might still be valuable, you will not really get to the bottom of ministry in less than six months.

Nathan Lawrence *is a Core Medical Trainee in London*

More information on the Good News Hospital (Hopitaly Vaovao Mahafaly), Mandritsara can be found at *mandritsara.org.uk*

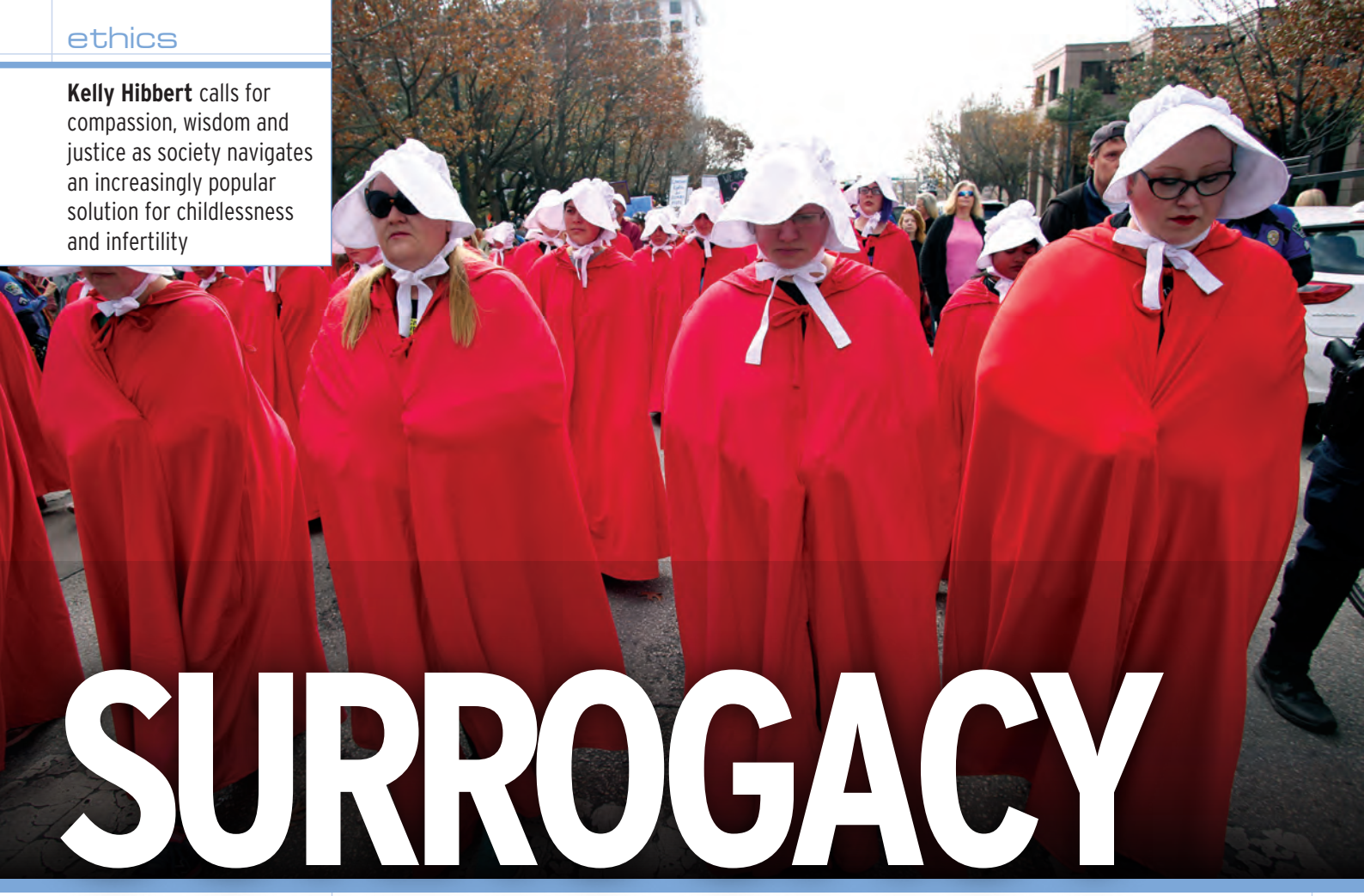
More information on short and long term healthcare mission opportunities, training and resources can be found on the CMF website at *cmf.org.uk/international*

Other short-term mission resources and opportunities can be found at *oscar.org.uk* and *globalconnections.org.uk*

FACTS

The Good News Hospital (Hopitaly Vaovao Mahafaly), Mandritsara was founded in 1995 by CMF members David and Jane Mann. It serves an area about half the size of Wales in a remote region of Northern Madagascar. Services include: a midwifery led maternity unit; a weekday outpatient unit; two 22 bed inpatient wards; two general surgical theatres and an ophthalmic surgery theatre; X-ray, ultrasound and path labs. They are always welcoming to volunteers and students on electives.

Kelly Hibbert calls for compassion, wisdom and justice as society navigates an increasingly popular solution for childlessness and infertility



SURROGACY

key points

- The unfulfilled desire for parenthood is a sad reality for many, and we must exercise compassion for people considering reproductive options.
- As with any reproductive technology, we need to consider: Just because we can produce a child using this technology, is it ethically and morally justifiable?
- Commercial surrogacy arrangements carry significant risk of exploitation. We should aim to defend the rights of the most vulnerable.

A brief internet search on 'surrogacy' will lead to many heart-warming stories of successful surrogacy experiences, a plethora of inspirational quotes and countless pictures of happy families, overflowing with gratefulness to their life-bringing surrogate. But there is a darker side.

Surrogacy is a complex, lucrative and global business. It is often poorly regulated and does not always result in a happy ending. As plans are underway to review the UK law on surrogacy, it's worth taking a deeper look at the issue.

Why choose surrogacy?

The heartbreak of infertility is real. One in seven couples struggle to conceive,[1] so most of us will know someone who faces this tragic reality. Michelle Obama recently revealed the emotional effect of suffering a miscarriage, before turning to IVF. 'I felt lost and alone, and I felt like I failed.'[2]

But some women have medical conditions that render them unable to carry a child, meaning that fertility treatments (such as IVF) are not an option. Same-sex couples seeking to start a family may opt to use a surrogate. As of January 2019, single people in the UK can also become a parent via surrogacy. There is also the worrying trend of 'social surrogacy' for entirely non-medical reasons: fear of losing a job or career, or concerns about the effect that pregnancy will have on their bodies.[3]

Surrogacy law

Currently, surrogacy legislation in the UK is based on the Surrogacy Arrangements Act 1985.[4] Under this Act, commercial surrogacy (ie. offering payment to surrogates) is forbidden – the surrogate only receives reasonable expenses. By implication, any surrogacy arrangement in the UK should be purely altruistic.

Further legislation under the Human Fertilisation and Embryology Act 1990[5] led to the introduction of 'parental orders'. At the time of birth, the surrogate is the legal parent of the baby and, if she has one, so is her partner. The intended parents must apply for a parental order to transfer legal parentage. The HFEA 2008 made it possible for a wider range of people to apply for parental orders, including people in civil partnerships.

The current law in the UK has been described as 'not fit for purpose'[6] and 'restrictive'.[7] In 2015, a survey carried out by the Surrogacy UK Working Group concluded that law reform was needed.[8] Therefore, the Law Commission, together with the Scottish Law Commission, has been granted £150,000[9] government funding to carry out a review of UK surrogacy law, with a view to implementing major legislative changes.

Aspects of the law which are likely to be reconsidered include:

1) Legal parenthood
2) International surrogacy
3) Regulation of surrogacy arrangements

Worryingly, there may be a radical move in favour of commercial surrogacy. At first glance, it may be tempting to think that women should be paid for selflessly enduring nine months of pregnancy. How is this different to providing any other service?

This is an important question and it's worth considering the experiences of other countries.

It does not take much digging to unearth dangerous practices around the world. Today, the US, Ukraine and Georgia see large numbers of UK citizens benefitting from their surrogacy services. Previously, India and Thailand were also popular hotspots for 'fertility tourism'. What can we learn from these two countries?

India used to be the world's largest international surrogacy destination, with an assisted reproduction industry worth £1.5 billion. A toxic combination of affordable costs, a large pool of surrogate mothers (usually impoverished women) and medical expertise allowed the industry to flourish. But in 2018, the Indian government passed the Surrogacy Bill, forbidding any foreign nationals from using surrogacy services in the country. The aim is to protect vulnerable and disadvantaged women from exploitation.

Similarly, legislative changes in Thailand followed some shocking examples. Consider the case of 'Baby Gammy', born to a Thai surrogate; diagnosed with Down syndrome, he was left behind while the commissioning parents took his twin sister home.[10] Or the 'baby factory' case: A 28-year-old Japanese millionaire was discovered to have fathered at least 16 children from Thai surrogate women.[11] These cases (amongst others) highlighted the risk of exploitation within Thailand's commercialised industry. In 2015, the government took the courageous step of banning commercial surrogacy for foreign nationals.

It is striking that countries which have experienced first-hand the devastating effects of commercial surrogacy have taken such radical steps to end it.

Biblical principles

We must not make light of the distress wrought by infertility. In the Bible, we read of tears shed, prayers uttered in desperation, and the sorrow of the barren womb. It's not wrong to want a child. Infertility is a result of the fall and it should cause our hearts to cry out, 'This isn't the way it was meant to be!'[12]

Medical and technological advancements are generous gifts from God, and it is good to use them to further his redemptive purposes in the world. This may include alleviating infertility. However, just because we can produce a child using a given technology, is it always morally right to do so?

On the surface, there are positive aspects of surrogacy. Many view it as an act of selfless generosity. There is beauty in giving; there is kindness in sharing.

However, we must not be naïve to the potential dangers, and the physical or emotional damage that could be caused. Whilst bearing in mind that Christians may come to different conclusions, and that every case is unique, it is good to evaluate surrogacy in the light of the Bible to help shape and guide our attitudes.

God's image

'Then God said, "Let us make mankind in our image, in our likeness…" So God created mankind in his own image, in the image of God he created them; male and female he created them.' (Genesis 1:26-27)

Human beings have the remarkable, undeserved privilege of being made in the image of God and therefore have a status and dignity that cannot be removed. Every child born through surrogacy is uniquely designed by God and valuable to him. Likewise, every surrogate mother, however poor or marginalised is precious to God with an inherent dignity as his image-bearer.

Surrogacy has been described as 'a form of exploitation of women and children, as it reduces the woman to a reproductive machine and the child to an asset in a business transaction'.[13] Do commercial surrogacy arrangements undermine the inherent dignity of humans made in God's image, by setting a price on the priceless? Perhaps the danger of exploitation and abuse is only a law change away.

Defending the vulnerable

'Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy.' (Proverbs 31:8-9)

Throughout Scripture, we read of God's heart for the vulnerable and his compassion for the needy. In speaking up for the voiceless and defending the rights of the poor, Christians mirror God's heart to a broken world. And who is more vulnerable than a newborn child?

The Law Commissions have stated the need to have 'surrogacy laws that work for the parents, the surrogate and *most importantly, the child*' [emphasis mine].[14] We should rightly seek to act in the best interests of the child.

Surrogates in the UK are commonly motivated by compassion. Nevertheless, it is a sad fact that the surrogate mother must be able to emotionally detach herself from the baby she is carrying in order to surrender the child willingly to the commissioning couple or individual. However, research shows that separating a newborn from its mother causes distress to the baby.[15] The surrogate is the person the baby needs most. Surely, the most fundamental right of the child is to be with the person who is most able to satisfy his or her needs? The current definition of the surrogate as the child's legal mother recognises this. We should seek to defend that right.

Our society holds the principles of autonomy, personal choice and individual rights in the highest esteem. At the same time, the possibilities offered by technology and science seem limitless. In our high-tech age of self-fulfilment, it may seem harsh to suggest that seemingly restrictive safeguards are just what society needs.

Navigating this issue with sensitivity is hard and we cannot do it in our own strength. We must pray for an abundance of wisdom and compassion – for babies, for surrogates and for all those longing to be parents.

Kelly Hibbert *is a junior doctor and a Deep:ER volunteer working with the CMF Public Policy team*

Surrogacy has been described as 'a form of exploitation of women and children, as it reduces the woman to a reproductive machine and the child to an asset in a business transaction'

references

1. Infertility. *NHS* 14 February 2017. *bit.ly/2EQBywa*
2. Ritschel C. Michelle Obama reveals she had a miscarriage before turning to IVF to conceive daughters: 'I felt lost and alone'. *The Independent* 9 November 2018. *ind.pn/2JR5hcD*
3. Kleeman J. 'Having a child doesn't fit into these women's schedule': is this the future of surrogacy? *The Guardian* 25 May 2019. *bit.ly/2Z5E6hP*
4. Surrogacy Arrangements Act 1985. *legislation.gov.uk*. *bit.ly/2IofqKH*
5. Human Fertilisation and Embryology Act 1990. *legislation.gov.uk*. *bit.ly/2WP2Op4*
6. Surrogacy laws set for reform as Law Commissions get Government backing. *Law Commission* 4 May 2018. *bit.ly/2jt6kjL*
7. Avramova N. The UK's restrictive surrogacy laws are hurting couples and pushing many abroad. *CNN* 18 January 2019. *cnn.it/2QFzLPo*
8. Working Group on Surrogacy Law Reform. Briefing Document. *Surrogacy UK*. December 2017. *bit.ly/2XkRDSc*
9. Fouzder M. Commission begins work on 'not fit for purpose' surrogacy laws. *The Law Society Gazette* 4 May 2018. *bit.ly/2H05fSe*
10. Thailand bans commercial surrogacy. *The Guardian* 20 February 2015. *bit.ly/2WGgh2s*
11. Mitsutoki Shigeta: 'Baby factory' dad wins paternity rights. *BBC News* 20 February 2018. *bbc.in/2wzE1qt*
12. Eg. Genesis 30:1-3; 1 Samuel 1:9-20
13. Portaru A. Renting Wombs is a Human Wrong, not a Human Right. *Public Discourse*. 27 April 2016. *bit.ly/2WmaQqf*
14. Surrogacy laws set for reform as Law Commissions get Government backing. *Law Commission* 4 May 2018. *bit.ly/2jt6kjL*
15. Maternal separation stresses the baby, research finds. *Science Daily*. 2 November 2011. *bit.ly/2leBTd5*

Following on from our last Juniors' Forum,[1] we focus on three groups to see how God is working in different ways around the country

JUNIORS' FELLOWSHIP GROUPS

New city, new job, new church... This is a familiar pattern for junior doctors, as training requires moving every few months or years. It's easy to feel unsettled and without anyone to turn to when life gets tough. This was my position when I first joined the *Hullies* in this friendly, quirky and remote part of Yorkshire. The junior doctors' group is a thriving support network, blessed by a local retired GP who offers up his house for dinner, discussion and prayer almost every week. With shifts, we can't all make it every time, but we know that we are always welcome to drop-in (even if it's just for the famous 'fusion risottos').

This year, we have been working through *Values Added*, a programme from PRIME (Partnerships in International Medical Education),[2] which has been challenging us about providing whole person medicine in the NHS. We share stories from the front line and discuss our dilemmas about how to live out our faith at work with accountability. We discuss what we have learnt and how it has made an impact on our everyday work. CMF provides plenty of resources for us to tap into for our discussions, and since I have been in Hull we have completed two courses: *Saline Solution*[3] and *The Human Journey*.[4]

> The junior doctors' group is a thriving support network, blessed by a local retired GP

While we are served by our juniors' group, we know it is important to serve the next cohort of juniors, and so we have linked with the local student group to run Bible studies and to support them to live out their faith as they step out on to the wards for the first time.

How could your group of juniors meet intentionally? How are you going to support and challenge each other as you train as Christian doctors?

This year, God has shown me the importance of little steps. Those seemingly 'trivial' conversations and 'fruitless' tasks can be woven together by God into something marvellous. Since moving to Portsmouth (somewhat reluctantly, I might add!) for Core Medical Training I have seen a small, but steadily growing, community of Christian healthcare workers develop.

God goes ahead of us and prepares the way for us to walk in. Long before I arrived, God had been stirring up the hearts of various individuals working within the hospital. There was a nurse working in training and development, who had for many years been faithfully, and often solitarily, praying for Christians within the hospital to unite and change the atmosphere – big dreams from a lady with a very big heart! There was also a pharmacist who felt prompted to run a hospital-based Alpha course for staff, and a research nurse with a heart for Christian community. All these individuals had desires that seemed no closer to realisation than when they were first thought of. Yet God led me again and again into conversations with many who were looking to see their identity as Christians impact their 'everyday' moments within the hospital.

> God led me again and again into conversations with many who were looking to see their identity as Christians impact their 'everyday' moments

As I worked, I met and formed friendships with Christian doctors, nurses and pharmacists, and over the past three years we have seen a small hospital-based Alpha course completed, started a monthly prayer meeting and now have a group of Christians who meet for food, fellowship and prayer at a home near the hospital. Though I haven't seen anything change significantly within the hospital, I have been very blessed by the fellowship and encouragement of fellow believers. I have been challenged to live more boldly for Christ and to trust that nothing, not a single moment is wasted with God.

Long shifts, random hours, and rotating every few months to different hospitals can take their toll on junior doctors, disrupting the usual rhythms of seeing family and friends, doing food shopping, exercise, and for Christians, church, small groups, and even quiet times – all things we need to stay well in mind, body and spirit. It can be difficult to switch off after intense shifts, especially when many specialities (including my own, paediatrics) are understaffed. You may feel that family and friends just don't understand. Not to mention exams and portfolios etc...

In West Yorkshire, we have created a 'home from home' for all our trainees. We have monthly events in the homes of members of our Catalyst Team,[5] where we share food and are ministered to. We often have a talk, but just as precious is the time before and during our meals catching up with everyone, from friends we've known for many years, to those on the same training schemes, to new additions – we have everyone from pre-medical students to retired consultants. In many ways, this set-up provides for us what we lack at work – a mix of juniors and seniors sharing life and supporting each other.

> In West Yorkshire, we have created a 'home from home' for all our trainees

We have run a series of Bible studies focused on resilience. We dug into how and why we can feel challenged by serious incidents, difficult working environments and what truths we can take from the Bible (as our armour) in what can feel like an uphill struggle. People were open about mental health problems and what they have found helpful to keep themselves going.

As CS Lewis put it: '*Friendship... is born at the moment when one man says to another "What! You too? I thought that no one but myself ..."*'[6] This really sums up what we aspire to in West Yorkshire, because when you know that God is with you and your friends are with you too, everything feels possible again.

Contributors: ***Tobi Adeagbo***, ***Katie Mayers*** *and* ***Rosalind Revans***

To share your stories email *Juniorsforum@cmf.org.uk*

references

1. Foot S. The body of Christian doctors. *Triple Helix* 2019; Spring: 9 *cmf.li/2lkjmfh*
2. Values Added. *values-added.org*
3. Saline Solution. *cmf.li/Saline*
4. The Human Journey. *humanjourney.org.uk*
5. CMF Catalyst. *cmf.li/Catalyst*
6. Lewis CS. *The Four Loves*. Glasgow: HarperCollins. 1960

David Jonathan Jones
looks at new opportunities for church engagement opened up by shift work

SHIFT WORK + THE LOCAL CHURCH

key points

- Becoming an F1 changes your relationship with your church in often dramatic ways.
- Starting in a new town, a new church and with new work patterns present a wide range of practical and spiritual challenges.
- Finding ways of meeting with and getting to know people in your church outside regular meetings and building a network of other Christian doctors is vital to keep you spiritually grounded.

The challenges of the leap from medical school to foundation training are well known: shift work, prescribing power, navigating the sometimes chaotic layout of a new hospital, traversing numerous IT systems, remembering countless log-ins and door codes, and coping with the challenges of short staffing (and the occasional resulting lack of senior support) are some well-known examples. What I failed to anticipate or adequately prepare for, however, was the impact that life as a junior doctor would have on me spiritually.

In a heartbeat, gone was the guarantee of a work-free Sunday, or of a free Wednesday evening to attend my church home group, or of a civilised nine am start to my working day that allowed me time to pray and read Scripture in the morning. Gone were my normal workday hours which so conveniently synchronised with the normal working day of every other church member I knew. Suddenly I found myself with days off midweek when all my friends seemed to be at work.

I was once a reliable church member, able to serve on numerous ministry teams and meet friends to socialise, or have fellowship at a regular time every week. Now my rota changed every four months and any meeting had to fit around this ever-changing rota. Not to mention, a 5pm scheduled finish time

In a heartbeat, gone was the guarantee of a work-free Sunday, or of a free Wednesday evening

that could, in reality mean anything from a 5-7pm finish time depending on the events of the day (staffing, patient illness, emergencies etc.). Then there were the night shifts, which hit me hard and seemed to eat into my days off. Rather than serve as true 'days off', this time had to be used to recover from rota-induced jet lag before soldiering through the next round of shifts.

Like many others transitioning to a new career stage, I had also moved to a new county to accept the training post I had been offered. Inevitably, this meant settling into a new church. How on earth could I start from scratch and put any firm roots down under these circumstances? Now it seemed, I couldn't commit to serve my local church in any of the roles I had previously enjoyed in my former church. I couldn't even commit to regular fellowship! I tried serving in a community outreach programme, but after another church member voiced frustration at my unreliability, I quickly stepped down. I felt spiritually disoriented, disengaged and disconnected.

I voiced my frustrations to my father-in-law (and friend) who happened to be an experienced church pastor, and then I heard it: simple, true, kind and obvious wisdom… how could I have been so blind?

'God has called you to a ministry of healing' he said. 'If all you can do is serve God through medicine then do that. Forget the other ministries; God has made you a doctor!'

Over the following months of ever-changing shifts and rotas, I prayed regularly, chaotically, spontaneously; read my Bible infrequently, unroutinely, yet reminding myself daily of God's grace. I am not saved by my works, my Bible reading or my prayers, but by Jesus's final great work. I opened up about my faith and found a work environment littered with Christians from all over the world: a lifeline, a 'church' in 'less-alone-ica'! My non-Christian colleagues became interested and would ask me about my faith and my ethical views. There were no dramatic conversions, but that was God's job not mine. I merely served as a witness.

I began using my weekdays off to meet one-on-one with pastors for coffee and I became fascinated by the similarities between their work and doctors: dealing with life and death, communication and counselling in times of crisis, being 'on call' for emergencies, and the rigorous academic study required for them to qualify. I also used midweek days off to meet retired Christian church members, mature in faith, as well as other church members I might not have naturally gravitated towards, but happened to be available midweek. (I even accompanied my wife to a mid-week women's Bible study, albeit to man the créche on an *ad hoc* basis!)

As a fan of mnemonics, I adapted what God was teaching me into a mnemonic I could use to encourage myself whenever needed (see right). I realise now that, contrary to my initial belief, shift work has its advantages: I have begun building diverse friendships, serving in unique areas of Christian ministry, in which 'regular hours' workers cannot easily serve, whilst remaining mindful that medicine is my primary ministry.

We work not for the NHS but for God; we are merely on extended NHS sabbaticals!

'*Whatever you do, work at it with all your heart, as working for the Lord, not for human masters.*' (Colossians 3:23)

'*Therefore, I urge you, brothers and sisters, in view of God's mercy, to offer your bodies as a living sacrifice, holy and pleasing to God – this is your true and proper worship.*' (Romans 12:1)

Thanks to the church members and leaders of All Saints Loose, Kent, who inspired this article and continue to offer endless encouragement, love and support. Thanks to Phil Playfoot (St John's, Crawley), my father-in-law and pastorally-gifted friend, for always listening.

David Jonathan Jones *is an ACCS-Acute Medicine trainee in Kent*

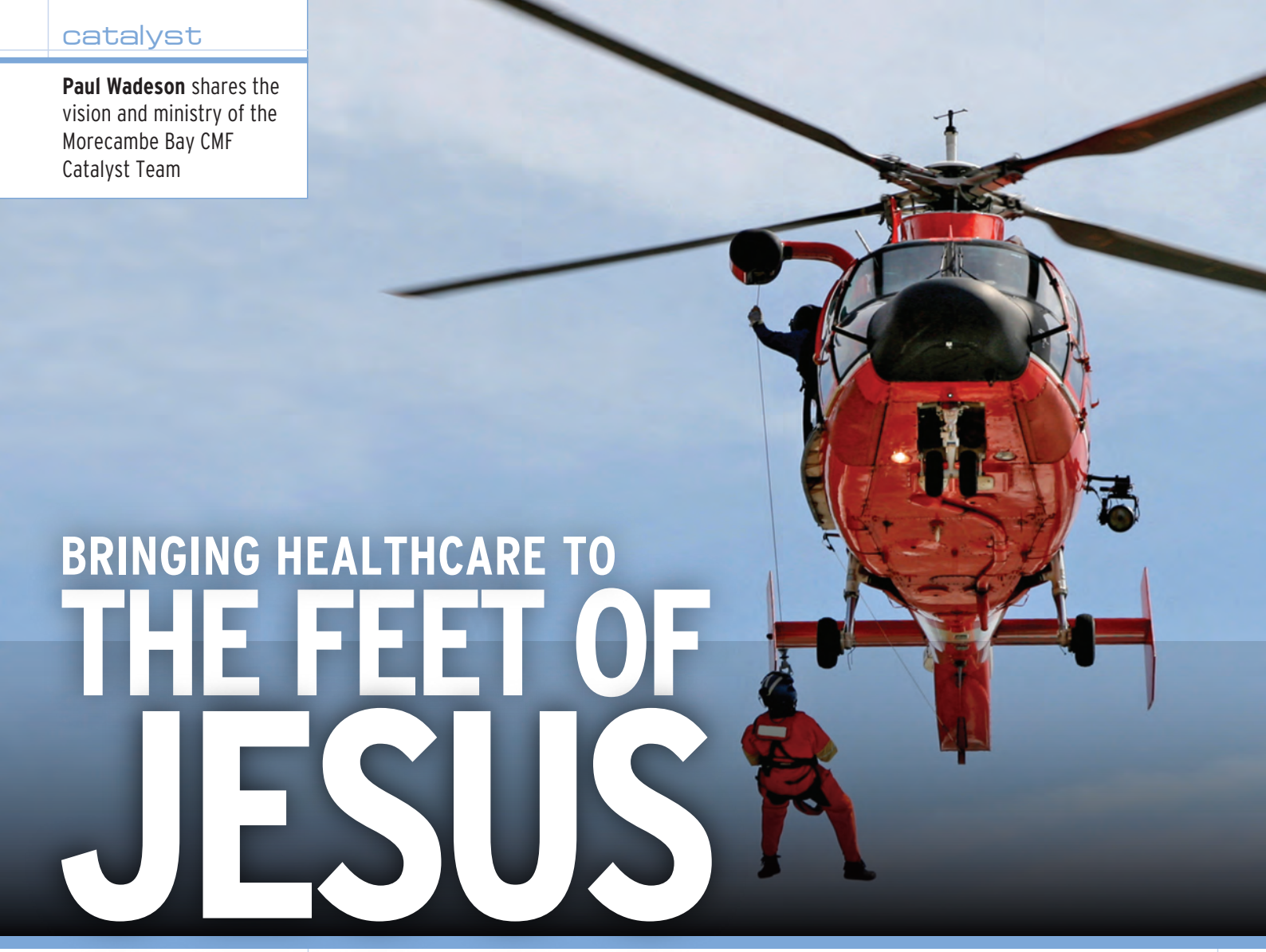
MEDICS: a mnemonic for shift workers

- **Meeting one-on-one:** Consider using some of your midweek days off to meet church pastors, retired Christian church members, and people you wouldn't naturally gravitate towards. You'll be surprised by how mutually edifying diverse friendships can be. [1]
- **Encouragement of others:** Physical absence doesn't have to mean total absence. Send emails, start remote discussions and consider sending written 'thank you' letters or emails to those who serve you and your family. These can have a huge and positive effect. [2]
- **Don't be late:** When you can attend church meetings, do everything you can to attend on time. Pastors will testify that this is very helpful and a great way to support them.
- **Intercession (prayer):** When you feel frustrated by work interfering with church-life. '*Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God.*' (Philippians: 4:6). Be open and honest with trustworthy church friends/pastors about the struggles of life as a junior doctor. Non-medical Christians will often be fascinated by your career and curious to follow-up your struggles. This can help add perspective as you are forced to reflect on problems over time. We all accept that it is sensible in a clinical context to ask for senior help early, this is also true spiritually, so do not hesitate in asking others to pray for you. [3] The Great Physician is listening.
- **Charity:** Be generous with your time, (covered under letters M, E, D and S) treasure and talents. Treasure – as doctors we earn more than other church members and have the ability to rapidly generate income through undertaking extra locum shifts. Be financially generous. [4] Talents – doctors are uniquely gifted and trained in learning and teaching, communication, leadership and public speaking, where practical use these talents to serve the church. [5, 6, 7]
- **Spontaneity:** Rolling rotas introduce a randomness to your life that can be frustrating and might not fit with your friends who work Monday-Friday, nine-to-five jobs. Try to embrace the spontaneity this introduces to your life rather than resent it. Note down what midweek ministries there are in your local church; speak to the leaders and consider becoming an extra pair of hands. Few leaders will turn you away if you show up and show willing! Serving *ad hoc* in more than one ministry can give you a unique view of church; a view you wouldn't have had if you were able to reliably commit to one ministry of your choice.

references

1. A useful resource on biblical friendship is Vaughan Roberts short book entitled *True Friendship*. Aimed at men, but applicable to anyone working demanding shifts that make friendships difficult. Roberts V. *True Friendship: Walking through life with your Christian Friends*. Leyland: 10 Publishing, 2013
2. Hebrews 10:24-25
3. 1 Timothy 2:1
4. 1 Timothy 6:17-19
5. Romans 12:10-13
6. 1 Peter 4:10
7. 1 Corinthians 12:4-7

Paul Wadeson shares the vision and ministry of the Morecambe Bay CMF Catalyst Team



BRINGING HEALTHCARE TO THE FEET OF JESUS

key points

- The NHS needs a compassionate, healing Christian presence as it deals with internal and external stresses.
- Christian health professionals cannot do this alone – we need one another.
- Working intentionally and prayerfully together in obedience to Christ, we can have a transformational effect on our workplaces and communities.

If you were to ask someone on the street one word they would use to describe Christians, what do you think they would say? Kind? Compassionate? Loving? I think if we are honest, there would be a mixed response. In fact, we might hear negative words such as 'judgmental' or 'intolerant'.

In Luke 4:22, we read: '*All spoke well of him and were amazed at the gracious words that came from his lips.*' It is unfortunate that Christians can be known more for what they are against than what they are for.

In John 1, Jesus is described as '*full of grace and truth*' (John 1:14). It is important to engage, and speak truth into ethical issues, but how can we also be known for our grace?

In Luke 5, we are told of a disabled man being lowered down through the roof to the feet of Jesus.[1] It's just so dramatic. You can imagine the four men trying to get him to Jesus, but the way in is blocked, mainly it seems by the Pharisees and Teachers of The Law, the ones with a reputation for being judgemental. The friends aren't deterred, they think outside of the box and lower the man through the roof. Jesus hears a sound and sees the man being lowered down. He 'sees their faith', declares the man is forgiven and demonstrates his authority to forgive by healing him.

My story

I qualified as a GP in 2005, and work in a practice based in Carnforth, Lancashire. I have recently become the Catalyst Team Leader for Morecambe Bay CMF which formed a year ago.

I love this healing story of Jesus because it sums up what the Morecambe Bay CMF Catalyst Team, is all about. I love the NHS. It has a dedicated, compassionate workforce, but in a lot of ways it is like the disabled man on the stretcher – needing healing. There are a lack of resources, high levels of stress and burnout and escalating issues of bullying. There are systemic issues related to poor communication and sometimes strained relationships between primary and secondary care and between management and the workers on the ground.

The Morecambe Bay team's tagline is to **bless, serve and bring hope**. We want to bring healthcare itself to the feet of Jesus to be healed and transformed and create a more compassionate, hope-filled culture. There are obstacles, like the crowds at the doors in the Luke account, but there are also ceiling breaking solutions, and Jesus is leading the way.

So how did our story start? I had just moved from being a salaried GP to a partner in my practice and was struggling with several issues, including a stressful, working environment, poor morale and some bullying. I remember going to my house group

and telling them that I was really struggling and thinking of resigning. An elderly lady in my group said she would commit to praying that the Lord would bring a Christian colleague into my practice to pray with. Three months later, through a very unlikely turn of events a new GP called Andy arrived. I felt a bit like I was in a Bond movie when I said to him, stroking my imaginary cat: 'I've been expecting you...'

We started to meet regularly to pray for each other and for God to turn the practice around, which he did in a series of events that still staggers me to recall.

Around that time, I approached a local Methodist minister and we set up a Listening Service in the practice, which was a way of helping the practice deliver more whole person care. In busy practice, we often don't have the time to listen fully and therapeutically to our patients. We had a CQC visit which rated the Listening Service as being 'Outstanding' and we shared the model with neighbouring practices to help them set up their own services.

From this, I learned that God responds when we cry out to him and about the transformational power of Christians gathering in their workplace to pray and support each other.

Not long after this my vicar encouraged me to go on a CPAS weekend to explore ordination. This was helpful in that while I didn't feel I was being called to ordained ministry, I did feel I had a clear call from God to form 'new centres on the edges'. I shared this with my vicar who encouraged me to focus on forming 'church on the edges' from within my role in healthcare.

So, a year ago, a few of us got together and formed the Morecambe Bay CMF (MBCMF) group. This group is very multidisciplinary in that we have had practice managers, receptionists, pharmacists, physios and OTs meet with us.

The group has an inward focus to support one other and explore together what it means to follow Jesus together in our workplaces. But we also have an outward focus, centred on serving, blessing and bringing hope to local healthcare.

Morecambe Bay Catalyst Team

However, we have only recently become an official Catalyst Team. When John Greenall (CMF National Field Director) came to share the concept with us, amazingly we found we had already formed a kind of 'proto-Catalyst Team' organically through the Holy Spirit's influence. So, when John told us about the vision for Catalyst Teams, it fitted like a glove, and we felt that we could benefit from the support and leadership of national CMF.

As a group, we gather together monthly, usually getting 20-30 people, alternating between a breakfast session with a relevant theme (eg. Parish Nursing, Culture of Joy, Dealing with Conflict) and a social (e.g. walk in the lakes, BBQ's etc.). We have a camping trip coming up in September, although some of us will be glamping!

We set up a Facebook group (Morecambe Bay CMF) which has over 100 members, we have a WhatsApp Bible in a year group, and an *Anam Cara* (soul friend in Gaelic) monthly book club.

We have been encouraged by our members saying that they feel the group is helping them connect their faith better with work. There have been several workplace-based prayer groups set up, both in GP practices and the hospital, where people are gathering to support each other and pray for their workplaces and patients.

So, what next? We want to continue to unite and equip Christians in healthcare to live and speak for Jesus Christ and to allow Jesus Christ to live and speak through them to bring healing and transformation to healthcare.

We have plans to run a Saline Solution course in Lancaster and to invite students. We have a team member who is focussed on allied health professionals who has the aim of bringing OTs, nurses, physios and others into the fold.

We are keen to connect with people who aren't CMF members. We have recently been authorised to advertise in the Trust and the GP news bulletins.

We have a particular concern for the growing workplace stress levels, particularly among junior doctors and nurses, and we are exploring how we can offer support. One idea was to put on a dinner for the new arrivals to the hospital with a talk on well-being at work. Another suggestion was to start a regular Bible study group for hospital workers to support each other and their colleagues. These are just a few ideas to encourage fellow Christians working in healthcare.

I have come to realise that all health and healing have their origin in Jesus. Healthcare is his instrument and he wants more than any of us to bring healing and wholeness through it. The amazing truth is that Jesus asks us to partner with him. He wants us to lay healthcare before him, so it can be healed and transformed so that it is fit for purpose. The other amazing truth is that we, the church, his body, are his hands of healing and transformation by the Holy Spirit. '*...for it is God who works in you to will and to act to fulfil his good purpose.*' (Philippians 2:13)

I'll leave you with a few questions to consider:

- What does it mean to bring healthcare before Jesus? What can you do? Can you gather with other Christians in your workplace? (If you don't know any Christians, pray for the Lord to bring you one.)
- What does it mean to be the hands of Jesus in healthcare? What would it look like for God's kingdom to come through us? Ask God to give you a vision of what this looks like, then commit to partnering with him to make this come to pass.

If you want to connect with us, look at our Morecambe Bay CMF Facebook page or email us on *morecambebaycmf@gmail.com*

***Paul Wadeson** is a GP in Carnforth, Lancashire and Catalyst Team Leader for Morecambe Bay*

I have come to realise that all health and healing have their origin in Jesus. Healthcare is his instrument and he wants more than any of us to bring healing and wholeness through it

CMF CATALYST

For more information on Catalyst Teams and setting one up in your area, visit *cmf.li/Catalyst* or email *volunteer@cmf.org.uk*

reference

1. Luke 5:17-16

I want a Christian psychiatrist:

Finding a path back to mental and spiritual wellbeing
Dr David Enoch

- Monarch Books, 2006, £8, 192pp, ISBN 9781854246844
- Reviewed by **Claire Wilson**, a Clinical Research Training Fellow in General Psychiatry in London

'I want a Christian psychiatrist' is the premise for Dr Enoch's reflections and is prompted by this same request that he has frequently received from prospective patients. He presents some of the difficulties faced by Christians experiencing mental illness, alongside opportunities for the Christian community to offer support.

Dr Enoch challenges some of these difficulties against a backdrop of parity of esteem between physical and mental health and asks us, should physical, spiritual and mental health really be any different?

While the book is suitable for the lay reader, it is also of relevance to Christian healthcare professionals, both psychiatrists and non-psychiatrists alike, indeed for all of those working with patients experiencing mental illness. It provides an insight into and rebuttal of the unique experiences of the mentally unwell Christian, including the guilt, shame and sense of failure.

Dr Enoch also highlights the barriers that these experiences can present to the Christian patient's engagement with treatment, and defends the medical model as one which can sit alongside pastoral support. Indeed, he discusses many similarities between Christianity and psychiatry and lessons that can be learned from both fields. In the process of so doing, he proposes several ways in which the church can serve members with mental illness, including prayer, counselling and a greater knowledge of the support available. As such, this is also a useful read for churches.

Thank God it's Monday (new edition)

Mark Greene

- Muddy Pearl, 2019, £13, 192 pages, ISBN 9781910012574
- Reviewed by **Liz Capper**, former Chief Nurse at St Bartholomew's Hospital in London and a former CMF Trustee

In the secular world of the NHS, you can talk openly and passionately about football, pop artists or *Strictly Come Dancing*, but not about your Christian faith. This book reminds us that we spend more time with our colleagues at work than almost anyone else. As Christians, our behaviour, attitudes and responses to every up and down are under constant scrutiny. Our lives tell out the reality of our faith.

Mark Greene regrets the lack of teaching from church leaders to help Christians focus on opportunities to witness in their day-to-day activity. Church members need to have their eyes open to the pressure individuals face and to commit to pray for boldness, courage and wisdom for each other. Greene reminds us there is not a hierarchy of Christian service. God calls each individual to serve him and make him known wherever they find themselves.

It is essential that Christians working in healthcare become part of a group who will pray and keep contact with non-believing staff. Shift work makes regular commitment difficult and it is easy to drift away and loose heart, but understanding and support keeps Christians in the health service focused on living for the Lord.

Nursing and medical students are actively warned about the inappropriateness of talking about faith matters.
The fear of being accused of intolerance or religious offence is very real. It can suppress a Christian's witness at work to the extent of only being open about faith off duty.
This book reminds us of all Jesus has done for us and the imperative of telling others. It demonstrates that intentional praying, godly living and wise use of opportunities can wonderfully open doors.

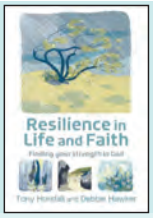
Lifecare

Solome Skaff

- Muddy Pearl, 2019, £15, 254pp, ISBN 9781910012611
- Reviewed by **Angharad Gray**, a psychiatrist working in Buckinghamshire

We are all in need of emotional healing and strengthening – to a greater or lesser extent. *Lifecare* is a purpose-filled 'course in a book' that I can wholeheartedly recommend. Biblically sound and God-honouring, it is richly insightful in its approach to the mind and is psychologically mature. It illuminates a way for us to thrive mentally and spiritually whilst growing in faith in Christ.
Particularly helpful are the interactive pages toward the end of each chapter, as they encourage the reader to engage actively at a level that makes this book an accessible, personal learning experience. The author maintains a careful and sensitive awareness to the probability that some readers may well have experienced deeply traumatic and complex interpersonal problems, pointing to the hope of transformational change ahead (yes, possible even in this life) through grace.

Although it may be the case that God could perhaps use this book to draw a person to Christ, it is essentially a book written to encourage and empower those who have already come to faith, as the basis for encouragement discussed rests largely on the work accomplished from justification, plus sanctification and discipleship. It is my impression that for some, either attending a face-to-face *Lifecare* course, or alternatively, committing to systematically working through the book with a trusted and mature believer, (rather than studying alone) would help maintain the necessary motivational strength, patience and resilience for change, to make this the efficacious, life-changing experience intended by the author.



Resilience in life and faith

Finding your strength in God
Tony Horsfall & Debbie Hawker

- Bible Reading Fellowship, 2019, £10, 192pp, ISBN 9780857467348
- Reviewed by **Julian Churcher**, a psychotherapist, painter, and a former GP and CMF staff member

Fluently written and an enjoyable read, the two authors of this volume complement each other in style and emphasis, clearly bringing seasoned experience to their subject. Drawing from a variety of disciplines, they reference other sources dating from the 1960s to the present.

Their approach is to describe spiritual, physical, emotional, cognitive and social aspects of resilience, while always emphasising the interconnectedness of each. Male, Old Testament examples of each aspect are interestingly described. A separate chapter looks at resilient women in the Bible. Paul's experience ('strength in weakness') and the supreme model of Jesus, illustrate resilience under the new covenant.

What can occasionally sound like trite advice (ie. to eat sensibly and get enough exercise, sleep and recreation) that might elicit a justified groan from hard-pressed clinicians, is put in the context of community. Interdependence and honesty about our emotional life are commendably promoted. The reader is urged more than once (with a helpful reading list) to develop in advance their theology of suffering.

Reading this has helped shift my perception of 'resilience' from simply 'individual toughness in adversity' to a more social concept, something like: 'doing life well in communion with God and in community with people'.

I loved reading that: '*Sometimes resilient people stay during a crisis, and sometimes they go*'. This typifies the imaginative, creative, flexible and above all wise approach of this volume, which I highly recommend.

Am I just my brain?

Sharon Dirckx

- The Good Book Company, 2019, £8, 128pp, ISBN 9781784982751
- Reviewed by **Rebecca Hodnett,** a Clinical Teaching Fellow at the Royal United Hospital, Bath

I was intrigued when I received my copy of this small, but potent book through the post. As a doctor and a soon to be neurosurgical trainee, I have come across many colleagues at work who would strongly favour the stance that we are simply our brains, and that the advances in neuroscience through functional imaging are proof of this.

Dr Sharon Dirckx has a deep history with both the world of neuroscience and apologetics. With her gift of teaching, she begins to unpack the underlying assumptions behind these questions: Why do we think? Are we purely machines? Is the belief in a soul out of date? Is free will an illusion? Has science finally explained religion away?

This book gives us a framework to tackle these questions and helpfully includes a glossary of terminologies early on (for which I was most grateful for). Dr Dirckx successfully presents balanced arguments, condensing and explaining the findings in neuroscience. Her argument is further enriched with long-standing philosophical perspectives whilst bringing us back to what the Bible has to say on the topic.

'Brains don't think; people think using their brains!'

The book brings us to the conclusion that our consciousness, which gives meaning to our thoughts, must come from a meaningful and conscious creator God!

A comprehensive yet accessible read – I would challenge you to not only read this for yourself, but also to share it with your sceptical colleagues!

General practice as if people mattered

Collected medical essays 1998 - 2017
Dr Gervase Vernon

- CreateSpace Independent Publishing Platform, 2018, £5, 202pp, ISBN 9781984360168
- Reviewed by **James Tomlinson**, a practising GP living in Birmingham

A collection of essays on diverse themes, this is a book to dip into and savour. The author's insights are shaped both by his Christian faith and by his work as a doctor in Malawi, as a GP in Essex and as a medical examiner working with a charity supporting asylum seeker health. The overall impression from these disparate pieces (many previously published in the *British Journal of General Practice*) is that of a person-centred doctor with a passion to practise good, value-derived medicine.

The writing is reflective, rich and honest considering carefully the authors experience alongside relevant literature. Helpful anecdotes are shared and lessons drawn. For me, the sections on what is a GP, the consultation, and the place of moral dialogue with our patients were thought-provoking and refreshing.

A recurring theme through the book is the challenge and limitation of converting the stories, patients tell us, with their differing framework of understanding for their symptoms, into the doctor's language – that of science and the rational (and conversely, interpreting the understanding of medicine to the patient).

With increased expectations on our limited (10 minute) consultation time as GPs both from patients themselves and from the State (eg. Quality and Outcomes Framework targets, medicines management, electronic referral, etc.), this book is a timely reminder that we can and must practise medicine as if people really matter.

eutychus

Crowdfunding treatment

Resource allocation is not a glamorous topic, but it can be a matter of life or death. We often pride ourselves in the UK that we have a health system that allocates funding according to need rather than ability to pay. That is unless you have a rare condition for which the only treatments are experimental or not yet licensed or funded on the NHS. There is an increasing trend to use crowdfunding websites to raise money to pay for such treatments for individuals. If you are a child with a sympathetic story that will attract funding, that can potentially be the difference between life and death. But spare a thought for those who have less 'fashionable' or appealing disease stories and cannot elicit public sympathy for their crowdfunded treatment. Furthermore, those who raise the funding can sometimes do so for a treatment with marginal or no benefit, over those who don't get the attention for treatments that might actually improve or save a life. Access to healthcare should not be based on a 'beauty contest'. *The Guardian* 20 May 2019 *bit.ly/2WI9LJe*

Stem cells offer heart transplant alternative

Yes, stem cell medicine is once again making hearts beat. Quite literally in this case, as tissue patches made of stem cells have been shown to repair damaged heart tissue and restore normal function in animal tests. The hope is that this will enable the repair of cardiac tissue damaged by ischaemic heart disease, restoring function, reducing mortality and reducing the need for heart transplants. Human clinical trials are a way off, and there are still many questions to address, but the potential benefits of adult stem cell medicine are becoming more and more apparent. *The Times* 4 June 2019 *bit.ly/2Rb93OW*

Pregnant women's 'safety bubble' expands in third trimester

The annoying habit of putting one's hand on a pregnant woman's stomach may be even more annoying than people realise. According to researchers at Anglia Ruskin University and Addenbrooke's Hospital, women's sense of personal space alters significantly in the third trimester, possibly as a protective mechanism. Or maybe it's just because they are irritated at people prodding and poking them in the name of research! Either way, next time you are tempted to place an unsolicited hand on a pregnancy bump, think twice, stand well back and ask permission first! *The Independent* 13 June 2019 *ind.pn/31zNRa4*

Death of a Dutch teenager

Frenzy erupted in the English-speaking press after it was reported that doctors had euthanised 17-year-old Noa Pothoven in the Netherlands. Noa suffered anorexia nervosa and had asked to have her life ended because of unbearable suffering. In reality, she was refused euthanasia as she did not meet with the criteria set out in Dutch legislation. However, with doctors and her parents, she had come to an agreement that she could starve herself to death with no intervention. Hysterical reporting of such stories does not help us to weigh up the ethics of allowing someone to die because of a mental illness, and of the real human tragedy for Noa and her family. *The Times* 5 June 2019 *bit.ly/2WBWZY3*

Freedom of conscience in Canada

CMF's sister body, CMDS Canada, along with several other pro-life and faith-based physician groups have made appeals to the Canadian courts against the issue of forced referrals for assisted suicide and euthanasia. By misrepresenting this as purely an issue of religion, the wider issue of the precedent set by forced referral on all areas of freedom of conscience has largely been overlooked by the Canadian courts and media. Many in the Canadian legal and medical professions now argue that freedom of conscience is 'one of the foundations of a democratic society', and that respecting this is not a binary conflict with the interest of patients. We wait to see if Canada resolves this, as the implications across 'The Pond' will be significant. *The Epoch Times* 28 May 2019 *bit.ly/30ShxyC*

China toughens gene editing rules

In late 2018, He Jiankui, a clinical researcher in Shenzhen, China, announced the birth of twins whom he had genetically modified for HIV immunity. This first (as yet unattested) case of human germline gene editing caused a global outrage, not least because of the lack of knowledge about the potential unintended consequences of such genetic engineering. The Shenzhen hospital where this happened now claim that He had no formal ethical approval for the procedure, and he was subsequently fired. The Beijing government has republished its guidelines, insisting that all such research requires full ethical approval and that human germline alteration is forbidden. China now joins most of the rest of the world in resisting human germline engineering. *The Hindu* 2 June 2019 *bit.ly/2IS8HJp*

In utero keyhole surgery for spina bifida

In a world first, surgeons at King's College hospital operated on a 27-week fetus *in utero* to close the exposed spinal cord of a baby with spina bifida. While the child was born prematurely six weeks later, early signs are good. Long-term, if he fares well and others are operated on successfully, this technique could reduce the number of children born with severe disabilities from spina bifida. It should also reduce the number of spina bifida babies being aborted because of the condition. *BBC News* 17 May 2019 *bbc.in/2VwA3sL*

AI is better than specialist doctors at diagnosing lung cancer

Yes, it seems that in addition to robot surgeons and caring machines, we also have expert systems that are taking over diagnostics. Researchers at Northwestern University in Illinois found that an Artificial Inteligence (AI) system was able to detect early cancer and pre-cancer in lung x-rays with greater efficiency than human radiologists. This has the potential to increase the efficacy of screening programmes and save lives. While it is stressed that this does not dispense with the need for human diagnosticians altogether, it is another area where machine learning has the potential to replace or diminish the role of professionals. Regardless, the role of diagnosticians will change as they work more and more closely with AI to improve the accuracy of diagnoses. *BBC News* 20 May 2019 *bbc.in/2JBjN8r*

Steve Fouch looks at our relationship with our Heavenly Father

OUR HEAVENLY DAD

'Because you are his sons, God sent the Spirit of his Son into our hearts, the Spirit who calls out, 'Abba, Father.' So you are no longer a slave, but God's child; and since you are his child, God has made you also an heir' Galatians 4:6-7

At a recent CMF conference, a young boy of no more than 18-months was discovering the freedom of walking and exploring a new place, when he ran up to me. I started to chat to him, but within seconds he heard his dad calling him, and ran off, climbing into his father's arms before looking at me and proceeding to point and exclaim at all the new things around him. Confident in his father's arms, he was happy to talk to me.

Abba is the Aramaic informal name for father, based on that most primitive exclamation of small children that we all know; *dada*, *baba*, *abba*. Jesus calls his heavenly Father *Abba* in Gethsemane as he prays for the cup to pass him by.[1] Paul twice urges Christians to remember that through Jesus's death and resurrection they are adopted into God's family as heirs (ie. like a first born son in a first century Jewish household) and so to call God *Abba*.[2]

That is both the intimacy and the amazing privilege that God pours out on us.

Like that father with his son, God holds us, protects and shields us, so that we can have confidence. He disciplines, comforts, guides and protects. He holds our hands when we are unsure, but lets us roam and discover, and when we get lost, he comes and finds us. He is our 'heavenly Dad'. There are times for formality, to approach his heavenly throne with awe and respect, penitence and worship, but there are also times when we are welcomed to just run into his presence like a child with their daddy.

Not everyone has had that kind of relationship with their human father, so it is not always easy to approach God in this way. It can be a painful process to let go of the damaged view of fatherhood our own dads may have given us. But ultimately that is what he wants for us all: To know him as our 'Dad in heaven'.

***Steve Fouch** is CMF Head of Communications*

references

1. Mark 14:36
2. Romans 8:15-17

cmf.org.uk/resources

CMF
Christian Medical Fellowship