Winter 2016

for today's Christian doctor

triple helix

NHS in crisis

values; boundaries in bioethics; stress and burnout; transgenderism

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

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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.

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CMF
Christian Medical Fellowship

No. 67 Winter 2016

contents

Christmas
The miracle of the incarnation

Many of our colleagues are sceptical of the miraculous elements in the life of Jesus Christ: the virgin birth, the healing miracles and the resurrection. They 'know' as health professionals that such things are medically impossible.

But the real miracle, on which all rests, and which we celebrate at Christmas, is actually the incarnation, the Word becoming flesh.[1] CS Lewis, in his classic book *Miracles*, calls it 'the grand miracle'.[2]

If we can accept the incarnation – the idea that God could become a human being – then all other aspects of Jesus' life naturally follow on. They are exactly what we would expect if God were walking on the earth.

Apologist Josh McDowell has suggested that if God became a man we would expect to see the following things:[3]

- He would have an unusual entry into life – which is exactly what we find in the virgin birth.
- He would be morally perfect. When Jesus challenged others to find him guilty of sin no one could answer.[4]
- If God became a man, we'd expect him to perform astounding miracles. The gospel accounts are full of them: he heals those who are deaf, blind and paralysed; he calms storms, walks on water and turns water into wine. According to eyewitnesses, Jesus healed diseases for which even today there is no treatment; instantaneously, irreversibly and unambiguously.
- We'd expect him to speak the greatest words ever spoken. People responded to Jesus in amazement. 'How did this man get such learning without having been taught?'[5] 'No one ever spoke the way this man does'.[6]

  Psychiatrist James Fisher has written: 'If you were to take the sum total of all the authoritative articles ever written by the most qualified of psychologists and psychiatrists on the subject of mental hygiene – if you were to combine them and refine them and cleave out all the excess verbiage – if you were to have these unadulterated bits of pure scientific knowledge concisely expressed by the most capable of living poets, you would have an awkward and incomplete summation of the Sermon on the Mount'.[7]
- If God became a man, we would expect him to have a lasting and universal influence. Why is it that all religions try to accommodate Jesus somehow, to find a place for him? In the words of historian Kenneth Latourette, it is simply because 'measured by his effect on history, Jesus is the most influential life ever lived',[8] profoundly shaping our worldview, our laws, our history, our culture.
- We would expect him to satisfy the spiritual hunger in man. Millions testify that Jesus Christ has filled the spiritual vacuum in their lives; that his promise that those who come to him will not thirst or hunger is amazingly true.[9]
- Finally, if God became a man, we would expect him to exercise power over death. The resurrection of Jesus Christ is the best attested historical fact in all of antiquity; over 500 witnesses to his rising from the dead.[10] It is the only logical explanation for the empty tomb, the dramatic change in the disciples and the spread of the early church.

But what does the incarnation mean for us personally?

First, it reminds us that Jesus understands us. He knows what it is like to be a human being. He knows hunger and thirst, pain and sorrow, bereavement and loss, rejection and betrayal. As the writer of Hebrews tells us, he can sympathise with our weaknesses because he has been tempted in every way as we are, and much more.[11]

Second, it reminds us that Jesus can help us: 'because he himself suffered when he was tempted, he is able to help those who are being tempted'.[12] What are our areas of weakness? What do we despair over? What is it that is stopping us growing as Christians? What is it we are fighting that perhaps no one else sees or knows about? He is able to help us.

Third, the incarnation is a model for us in our own Christian lives. We are called to walk in Jesus' footsteps. The cross is a pattern for us to follow. We are to carry the cross,[13] to take our share of suffering,[14] to bear the burdens of others.[15]

Fourth, the incarnation helps us in our evangelism. It challenges us to cross social barriers as Jesus did, to make ourselves accessible and vulnerable, in the way that Jesus was, to be, in the words of Paul, 'all things to all people'.[16]

But finally, and most importantly, the incarnation reminds us of why Jesus came, because Christmas is the prelude to Easter. The same Jesus who grew in the womb and lay in the manger was sent to die on a cross and rise from the dead in order to reconcile us to God.[17]

Christmas starts and ends with Jesus Christ. Let's keep him at the centre.

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

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news reviews

NIPT

Eugenics by another name

Review by **Peter Saunders**
CMF Chief Executive

The government, on 30 October, approved a new test for pregnant women that will make it much easier to detect and destroy babies with Down's syndrome (DS) in utero. According to the BBC, the non-invasive prenatal test (NIPT) will be rolled out by the NHS from 2018.[1]

It is claimed that NIPT will reduce the number of women who need invasive tests like amniocentesis and chorion villus biopsy, which carry a 1-2% risk of miscarriage.

The move to make NIPT available on the NHS is deeply controversial[2] and has led to the launch of the 'Don't Screen Us Out' (DSUO) campaign.[3] DSUO describes itself 'as a grass-roots initiative supported by a collection of people with Down's syndrome, families and Down's syndrome advocate groups led by Saving Downs Syndrome'.[4]

They say that, given the fact that 90% of babies who are prenatally diagnosed with Down's syndrome are currently aborted,[5] the result will be 'a profound increase in the number of children with Down's syndrome screened out by termination'.

A new study published in the *British Medical Journal* on 4 July 2016 backs up their concerns.[6]

The lead author professor Lyn Chitty and her colleagues calculate that in an annual UK screening population of 698,500, offering NIPT (as a contingent test to women with a Down's syndrome screening risk of at least one in 150) would increase detection by 195 cases with 3,368 fewer invasive tests but, crucially, only 17 *fewer* procedure related miscarriages.

If rolling out NIPT will result in 195 more babies with Down's syndrome being detected, then assuming that 90% will then be aborted, that means almost 180 more abortions for Down's syndrome each year. In total last year there were 3,213 babies with disabilities aborted in Britain, over 1,000 of them more than halfway through pregnancy. Of these, 689 had Down's syndrome.[7]

Sally Phillips drew attention to the issue dramatically in a BBC documentary *A World Without Down's Syndrome*,[8] which aired on 5 October. 'What's so dreadful, to the world, about Down's syndrome?' she asked. The *Bridget Jones* actress, who has a son with the condition, questioned the ethics of pregnancy screening and abortion and asked why affected babies are viewed as a 'burden' on society.

The real test of a society is in what it values and in particular how it treats its most vulnerable members, especially when it costs something emotionally and financially to do so.

Britain, by this reckoning, is not heading in a good direction.

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The Sustainable Development Goals one year on

A great opportunity for the church to grasp

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

How do you transform the world? Marx thought it would be through the revolution of the proletariat, while Facebook expect it to be the ubiquity of their social network.

The United Nations have pinned their transformational agenda on 17 Sustainable Development Goals (SDGs).[1] The SDGs cover everything from ending poverty and hunger by 2030 to taking action on climate change and social inequality. There are 169 targets, and a complex system of standardised metrics to evaluate progress towards them. This is a truly ambitious and all-encompassing agenda. It is hard to think of many national governments, even with a strong electoral mandate, that would dare to have a manifesto laden with such high expectations.

At the heart of the Gospel is a God who redeemed a broken and hurting humanity through Jesus' death on the cross. He continues to work through the Holy Spirit and in the church around the world.[2]

While the SDGs echo some of the practical outworking of this biblical hope,[3] we have to be aware that the Bible also warns us that the powers and kingdoms of this world will, in time, all bow before Christ.[4]

So is there a case for a Christian engagement with the SDGs? The answer is a qualified 'yes'. For, while the UN system *does* seem to want to work with us at the moment, and there is room for partnership, we must be as 'wise as serpents yet innocent as doves'.[5] While much in the SDGs is admirable, the devil is always in the detail. We should never compromise the values of God's kingdom nor our mandate to proclaim the good news of Jesus to every corner of creation.[6] In cooperating with the UN and major donors and governments, we should always be upfront about our values and priorities. 'Co-belligerence' is good but it has its limits.[7]

The SDGs present a great opportunity for the church to fulfil its missionary calling. If that call currently happens to coincide with the agenda of the UN and secular funders, that is great – we will work together. God is bigger than the church and his kingdom is being worked out in the 'secular' as well as the 'sacred'. But if God's agenda and that of the wider world no longer coincide, then we will continue to do the work to which we have been called regardless, because in the end we serve the highest authority.

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PrEP

Big questions remain

Review by **Peter Saunders**
CMF Chief Executive

The Court of Appeal ruled on 10 November that the NHS in England can fund a drug that can reduce the chance of people catching HIV whilst engaging in high-risk sexual activities.[1]

The once-a-day pill known as PrEP, trade-named *Truvada*, consists of two antiretroviral medications used for the treatment of HIV/AIDS (tenofovir and emtricitabine or TDF-FTC) and costs £400 a month per person. The total cost to the health service could be in the order of £10-20m.[2]

According to the CDC (Centers for Disease Control) PrEP is for people who do not have HIV but who are at substantial risk of getting it. It should be used in combination with other 'HIV prevention' methods, such as condoms, but even in these circumstances is not foolproof.[3]

The CDC reports studies that have shown PrEP reduces the risk of getting HIV from sex by more than 90% when used consistently.[4] Among people who inject drugs, PrEP reduces the risk of getting HIV by more than 70% when used consistently. But these figures are what is achievable with good adherence (consistent use), and many of those most at risk are very likely not to adhere to taking the pills regularly.

An authoritative Cochrane review is far less reassuring. Overall, results from four trials (Baeten 2012; Van Damme 2012; Grant 2010; Thigpen 2012) that compared TDF-FTC versus placebo showed a reduction in the risk of acquiring HIV infection by about 51%.[5] Marked differences between the studies were attributed to differences in levels of adherence.

Many will be shocked at the levels of promiscuity reported in these high-risk groups. In one study in the Cochrane database, during screening, participants reported an average of twelve coital acts per week with an average of 21 sexual partners in the previous 30 days.

It is only when these facts are known that the highly addictive nature of high-risk sexual activity, especially amongst male homosexuals, becomes evident. PrEP is not a prevention strategy at all. It is rather a harm reduction strategy aimed at lessening the damage that people addicted to high-risk sexual behaviours are doing to themselves. More akin to clean needles for drug addicts, filter cigarettes for smokers, protective gloves for compulsive burglars or seatbelts for habitual joy-riders.

NHS England was right to challenge this judgment which lumbers them with funding an unproven drug. The only effective way of preventing HIV infections, as opposed to *reducing the chance of catching them*, is by addressing the high-risk sexual behaviours that lead to them.

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Sex education programmes are largely ineffectual

Large new research review

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

A recent Cochrane review of studies on school-based sex education, combining peer-reviewed data from more than 55,000 young people from Europe, Latin America and sub-Saharan Africa, has found that the mainstay of the current approach to sex education is not working.[1]

School-based sexual and reproductive health programmes are widely accepted and implemented as an approach to reducing high-risk sexual behaviour among adolescents, however when the Cochrane review looked at the impact of such programmes on pregnancy rates and sexually transmitted infections (STIs) they found no significant reductions in either among the young. Lead author of the review, Dr Mason-Jones said: '*As they are currently designed, sex education programmes alone probably have no effect on the number of young people infected with HIV, other STIs or the number of pregnancies…*'[2]

More positively, the review also found that a small cash payment, or free school uniform, can encourage students to remain at school, especially in places with financial barriers to attending, which helps to reduce pregnancy rates and STIs.

The authors say that previous reviews of sex education programmes are based on self-reported behaviours of young people, which are prone to bias and are notoriously unreliable, whereas the Cochrane review only included studies featuring objective measurable biological outcomes from records or tests of pregnancy and STIs. When the authors excluded studies that were at high-risk of bias, they found 'no effect' on long-term pregnancy prevalence in the remaining studies.

Clearly further objective measurable evidence is needed, because if current sex education programmes are not working to reduce pregnancy and STIs among the young, this is highly significant. It may be that current primary prevention strategies for STIs and unintended pregnancies need to be re-evaluated.

Dr Trevor Stammers in a 2007 BMJ editorial warned that promoting correct use of condoms will not lead to a reduction in STI rates and pregnancies because much teenage sex has little to do with sex itself but is connected with a search for meaning, identity and belonging.[3] The Cochrane review cites the need to address wider structural issues (in this case, educational achievement). Stammers would add parental influence as well. Certainly, a much more comprehensive approach is key to improving outcomes, incorporating parental involvement and opportunities for young people.

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Richard Vincent reflects on why we need to be clear about our values and our reasons for holding them

WEAR YOUR VALUES

key points

- Values are a key force shaping our attitudes and behaviour.
- Identifying our internal values is a valuable exercise, helped by reflecting on our priorities and our actions.
- The Bible gives many examples of the values Christians are called to adopt as our basis for living and we are given the Holy Spirit to help us.

The idea for the title of this article emerged after seeing an advertisement for eco-friendly jeans. By buying 'sustainable' denim, your purchase would not only bring sartorial excellence but would also proclaim values of global ecology and fair trade. These values, as the manufacturers hoped, could be a deciding factor in choosing their brand.

Values feature increasingly in the dialogue and presentation of organisations, authorities, and professional groups. They serve to define the key drivers and characteristics of their operation and, by implication, the desired attitudes and motivation of those who work within them. Our personal values, arising from our core beliefs, are the most energetic determinants of our behaviour.[1] They provide an internal guide to our choices in all situations.[2] They powerfully influence the attitudes and decision-making that become visible in our actions, our priorities and our relationships.

Values are described in various ways, though often only by a single word or brief phrase – *altruism* or *working in partnership with a wider team*, for example.[3] They vary in scope from broad ideals covering many situations, as in *faithfulness* or *justice*, to more specific applications, such as *continuing improvement* or *timeliness*. These latter examples often reflect behaviours that fall within a broader principle; for example, the value of *punctuality* could be seen as part of the more general value of *respect*. When used by organisations these more specific values can often be re-cast as goals or objectives. The boundaries of these various definitions seem rather porous, though all present behaviour judged to be ideal. 'Higher' values focus as much on our attitude to others as on the behaviours that they endorse.

All good?

In speaking about values it is usually implicit that they are *good*, portraying a high moral code and enabling individuals and communities to flourish. Such positive values – particularly those with wide application – can be considered *virtues*. In turn these can be built into a wise system of ethics set alongside systems based on rules (deontology), principalism or consequences (utilitarianism).[4]

But values may also be potentially limiting with negative effects on our personal growth and peace as well as separation, doubt and mistrust in relationships with others. These adverse effects may well arise in practice if, for example, the values of popularity, control or wealth provide our overriding motivation.

Know your values

We are encouraged to reflect on the personal values that shape our lives and our clinical practice.[5] Teasing them out, however, may be more difficult than expected. In the 'iceberg model' of NHS culture,[6] while behaviours and discourse stand out visibly above the water-line, the foundational beliefs, attitudes, and values that support them are darkly submerged. Searching for them requires heart and mind, curiosity and honesty; and it is befitting that we make the attempt in a spirit of prayer. Self-deception always crouches at our door,

prompting us to list more noble values than those which, in reality, determine our day-to-day decisions, actions, and reactions.

One practical way to start an exploration of our values system is to use the acronym **SALTED**:

S - spending: on what do you spend your time and your money?
A - anger: what makes you most angry?
L - loss: what would you consider your greatest loss?
T - trust: when things are overwhelmingly threatening, whom or what do you really trust most?
E - energy: what energises you most?
D - delight: what causes you the greatest delight?

Another approach, particularly in relation to clinical practice, is to list the values and characteristics you would like to find in a perfect health professional, one whose help you are seeking for a difficult illness. Discovering how far you match up to these ideals will require time and honest reflection. Constructive comments on your work by a trusted team member could help. When this exercise was undertaken recently by a group of obstetricians, midwives and nurses in Sierra Leone they conjured up 33 personal values judged desirable in an ideal health professional. Interestingly, just three related to clinical skills while the remainder addressed personal attitudes or interactions with patients and staff.

Additional benchmarks against which to assess our professional values can be found in documents from the NHS,[7] the Royal Medical Colleges, the General Medical Council[8] and other professional bodies where values themselves are named or preferred professional behaviour is described (from which their underpinning values can be discerned).

A biblical perspective

Above and beyond these human writings lie the authoritative revelations of the God who made us. Throughout, the Bible exemplifies and calls us to live according to the values and pattern of the kingdom of God – in stark contrast to the norms of our fallen world. The Old Testament often presents rules to fashion his people into God-centered living; but *love* as the primary, over-riding and enabling value is certainly there too, not least in Deuteronomy and Leviticus[9] as quoted by Jesus in Matthew[10] as the summary of the Law and the Prophets.

What can we learn of Jesus' values from his words and actions?

- He maintained obedience to his Father in uninterrupted righteousness.
- He treasured communion with his Father.
- He embodied truth and integrity. There was no variance at all between what he believed, what he said and what he did.
- His care and advocacy for the poor, the sick and the imprisoned was outstanding.
- He showed no fear of men or what they could do.
- He taught and exemplified forgiveness and generosity far exceeding our expectation and capacity.
- Where necessary he was open, courageous and straightforward in opposing the cultural and religious norms of the time.
- He regarded material riches as a potential danger, easily able to usurp the place of everlasting spiritual treasure as a human priority.
- He was committed to a life of humility.
- He both commended and demonstrated accessibility and gentleness.
- He upheld and exemplified justice, mercy, and faithfulness.
- He was love.

Beyond the gospels, the New Testament offers other descriptions of heavenly values to be embedded in our lives with the help of the Holy Spirit.[11]

When values are in conflict

In his epistle to the Romans[12] Paul expresses the dilemma we face while trying earnestly to live as Jesus' disciples. As his followers, we are committed to his values and seek his help fully to adopt them as the drivers of all our attitudes and actions. But contrary, negative or limiting values can so readily rise up in opposition. The nagging values of popularity or material success could easily displace our call to behave with altruism, integrity, humility and generosity. But where this happens we are not to despair but rather consider how our noble values have been hijacked, and then return to Jesus to seek his forgiveness and the power that enables his values to be expressed in all that we do.

In addition to the challenge of a values-conflict internally, our professional practice will afford many interactions with those whose values and priorities do not match our own. How we approach such discord in the organisations where we work necessitates drawing heavily on our core values of respect, kindness, justice, and mercy together with prayer for wisdom and the humility to seek the guidance of others where appropriate. And with the patients and relatives whom we attend, such an approach will also be required, particularly as we develop a therapeutic interaction that takes full account of their values and preferences as well as our own.[19]

Wearing your values

An identity between our internal values and our external behaviour, without restriction or distortion, defines the value of integrity. It has been said that the closer this match can be achieved the more likely we are to be at peace, to have appropriate self-confidence, and to flourish. Integrity means doing the right thing even when nobody is watching. Some regard integrity as the crowning value on which all others depend since it makes plain by our behaviour the internal values that propel us.

So aim for integrity: take all your good values and wear them!

Richard Vincent *is Emeritus Professor of Cardiology and formerly Associate Dean of the Brighton and Sussex Medical School.*

Prominent biblical values

LOVE
– *with true altruism*

RESPECT
– *without judgment*

HUMILITY
– *servanthood, always*

INTEGRITY
– *outside = inside*

FORGIVENESS
– *repeatedly showing mercy*

KINDNESS
– *everyone counts as family*

FAITHFULNESS
– *even at personal cost*

JUSTICE
– *on behalf of others*

UNEXPECTED GENEROSITY
– *of spirit, goods, time, attention*

RIGHTEOUSNESS
– *without self-congratulation*

UNITY
– *while embracing differences*

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Based on a talk given at the first Balkan ICMDA Regional Conference in 2013

Stefan Gleeson offers tools to help understand the impact of stress on individuals and teams

SUPPORTING COLLEAGUES IN CHALLENGING TIMES

key points

- Many UK doctors experience burnout at some stage of their career, and up to 20% suffer from depression.
- A link is recognised between patient safety and how effective teams are as learning environments.
- Christians are called to be peacemakers and practise forgiveness.

'So Abram said to Lot, "Let's not have any quarrelling between you and me, or between your herdsmen and mine, for we are close relatives. Is not the whole land before you? Let's part company."'[1]

'"Come now, let us settle the matter," says the LORD. "Though your sins are like scarlet, they shall be as white as snow; though they are red as crimson, they shall be like wool."'[2]

Conflict and arguments are commonplace – whether with a relative, colleague, or even with God. Reasons for such arguments range from irritability, due to long working hours, to personality differences and value clashes. As Christians our reactions are important not just because of relationships *with* others, but also in what they say to others about Jesus.

Dr Purple was three weeks into a new job. With a new contract threatening to eliminate her (already precarious) work-life balance, she asked her colleague, Dr Red, for advice. Dr Red was rude and abrupt. Dr Purple had to consider whether to: withdraw (and cope alone), go on the attack (pointed remark), or report to a senior (with potential long-term damage to relationship). What did she need to think about before reacting?

Here is a list of considerations; it is by no means exhaustive.

Team Environment: healthcare is becoming characterised by ongoing resource pressures in the face of rising demand. A drive to 'do more with less' leads to overstretched staff struggling to display compassion when emotionally overwhelmed. A single 'extra' demand on staff can lead to a less than professional response.

What of the doctor? Anthropological studies have found a tension between a doctor's need to become self-sufficient and the skills required for teamwork.[3] Competitive behaviour is often seen long after training is completed.

Consider which of the following zones characterises your team (bearing in mind that most teams will have gone through a red zone at some time). [See Box 1].

Box 1: Green-Red zones of working [4]

GREEN ZONE	RED ZONE
high trust	low trust
dialogue	high blame
excitement	alienation
honesty	threat
friendship	fear
laughter	anxiety
mutual support	guardedness
sincerity	hyper-rivalry
cooperation	hostility
friendly competition	denial
shared vision	withholding
flexibility	hostile arguments
risk taking	risk avoidance
learn from mistakes	cynicism
open to feedback	suspicion
face difficult truths	tendency to hide mistakes
take broad perspective	external motivators
sense of contribution	deadness
internal motivation	greed
ethical behaviour	sense of entitlement
WORK = FUN	**WORK = PAINFUL**

The GMC recognised the link between patient safety and *learning* environments last year. [5] Indeed, it is often medical students/trainees who raise concerns where red zone working is evident, but they can also point to areas of good practice: 'the environment was inquisitive, participatory rather than observation; not just about throughput' (*Southampton Medical Student,* 2014). There is evidence that Trusts, working with education providers, can turn work environments around. [6]

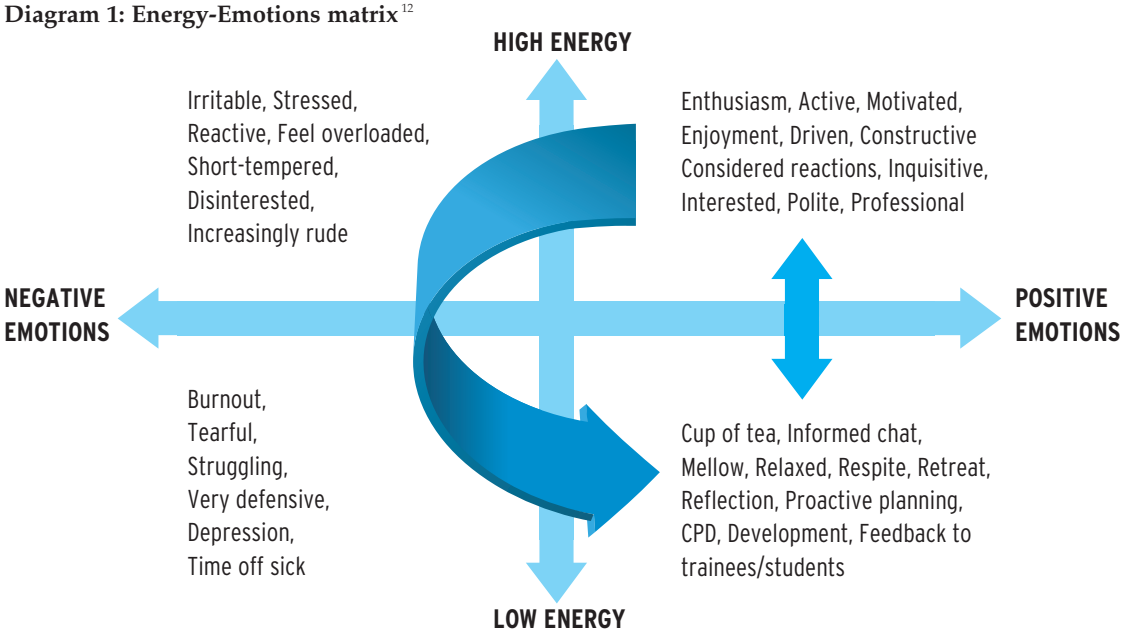
When Martha turned to Jesus, stressed that no one was helping her, we see in her a picture of the modern healthcare worker. Jesus told her that 'only one thing was needed'. [7] Role models are crucial in the development of future doctors, [8] so how we remain in Christ is essential if we are to influence teams for good. We should provide ethically responsive behaviour to challenges (saying sorry after an argument); take responsibility; be accessible, reliable, respectful, compassionate and self-appraising. We should aim to be wise doctors, 'nurturing the mind'. [9]

Secure in Christ, we work towards establishing effective teams, which are characterised by non-defensiveness, emotionally accessible care, constructive interaction, valuing others, situational (political and managerial) awareness, the ability to accept criticism and give people the benefit of doubt. [10]

Values: these are crucial to our motivation. The reason we went into medicine (hopefully) was to help people get better. The reality, in the current healthcare climate, is that our work is often beset with governance obligations – revalidation, ticking boxes to meet a standard (rather than formative development) and rota gaps. We can find ourselves reacting abruptly to competing demands when care is not patient-centred and resources are lacking. What can we do? We need to find ways to influence the political landscape (we cannot do this alone), but we also need to remember that we are human. Pablo Martinez writes of the duty of good stewardship in caring for our own wellbeing, or 'garden', in order to be able to look after others. [11]

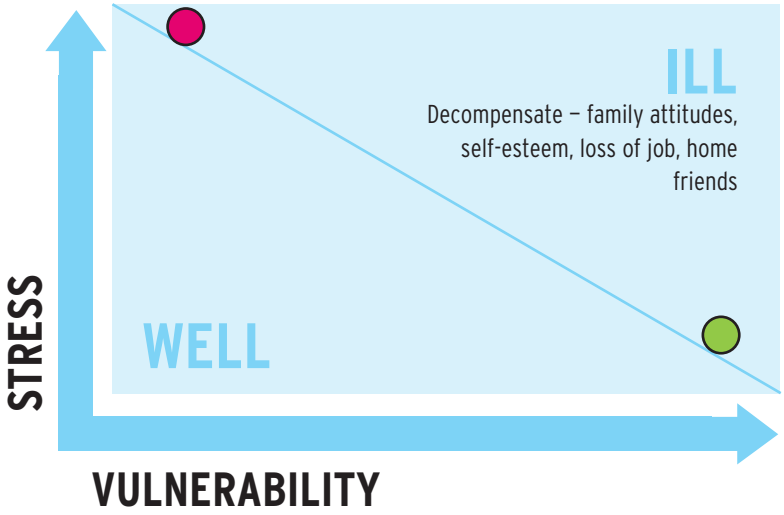
In the Energy-Emotions matrix below [Diagram 1], psychologists recognise that we can only last for two hours in the performance (top right) quadrant before either passively finding ourselves in survival mode (left top quadrant, characterised by stress) or proactively making a break to the recovery zone (bottom right). If we continue in stress/survival mode, we will burnout and be forced by sickness to return to the recovery zone. Jesus recognised this well when stretched by demand. He took himself regularly to a quiet place to reflect, pray and listen to his Father. [13]

Diagram 1: Energy-Emotions matrix [12]



A drive to 'do more with less' leads to overstretched staff struggling to display compassion when emotionally overwhelmed. A single 'extra' demand on staff can lead to a less than professional response

Diagram 2: Vulnerability-Stress model



Recognising the interaction between our vulnerabilities and stress

A **Vulnerability-Stress model** [Diagram 2] is one that may help us understand ourselves or our more challenging colleagues. It reflects the tipping point at which an additional level of stress overwhelms our coping mechanisms and health defences. It can help us understand why someone else may be stressed when we are not. Essentially, the more vulnerabilities (genetic, developmental, maturity) the more likely it is that even small sources of stress lead to illness (●). When ill, other factors may conspire to keep us ill (eg poor self-esteem). If we have few vulnerabilities (no family history of illness, great childhood), then it may still be possible to become unwell if we add sufficient stress (●).

Perception: our perception of others is affected by our own development, current health and circumstances.

Development: one in a hundred people have an autistic view of the world. The prevalence is higher among doctors, who might be unintentionally rude without noticing, not engage in small talk and need detailed instructions. A gentle but direct approach can work and a GP referral for a diagnosis can help autistic doctors understand themselves better.[15]

Current health and circumstances: in the UK between 25-76% of doctors experience burnout at some point in their career and up to 20% suffer from depression.[16] During acute stress, we are often preoccupied with the source (eg complaints[17]) so we find ourselves irritable with colleagues and/or emotionally exhausted with loss of concern for patients. Acute stress tends to resolve fairly quickly. However, depression, substance misuse and personality disorders need to be addressed via primary care. Finally, if home circumstances are difficult, colleagues may present with either absenteeism or presenteeism (avoiding home) from/at work.

How should we respond?

We need first to recognise that we have 'all have sinned and fall short of the glory of God';[18] we are unable to manipulate others into change. 'Seek first to understand',[19] while maintaining boundaries (you are not there to please people).[20]

Secondly, recognise your resources: Jesus called us into our profession and wants us to bring the challenges to Him. We need to develop active listening skills to get to the heart of the matter.[21] The 'matter' may be to do with a mix of the 'challenging other person' (health, performance, culture) and/or our own 'challenging selves' (eg via 360 degree feedback). Improve your awareness of support organisations; share with mentors within your church/organisation and keep records.

Finally, we need to forgive others.[22] We are invited to 'ask God to bless everyone who ill-treats you. Ask Him to bless them and not to curse them'.[23] In the Sermon on the Mount, Jesus calls us to be peacemakers, to seek peace and pursue it but remember that if people do not want to live in peace with us, Jesus' instruction was qualified with 'if it is possible' and 'as far as it depends on you'.[24] The cost of peacemaking may involve 'painstaking listening, witnessing bitterness, apologising if we are to blame, making restitution'.[25] However, as John Stott says, 'always temper justice with mercy and mercy with justice'.[26]

Ultimately Jesus knew his disciples, and he will meet us where we are at.[27] As we deal with challenging colleagues and situations, He will remind us: 'Be still and know that I am God - I will be exalted among the nations'.[28]

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Based on a seminar at the CMF National Conference in April 2016

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Matt and Clare Davis offer important principles for money management

FINANCE IN THE EARLY YEARS

How does an article about handling money make you feel – thankful; blessed; afraid; guilty; envious? Perhaps you feel like the wealthy oil baron John Rockefeller who when asked 'how much money is enough?' replied 'always just a little bit more'. When we got married a year ago we knew we'd have to review our finances together, but we subsequently became experts in procrastination! Finally we were convicted to act by a sermon at church on 'The Parable of the Talents'.[1]

We were reminded that all of our wealth is really God's and we should use it for his glory. When we start to manage money God's way our approach cannot represent adding a small extension to an otherwise unchanged house. Instead, we need to rebuild the entire house, starting with sound biblical foundations.

But why is it so difficult? It may be that for many our approach to finances derives as much from habits learnt from parents, friends or colleagues, and fears or dreams for the future, as it does from anything learnt at church. Money seems to promise a good life now and security for the future. As Christians we might know that only Jesus can promise 'life to the full'[2] and eternal life but the conflict between earthly passions and a life in step with the Spirit continues.[3] A right understanding of God's mercy should transform our attitudes, priorities and actions. As we set out to rebuild our money management, we divided our spending into four categorises. Each provides its own challenge, but the Bible provides guidance in every area.

Necessary expenditure

Even in the most mundane spending – rent, utilities and council tax – the Bible still commands our attention. Strikingly, our ability to earn money is a God-given grace and we must be wise with what we have.[4] We were able to significantly reduce our monthly outlay by using a price comparison website. More recently, we have been inspired and challenged by Tearfund's green energy campaign[5] to care for creation and have saved more despite switching to a green utilities company. Jesus taught we must pay the tax we owe,[6] but there is provision in law to reclaim tax on unavoidable professional expenditure – for example indemnity, BMA and college membership, equipment and exams.[7] If you are a higher rate taxpayer you can also claim tax relief on gift-aided giving.[8] Any reclaimed tax can, of course, be given again!

Giving

If asked to find a verse about giving, we doubt many would immediately turn to John 3:16. Yet, for inspiration as to how we should give, we can do no better than to look at the biblical narrative of God's generosity and provision in creation and his sacrificial gift to a fallen humanity. We only ever give out of what we have been given, and even the ability to give is a grace.[9] In deciding where to give, we were motivated by the accounts in Acts to prioritise giving to the local, and then the global church. Paul was clear that giving should be planned, reliable and proportionate to what we have.[10] On junior doctor rotas it was frustrating not to be able to reliably commit to serving at church or on youth camps. Yet, Clare was challenged by a personal letter she received from an organisation she had been supporting financially, explaining how her gifts had helped others running youth work.

Discretionary expenditure

How much to spend on luxuries, rather than essentials, is perhaps the most subjective and personal challenge. We certainly had different expectations. And it is easy for tastes to expand as disposable income rises. The Bible is clear on principles. Perhaps surprisingly, the Bible encourages us to earn and spend money enjoying God's creation,[11] yet at the same time we must live for the new creation and use everything to build his kingdom.[12] We recognise we lived comfortably as junior doctors and so we have tried not to let our spending increase now we have more disposable income. Early in our marriage we set out a budget for these expenses which we keep track of each month. We discuss large expenses and tend to sleep on the decision to avoid impulsive extravagance.

Saving

The final category is saving. The Bible seems to encourage prudent saving in order that we can provide for ourselves and our families in the future. However, we are warned not to become proud or reliant on our bank account for security.[13] Practically, Clare and I have found it useful to set saving targets that are based on expected specific expenditure rather than simply 'saving for a rainy day'.

We are aware that managing money is often a challenging area of our Christian lives. As we have gone from medical students to junior doctors to GPs we have seen a widening gap between our lifestyles and those of our peers. While this gap sometimes leads to frustration or jealousy, we feel that it is right that our finances bear witness to our transformed priorities. Over the last twelve months we have had some difficult conversations, yet on reflection it has been great to be able to challenge and encourage each other. If you are married we would encourage you to discuss these things with your spouse. If you aren't married, it could be really useful to discuss these things with someone you trust who can hold you accountable. How amazing will it be if one day we are greeted with the words of Jesus: 'Well done, good and faithful servant... come and share your master's happiness'?[14]

Matt and Clare Davis *are GPs based in Leicester.*

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Anthony Bell surveys the scale of the NHS crisis and some of the proposals for change

NHS IN CRISIS

key points

- The NHS is entering a third decade of administrative turbulence and cost pressures. Almost every measure of performance is getting worse.
- Waiting times for cancer care, accident and emergency attendances, ambulances and routine operations are all rising.
- Large efficiency savings are needed by 2020 with risks ahead for patients if healthcare becomes further fragmented.
- The latest proposals include localised sustainability and transformation plans (STPs).
- Clinicians and students need to ensure that opportunities for positive change are not missed.

A King's Fund review during the last Parliament commended NHS performance in the face of huge challenges, despite the coalition government's damaging and distracting reforms of the health service.[1] The review warned that patient care would deteriorate as service and financial pressures became overwhelming. The chief economist at the Health Foundation described the NHS financial position last year as 'dire', with three quarters of hospitals unable to balance their books.

The present government has inherited a health service that has run out of money and is operating at the very edge of its limits.[2] The extra £8 billion a year NHS England says is needed by 2020 is the minimum that will be required unless new savings materialise, and the figure was reached after assuming highly ambitious efficiency savings of £22 billion by 2020.

Simon Stevens, who became chief executive of NHS England in 2014, favours the development of new models to suit local needs. Possibilities include 'Accountable Care Organisations' as found in Spain, the United States and Singapore, to integrate primary and acute care. Some large UK hospital Trusts could do acute care and community care in their area. The Trust could employ general practitioners and community health staff as well as hospital staff, potentially uniting doctors, nurses and paramedical professionals to co-ordinate care.

Measures that could curb the rise in hospital admissions and the impact of our ageing population, which are the source of most pressure in the NHS, include hospital video links to care homes to prevent emergency admissions for cuts and grazes following falls, and to give advice on management of conditions like diabetes mellitus. Pilots in West Yorkshire have reduced emergency admissions from care homes by 35% and A&E attendances by 53%.[3]

Investment in the NHS needs to be backed by a strong economy. The July Budget in 2015 restated a commitment to an extra £8 billion in 2020, yet financial problems have been described as 'endemic' – with even the best run hospitals forecasting deficits and predicting that NHS providers could slip further into the red – and 'bleak' – with nearly 80% of Trust Finance directors predicting a worse position at the end of 2015 than the year before.

In A&E, the proportion of people waiting over four hours for treatment is at its worst level since 2004. Waiting lists for non-emergency treatments have not been so high since 2007. Whole areas of the NHS in England have been placed in special measures, including community services and social care as well as hospitals.

Doctors and nurses face the fundamental challenge of the tension between quality of care and financial performance. Maintaining quality of care is vital, not least in high litigation risk specialties. A further challenge is ensuring adequate investment in facilities

and staff at Hospital Trust level. As Robert Francis concluded in the Mid Staffs inquiry: 'there is a need for openness, transparency and candour in all staff and NHS management needs to be evidence based and accountable in the same way that doctors and nurses are… appropriate infrastructure is needed for them to do their jobs well'.[4]

A potential opportunity

In December 2015, sustainability and transformation plans (STPs) were announced in England to shape the future of health and care services within a geographical area.[5] But what will STPs really do? The five-year STPs cover all areas of NHS spending in 44 local populations ranging from 300,000 to 2.8 million, with an average of 1.2 million people. STP leaders are largely chosen from clinical commissioning groups and NHS and Foundation Trusts, but some are from local government.

The scope of STPs is broad, with three aims:

- improving quality and developing new models of care
- improving health and wellbeing
- improving efficiency of services

While the focus is mainly on NHS services, STPs must also cover better integration with local authority services. The timelines for developing and approving STPs have proved somewhat fluid, the original deadline for submitting plans was the end of June 2016, but most plans will now be further developed and re-submitted by October and are likely to be assessed and approved in phases. From April 2017, STPs will become the only way to access NHS transformation funding, with the best plans receiving funds more quickly.

Changing priorities

STPs represent a shift in the way the NHS in England plans services.[6] They reverse the 2012 Health and Social Care Act, which strengthened competition, and instead encourages organisations to collaborate, reflecting a growing consensus that integrated care is required to meet the needs of the population.

The shift acknowledges that the financial problems in different parts of the NHS cannot be addressed in isolation, and providers and commissioners are being asked to come together to manage the collective resources available for NHS local populations. In some cases this may lead to 'system control totals' (financial targets) being applied to local areas by NHS England and NHS Improvement.

This represents a very 'new' way of working for the NHS. It might also include collaboration with other services beyond the NHS to focus on the broader aim of improving population health and wellbeing, not just on delivering better quality healthcare.

But developing STPs is not a simple task. Some STP footprints are large and involve many different organisations, each with their own cultures and priorities. Finding time to work on STPs can be challenging, given the severe service and financial pressures facing NHS organisations. Moreover, the timescales set by NHS England to write STPs are tight.

Perhaps the biggest challenge is to develop STPs in an NHS environment that is no longer designed to support collaboration between organisations. NHS providers are under significant pressure from regulators to improve organisational performance by focusing on their own services and finances rather than working with others for the greater good of the local population. The dissonance between place-based planning and the continuing focus on organisational performance in the NHS is stark.

The task of developing STPs may be challenging for some areas; making it happen will be altogether more difficult. There has been limited time for public involvement in the plans so far and changes to incentives and performance management in the NHS may be needed to overcome the barriers that get in the way.

The ultimate prize on offer from STPs is the opportunity to integrate health and social care services more closely and to provide a platform for improving population health. But there are some reasons to be cautious about the kind of benefits that will be delivered and concerns have already been raised that leaders have focused on plans for reconfiguring acute hospital services, despite evidence that major acute reconfigurations rarely save money and can fail to improve quality (and in some cases even reduce it).

Doctors and nurses must be able to work within a structure that balances care quality and safety with efficiency, that ensures unfettered patient access to care based on clinical need, and that builds and sustains the skilled clinical workforce. The present infrastructure for clinical care across the UK fails to deliver this in many areas. Innovation and ground-breaking ideas also need to be nurtured and not stifled. Clinicians need to be able to innovate and validate new advances in patient care free from commercial pressures and overburdening bureaucracy.

With the new 'post-Brexit' government, the NHS will change and clinicians will change with it. The worldview of Christian clinicians, driven by love for our neighbour and Jesus' parable of the Good Samaritan, make our engagement with these transformations essential to ensure that care is centered on patients' needs and that quality is not compromised. Our patients risk being short changed if we become back footed and unable to take the lead to make the most of the opportunities ahead.

Call to action

- Christians are a morally distinctive voice, called to be salt and light at all levels in the NHS
- There is scope for Christians to be engaged in working for change and shaping the future, for instance from the ground up within STPs
- There are growing opportunities for partnership between Christian students and clinicians to work with local churches to offer integrated social care

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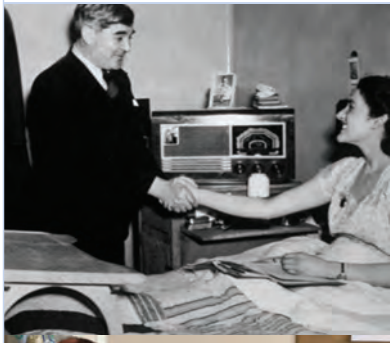
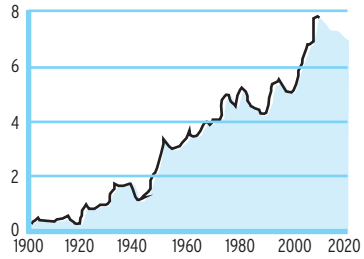


Healthcare: UK from 1900-2020



Percentage of Gross Domestic Product spent on UK Healthcare

Clinicians need to be able to innovate and validate new advances in patient care free from commercial pressures and overburdening bureaucracy

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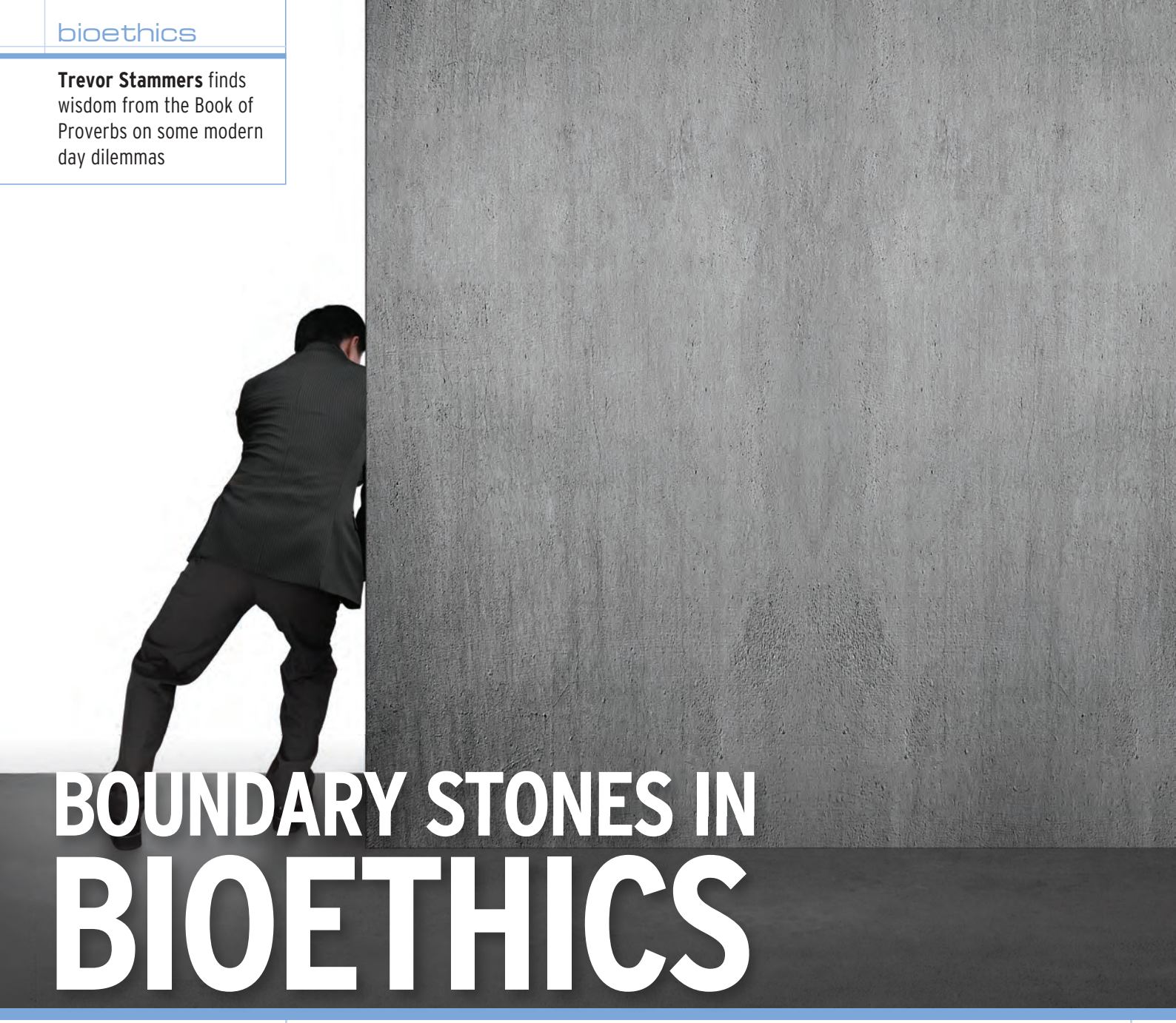
Based on a seminar at the CMF Junior Doctors' conference in October 2016

Trevor Stammers finds wisdom from the Book of Proverbs on some modern day dilemmas



BOUNDARY STONES IN BIOETHICS

key points

- Boundary stones help society maintain respect and continuity with previous generations. They remind us we are not autonomous islands.
- Ethical issues of IVF, gene editing, gender dysphoria, cybernetics and transhumanism all have in common that they seek to move boundary stones set by God.
- Moving boundary stones in human relations has often produced unforeseen consequences that bring pain and misery.
- Scripture makes clear that God will hold us accountable for boundary moving and its consequences.

Counter-intuitively, ancient literature in the Bible offers insight into some of the thorny ethical issues of our times. One that came to mind recently is found twice in the book of Proverbs: 'Do not move an ancient boundary stone set up by your ancestors'.[1]

In the New Century Translation, the second phrase is rendered 'because those stones were set up by your ancestors', making this more of an explicit explanation than just an adjectival clause. Then Proverbs offers another explanation, which shows why disobeying the initial command is such a serious matter. 'Do not move the ancient boundary. Or go into the fields of the fatherless, for their Redeemer is strong; He will plead their case against you…'

The boundary stone signifies two things. Firstly, respect for and continuity with previous generations. We acknowledge that we are not autonomous islands. We are connected to the mainstream of community which conceived, birthed and nurtured us. Roots are important in our lives and if we become torn from them, especially in infancy, this can cause great harm.

> Sexual union and reproduction are intimately linked in Scripture. Every discovery of technology that separates these two is a double-edged sword at best and an unmitigated evil at worst

Secondly, the boundary stone signifies ownership. The boundary stone indicated who owned the land and for others to enter it and take it by moving the boundary was theft. God is declared as the defender or redeemer of those wronged by such a move, declaring he will act against those who take what is not theirs.

I suggest that what the ethical issues of IVF, gene

editing, gender dysphoria, cybernetics and transhumanism all have in common is that they seek to move boundary stones set by our Heavenly Father signifying both our kinship [2] and our ownership [3] by him. All of these boundary stones I have in mind are found in the early chapters of Genesis and I shall take them in the order they appear.

First, we are sexually differentiated in a specific way. Recently a school in Brighton encouraged its pupils to identify with one of 23 different genders, [4] including 'gender fluid' 'demi-boy' or 'non-binary'. Though gender is not synonymous with chromosomal sex and chromosomal intersexes can and do occur, the Scriptures clearly and unequivocally state that we are differentiated in a sexual binary.

Genesis states: 'So God created mankind in his own image, in the image of God he created them; male and female he created them'. [5] This is not a text to make you feel guilty if you are a male who prefers ballet dancing to football, or a woman who would rather be an astronaut than a homemaker. It is just stating the reality we observe around us and is imprinted in nature – what is 'understood from what has been made, so that people are without excuse'. [6]

In a recent interview, Eddie Redmayne revealed that filming *The Danish Girl* had been an education for him in which he had learnt for the first time that gender is fluid. [7] What he is actually saying there is that a boundary stone has been moved in his life and he is totally unaware of the danger of it both to him and his many fans.

A second boundary stone can be inferred from Genesis: 'And God blessed them. And God said to them "Be fruitful and multiply"'. [8] Subsequently the mode of achieving this comes in the following chapter: 'A man shall leave his father and his mother and hold fast to his wife and the two shall become one flesh'. [9] Sexual union and reproduction are intimately linked in Scripture, every discovery of technology that separates these two is a double-edged sword at best and an unmitigated evil at worst.

Initially, 20th century technology made it easy and safe to separate sexual union from procreation. Who can deny that the advent of contraception, whatever its many benefits that most Protestants and many Catholics take advantage of, has contributed to increased sexual immorality, the sexually transmitted disease crisis and ever-increasing demand for abortion?

IVF, though it has brought the joy of children into the lives of many, has also separated procreation from sexual union. It has thus provided the foundation for not only the commercial exploitation of women worldwide for their eggs but also for many of the techniques of the new genetic revolution. With both human cloning and with artificial gametes derived from induced pluripotent skin cells for the first time, man may be able create man in his own image.

This ability is still in its infancy but it will inevitably increase, at least among the rich nations, if the technology makes it possible. What is the origin of this strong drive that makes us so want to have children who are our genetic offspring if at all possible? This seems to be part of the image of God in us, but if we use unethical means to achieve legitimate God-given yearnings, the costs could be very high.

The third and final boundary stone is found in Genesis 2 and its context: 'The man said, "This is now bone of my bones, and flesh of my flesh; she shall be called woman"'. [10] To be human is to be embodied. We are ensouled bodies as much as embodied souls and in the resurrection to come God will 'transform our lowly bodies so that they will be like his glorious body'. [11] Our bodies are not an optional extra and contra Plato, our eternal destiny is not that our disembodied spirits ascend to the world of the forms, but rather that we eat and drink with our Lord at his wedding feast and enjoy heavenly union with him for evermore. [12]

In *The Givenness of Things*, [13] Marilynne Robinson writes:

Disliking subjectivity will never make it go away. Here is an idea that would make Descartes blanch. Apparently there are scientists who believe that at some point fairly soon, we will be able to upload our minds to computers, freeing ourselves from our bodies being therefore immortal.

This is reminiscent of the serpent's provocation of Eve to move another boundary stone: 'God says we must not eat it or touch it or we will die. "You will not die for God knows that your eyes will be opened when you eat it"'. [14] Robinson continues:

I suppose they will programme in the virtual experience of taking the uploaded dog for a walk in the virtual park, through the rain on random assorted virtual days adjusted to reflect the weather patterns in some selected place and season...

We are not just fighting against flesh and blood in our calling as Christian healthcare professionals but against the powers of darkness and of that ancient serpent whose head is not yet completely crushed. [15] Let us understand the times, discern what the Spirit is saying [16] and do all we can to open our eyes and the eyes of others to the reality of the living God who will hold us accountable for our actions and who warns that there are boundaries we should not cross or move.

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IVF, though it has brought the joy of children... has thus provided the foundation for not only the commercial exploitation of women worldwide for their eggs but also for many of the techniques of the new genetic revolution

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Rick Thomas looks at transgenderism and the agenda feeding it

GENDER & SOCIAL CHANGE

key points

- Autonomy has become 'the moral wallpaper of the modern world' and it demands that we do not impose our moral code on others.
- The transgender movement seeks the deconstruction in society of sex and gender, and traditional models of marriage and family, no less.
- The 'new orthodoxy' being proposed is turning a blind eye to research. Most children presenting with gender incongruence in their primary school years will desist during adolescence.

Government legislation and professional guidelines reflect cultural trends. As culture changes, and with it the notion of what is generally acceptable, the lawmakers follow suit. Thus, what was deemed unthinkable by one generation may be tolerated by the next and commonplace for the next.

Ours is an 'iWorld',[1] in thrall to the cult of individualism. The roots lie in the period of the Enlightenment – the assertion of human reason over divine revelation. Today, autonomy has become 'the moral wallpaper of the modern world'.[2] It is expressed in the appeal for authenticity, the cry for freedom to be 'who we really are', to find personal meaning within ourselves. The one thing we must never do is allow others to impose some external moral code on us.

In this world, traditional binary gender roles are portrayed as constricting social constructs; we must free ourselves to define our own gender identity. Until recently, Facebook offered 71 gender options to enable users to be their *true, authentic selves*. Now they simply offer three options – male, female and 'custom' – allowing users to insert any label of their choosing, and to change it freely. Gender has been liberated from biology and even those who are uneasy about these changes feel deeply reluctant to challenge any individual's chosen identity, so profound is our culture's commitment to individual liberty and the right to self-define.

The transgender 'movement', like the wider LGBT movement, is not simply about advocacy for acceptance of people who are gender-nonconforming. Its goal is the deconstruction in society of sex and gender, and traditional models of marriage and family, no less:

When we no longer ask 'boy or girl?' in order to start gendering an infant… only then will men and women be socially interchangeable and really equal. And when that happens there will no longer be any need for gender at all.[3]

Such activists would have us believe that Gender Dysphoria – the distress experienced by those whose sense of gender identity is not congruent with their natal sex – is the result of societal pressures to conform to traditional gender roles. Deconstruct those roles, accept the notion of gender as 'fluid', and dysphoria will be no more!

We do well to be aware of this agenda and consider an appropriate response to the activists. The danger is that in seeking to be culturally robust we lose sight of those who are struggling with true gender dysphoria and who desperately need compassionate and sensitive care.

Political trajectory

The cultural trajectory is mirrored in political changes. In 2004, the Gender Recognition Act permitted transgender people to be legally recognised in their 'acquired' gender. Those who are 18+, have been diagnosed with Gender Dysphoria, have lived for a minimum period of two years in their acquired gender and who intend to continue in the same way, may apply for a Gender Recognition Certificate that may be used to obtain a new birth certificate.

The Equality Act 2010 made it unlawful to discriminate against transgender people, and the Marriage (Same Sex Couples) Act 2013 stipulates that a marriage may continue following one partner's gender transition, given the agreement of the other.

In 2016, a House of Commons Women and Equalities Committee report recommended an update to the 2004 Gender Recognition Act that would:

- make 16 and 17-year-olds eligible to apply for gender recognition
- streamline the assessment of child and adolescent service-users to enable earlier use of puberty-blockers and cross-sex hormones
- move Government departments towards 'non-gendering' official records

Medical trajectory

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-4, 2000) listed cross-gender identification as Gender Identity *Disorder* (Code 302.58). In the fifth edition (DSM-5, 2013), the same phenomenon is renamed Gender Dysphoria (GD), shifting the emphasis from gender incongruence as a disorder to the distress (dysphoria) associated with the experience of that incongruence.

It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.[4]

This change appears to have been ideologically driven, the aim being to re-classify gender incongruence, removing it from the list of pathological conditions. As a result, the goal of treatment has moved from the correction of a disorder to the relief of distress. It has become unacceptable to view GD as a form of body dysmorphia, a problem of the mind, with treatment aimed at re-aligning the patient's mind with his/her biological sex. Instead, gender identity is viewed as a matter of individual choice and the goal of treatment to re-align the patient's body with his/her choice. But in a gender-fluid world, there can be no assurance that an acquired gender identity will prove as permanent as the results of reassignment surgery.

The Royal College of Psychiatrists published its *UK Good Practice Guidelines*[5] in 2013, and the General Medical Council (GMC) updated its guidance for doctors treating transgender patients in 2016.[6] GPs are encouraged to refer patients with gender dysphoria to their nearest Gender Identity Clinic (GIC) for consideration of treatment with hormones. Currently there are only a handful of such clinics in the UK and waiting times for appointments can be in excess of twelve months. There is concern that, in the meantime, desperate patients may self-medicate with hormonal products acquired via the internet from non-regulated sources. Patients with co-morbid mental health problems may be referred locally for mental health assessment whilst waiting.

Transgender and children

Cultural change is also reflected in education. In parts of Australia, children as young as three and four years old are being 'helped' by education authorities to undergo gender transition.[7] It appears that 'transgender infants' are being recruited as poster children in support of an ideology lacking a basis in science.

Closer to home, schools and local authorities are encouraging gender-confused children towards trans identities, adopting trans names and pronouns, sometimes against the wishes of their parents.[8] Where parents object, the threat of having their child taken into care may encourage compliance.

The new orthodoxy is turning a blind eye to research. Of those children who present with gender incongruence in their primary school years, a majority will desist naturally during adolescence.[9] 80% of children referred to the Gender Identity Development Service in London's Tavistock and Portman NHS Centre subsequently chose as adults to stay with their natal sex.[10]

Attitudes are hardening. A recent scholarly Report[11] by psychiatrist Paul McHugh and biostatistician Lawrence Mayer, of Johns Hopkins Hospital, found no scientific evidence to support the hypothesis that gender identity is independent of biological sex and also concluded that neither genetics nor brain structure plays a significant role in whether people identify as straight, gay or transgender. However, their findings were strongly denounced by students and faculty members at their own hospital as 'a misguided, misinformed attack on LGBT communities'.[12] Science that counters ideology is clearly bad science!

Resisting the tide

In responding to the changes around us, let us affirm:

- facts, not ideology, determine reality
- sex is a fixed biological binary (except in rare intersex conditions)
- when gender identity is divorced from biological sex, chaos ensues and fantasy rules
- when an otherwise healthy boy/man believes he is a girl/woman, the problem lies in his mind, not his body
- social pressure on children/teens to self-define too early must be resisted
- gender incongruence is a disorder, not a reason to celebrate diversity
- the least invasive option of care is the best option, eg changes in name and dress mode rather than hormones and surgery
- there is no horizon to compassion and care, but there are treatment options that are better not endorsed

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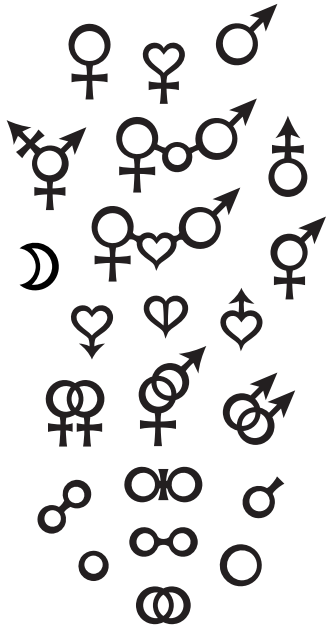

Ours is an 'iWorld' in thrall to the cult of individualism. The roots lie in the period of the Enlightenment – the assertion of human reason over divine revelation

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Roxana Walker identifies important biblical principles

OVERCOMING STRESS & BURNOUT

key points

- Stress is a huge challenge but not everyone approaches it in the same way.
- Proverbs extols the value of wisdom, and James tells us that God will guide us if we ask him for wisdom.
- Keep the Sabbath: we are not machines and cannot work to capacity all the time.
- Know you can ask for help.

Stress levels in the NHS are at an all-time high. A survey carried out by the British Medical Association in 2015 found that 68% of responding GPs in England felt that their workload was unmanageable either 'a lot of the time' or 'all the time'.[1] The government is trying to deliver a seven day NHS with already over-stretched resources. Junior doctors have been taking industrial action over the threat of a new contract that they believe has serious implications for patient safety and quality of care.

Consultants are required to spend an increasing number of hours at work rather than being on-call from home. As medical science advances, patient expectations increase and with them the fear of litigation and the cost of indemnity cover. The Care Quality Commission (CQC) has a mandate to inspect every medical facility, which carries with it a host of obligations that have to be fulfilled.

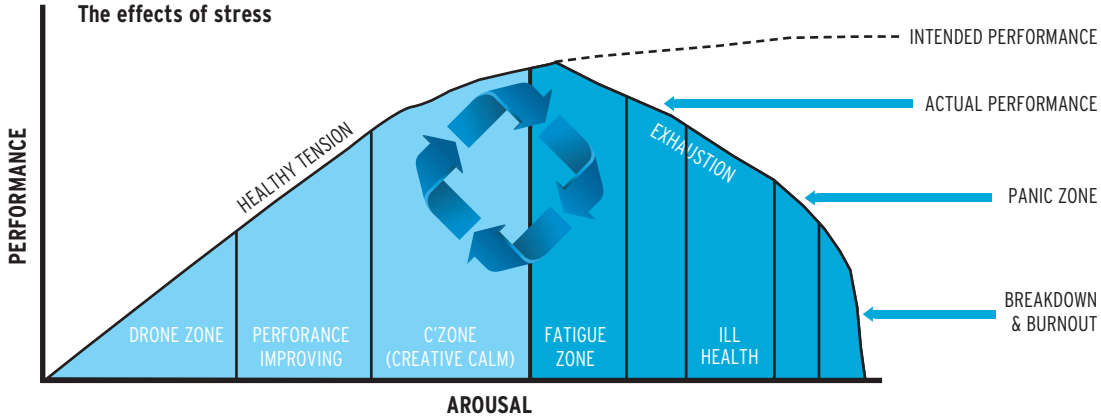
'Stress' may be defined as 'any pressure from the outside world that causes us to feel an inward sense of strain'.[2] Another definition, which can provide a helpful model, is 'the experience of the difference between the perceived demands upon a person and one's perceived ability to meet those demands'. Work demands can take the forms of: increased working hours or patient numbers; covering for absent colleagues; studying for exams; trying to meet the requirements for training, revalidation or CQC; trying to please difficult colleagues or demanding patients; fear of complaints or litigation. Demands can also come from outside of work, such as church commitments, family illness or relationship difficulties.

The issue of perception is important because it brings the role of personality into the picture. A confident person may see a new target as a challenge and take it in their stride, whereas a perfectionist or an anxious person may see it as a burden or a threat. There is also a great variation in terms of activities people find stressful. Some people love the buzz of emergency situations while others find them terrifying; some thrive on listening to people's problems while others find this a draining experience.

The effects of stress

Some degree of stress can be healthy, in that it stimulates and stretches us and prevents us from becoming bored. In 1979, Peter Nixon produced a graph to illustrate the relationship between arousal (or pressure) versus performance.[3] Up to a certain point, increasing pressure produces greater output, but beyond a certain point the pressure becomes too much and a person's achievement starts to decline.

Most healthcare professionals have some degree of resilience and ability to cope with stress, and to a certain point will cope quite well with the demands of their job. But when the tipping point is reached on a sustained basis, a person's health will begin to suffer.



Family relationships may suffer if the person is spending excessive hours at work or worrying about work, and marriages may fail or children miss out on quality time with their parents. Church commitments and devotional time can easily be squeezed out, and a Christian can become cynical or lose their love for the Lord and commitment to his kingdom. Some people develop unhealthy coping mechanisms such as drinking to excess, abusing prescription or illicit drugs, over-eating or skipping meals and living on junk food. Others will develop physical symptoms in response to stress, such as irritable bowel syndrome or headaches. Others still will experience insomnia, anxiety and mood changes that could lead to burnout or depression.

'Resilience' has become a buzzword in the NHS, and may be defined as 'the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity'.[4] Some of the secular resources available contain wise and valuable advice. But how can God's Word help us to cope under pressure and navigate the storms of modern day life?

Principles from God's word

Seek wisdom

The book of Proverbs extols the value of wisdom, and James tells us that God will guide us if we ask him for wisdom.[5] One example of God's guidance comes in the form of Jethro, Moses' father-in-law. He observes Moses hard at work, sitting from morning to evening listening to the disputes of the people and deciding the course of action to be taken in each case. After observation, Jethro says to Moses, 'You and these people who come to you will only wear yourselves out. The work is too heavy for you; you cannot handle it alone'.[6] He advised Moses to train and appoint officials to serve as judges, who could arbitrate on most cases themselves and come to Moses only with the most difficult cases where they needed his input. Jethro had concerns for Moses' health and for sustainability, and was also looking at how others may serve and develop their gifts.

As ever, we can also learn from the life of Jesus. He spent much of his time listening to people's needs and healing the sick, but he knew that he also needed time with his Father. He needed to listen for what to do next, for the bigger picture, and this included teaching and spending time with a small group of disciples in order to prepare them for their future commission.

When we are struggling with the demands of our work, we need to seek God and his wisdom. Are there things we could delegate? Are there things that we need to stop doing? Have we taken on too much in our church commitments, and do we need to say 'No' to some requests? Could we re-organise our working day or working week in order to make it less burdensome? Or are there bigger questions which need to be asked, such as whether we should reduce our working hours or whether we are in the right job or specialty?

Remember the Sabbath

'*Remember the Sabbath day by keeping it holy. Six days you shall labour and do all your work, but the seventh day is a Sabbath to the LORD your God. On it you shall not do any work... For in six days the LORD made the heavens and the earth, the sea, and all that is in them, but he rested on the seventh day. Therefore the LORD blessed the Sabbath day and made it holy.*'[7] Originally the Sabbath referred to Saturday, but Christians now generally regard Sunday as 'The Lord's Day'. In the healthcare professions there are clearly times when we are required to be at work on a Sunday, and this is right and proper for the care of patients. But there are some important principles to observe: God created human life to follow a pattern of work and rest, both on a diurnal and a weekly basis. We are not machines that are able to keep working at full capacity all the time. The Sabbath was created not only to rest from work but also to give our full attention to God. We need to look closely and honestly about how we use our Sundays. Many Christians are so busy with church activities, entertaining and family responsibilities that Sundays are not restful at all. If this is the case, we need either to re-order our Sundays or find some time during the week when we stop and rest, learning to trusting God with our 'to-do' list.

Alongside this, we need to remember the general principles of self-care, and apply to ourselves the advice we give to our patients. This includes getting enough sleep, eating properly, regular exercise, and making time for family, friends and leisure. 'Knowing ourselves' can mean developing an awareness of how we function, what causes us stress and which activities are most likely to refresh and restore us.

Know when to seek help

However wisely we try to live, there will come a time for many of us when we do start to experience the symptoms of burnout, anxiety or depression. It can be very difficult to recognise these symptoms in ourselves, but if this does happen it is essential that we seek medical help. Christian health professionals are not immune to mental ill-health any more than we are immune to physical illness. We should not go into denial or attempt to self-medicate. We should turn to the Lord in our distress, but this does not preclude consulting our GP, and if necessary a counsellor or psychiatrist, and following their advice. It may be necessary to have time off work, and this is essential if our concentration or judgment is affected.

Depression is never easy or pleasant, but often periods of illness are times of learning and growth, so that we may emerge with new insights and wisdom, and with new compassion to help others who are going through times of darkness.

I would like to close with a few words of encouragement from Scripture: '*Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God*'.[8]

***Roxana Walker** is a part-time GP and a volunteer support worker for Nottingham Pregnancy Crisis Centre.*

A confident person may see a new target as a challenge and take it in their stride, whereas a perfectionist or an anxious person may see it as a burden or a threat

glossary

Depression is an illness characterised by low mood and a number of other symptoms which may include loss of interest or enjoyment in usual activities, sleep difficulties, increased or decreased appetite, fatigue, poor concentration and low self-esteem.

Burnout is a syndrome of emotional exhaustion, involving the development of low self-esteem, lack of motivation and a loss of concern and feeling for others. There is often an overlap between depression and burnout.

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Spiritual Care at the end of life

The Chaplain as a 'Hopeful Presence'
Steve Nolan

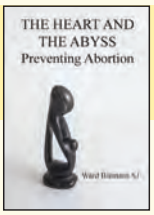
- Jessica Kingsley, 2015, £18.99, 360pp, ISBN 9781849051996
- Reviewed by **Gareth Tuckwell**, formerly of Burrswood Christian Hospital, now Regional Director of Macmillan Cancer Support

Within your working life, have you ever felt that you had nothing to offer when faced with a dying person or their family? This book is invaluable if you find yourself alongside someone who is dying.

The reader is drawn into a series of moments between a chaplain and a person who is dying. The author reflects with rich learning that is not only well researched but authentic. He develops his theory of the chaplain as a 'hopeful presence' – a presence that moves from a transference-loaded first contact to a hope-enhancing relationship.

Nolan encourages us that, when our therapeutic armoury is exhausted, what we have to offer relationally can be even more important. A person-centred relationship with the dying person often has a transforming therapeutic dynamic. At the heart of good end-of-life care is having the courage to be a loving 'presence' as much as controlling symptoms.

The balance between professionalism and humanity is never an easy ride. Can we be both professional and human whilst bringing the light and love of Jesus into our relationships? How do we enable the person who is sick to be the person they need to be?



The Heart and the Abyss

Preventing Abortion
Ward Biemans SJ (Society of Jesuits)

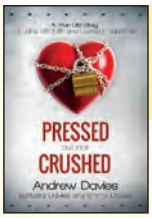
- Connorcourt Publishing, 2016, 390pp, ISBN 9781925138962
- Reviewed by **Mark Houghton**, GP in Sheffield

Is abortion a safe and simple solution for unplanned pregnancy? Everyone should be ready to answer that question because 2017 marks the 50th anniversary of the British abortion law. This book is a minefield of information on the unsafe side-effects of abortion. It opens up the realities of abortion risks to patients before they choose.

Ward Biemans is a Dutch-speaking Jesuit academic. He compares the British and Dutch abortion scenes. Compared to the Netherlands, one reason for the higher teenage abortion rate in Britain is the absence of a legal requirement for parental consent for teenage abortion. Citing evidence from across the world, he says teenage abortion can be reduced by 10–20% where there is compulsory parental notification.

Biemans is compelling reading, but not easy! He compassionately explores the heart-breaking medical side-effects on women; and also the psychology, politics, law, theology, history, finances, feminism, autonomy and ethics of this divisive procedure.

How do we know about risks such as suicide and preterm birth after abortion? Because medical mass abortion has terminated about 1.5 billion unborn humans in 50 years, leaving countless damaged women and partners who testify. I was glad his closing chapter brings hope for reducing the numbers of unwanted pregnancies and the damage abortion causes.



Pressed but not crushed

A true-life story of living with faith and locked-in syndrome
Andrew Davies, Barbara Davies and Emma Davies

- Malcolm Down Publishing, 2015, £8.99, 200pp, ISBN 01707880098
- Reviewed by **Steve Sturman**, Consultant Neurologist (Neurorehabilitation) based in Warley, West Midlands

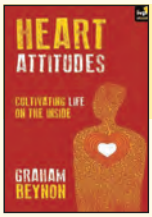
This very honest book tells the story of Andrew, a successful dentist whose life is going very well (including his Christian life). Then, one day, a stroke shatters this and leaves him with Locked In Syndrome (LIS).

The book charts a succession of healthcare failings: the GP suggesting neck manipulation that was possibly causal; A&E that initially turned him away; unsympathetic and mechanistic acute care; nursing perceived as inadequate and disrespectful; embedded incompetent lack of compassion in the rehab unit, unchallenged by management.

Andrew, his wife and mother eloquently describe the nightmare, redeemed only by a church family that provided amazing support. There's a lot of anger and some perplexity. Andrew is still grappling with the 'Why?' question – full credit for truthfulness. It is still early in the journey, but God's mercy shines through.

The book certainly encourages readers to see how precious church family is. Where it really scores, however, is in making us uncomfortable about the way the system endemically fails vulnerable people and delivers inadequate care.

A book that should be required reading for Christians caring for people with severe disability.



Heart Attitudes

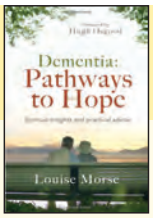
Cultivating life on the Inside
Graham Beynon

- IVP, 2014, £8.99, 174pp, ISBN 9781783591718
- Reviewed by **Stefan Gleeson**, Consultant Psychiatrist based in Hampshire

The 'heart' is referred to some 830 times in the Bible. As Graham Beynon puts it, 'God is deeply concerned with who we are, not just what we know… God wants his truth to shape us.' The gospel is central to Beynon, who makes clear from the beginning that the heart attitudes he wishes to explore are to do with our relationship with God rather than with others. Of course, we know that if you get the former right, the latter follows.

I took this book on holiday, half expecting to put it aside at some point, in favour of some novels I had brought along. Instead, I found myself reading it from cover to cover, mesmerised by disarmingly accessible prose laced with stories, practical examples and beautifully succinct chapters on love, fear, joy, peace, humility, confidence, thankfulness, contentment and hope. I felt challenged by the contrast between the hedonistic Riviera culture I was immersed in and Benyon's incisive focus on the gospel.

The highlight for me is how the author addresses some fundamental questions we don't always get right as Christians. We can live a life that is in name 'Christian' but in practice continues with a worldview and heart attitude infused by the surrounding culture. Beynon rightly focuses on what God is conveying in the gospel. I cannot recommend this book enough.



Dementia: Pathways to Hope:

Spiritual insights and practical advice
Louise Morse

- Monarch, £7.99, 2015, 160pp, ISBN 9780857216557
- Reviewed by **William AM Cutting**, an Oxford-based paediatrician, carer and writer encouraging senior citizens

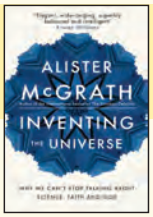
In a world where the word 'dementia' brings dread and despair, Louise Morse is a shining herald of hope in a book loaded with information and positive ideas.

She has woven together personal stories from many people, results from various scientific studies, practical ideas and common sense, along with biblical messages of hope based on God's promises.

She indicates that dementia is a very varied disease in its presentation and progress. It is as varied and personal as the individual brain, the personality background and spirit. The diagnosis does not spell the end of life, and there may still be good years of life.

There is no medicinal 'cure' but there is often some 'plasticity of the brain'. A range of interventions can improve the quality of life and slow the progression of the disease. In particular Morse describes the application of cognitive behavioural therapy (CBT) with spiritual strengthening to 'Boost Brain and Soul'.

Hope in modern parlance is something that you desire but may or may not happen. Hope in the biblical sense, she declares, is much more. It is confident expectation that something will happen because God is in it.



Inventing the Universe

Why we can't stop talking about science, faith and God
Alister McGrath

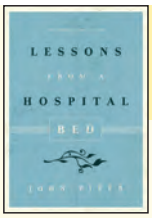
- Hodder & Stoughton, 2015, £9.99, ISBN 9781444798463
- Reviewed by **Peter May**, retired GP based in Southampton

The author considers big questions raised by science and religion and how they mutually enrich one another. There is a tendency among Christians to reduce 'faith' conversations to the central details of the gospel story. Consequently, there often doesn't seem much to discuss and unbelievers feel preached at.

This is not McGrath's style. He thinks the existence of God is deeply interesting and that if we are to explore these depths with others then we need to think both broadly and deeply about the underlying issues. Using his own personal story, he describes the development of his thinking from cocky atheism adolescence to a richer understanding of both science and faith at university.

The awesome wonder of the night sky, the limitations of scientific descriptions, the quest to find a basis for both morality and human significance drove him to find adequate 'maps' to make sense of it all. 'Human life is incredibly brief when seen against the backdrop of cosmic time,' writes McGrath. A larger and more relevant map is needed.

The result is a beautifully written, well-informed and wide-ranging account to deepen our understanding of the modern world. It's an excellent book to lend to unbelievers. While reading it, I was interrupted by an atheist and we soon got into a constructive discussion.



Lessons from a hospital bed

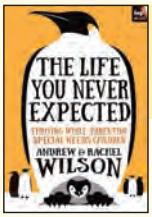
John Piper

- IVP, 2016, £4.99, 75pp, ISBN 9781783594238
- Reviewed by **Janet Goodall**, retired Paediatrician based in Stoke

This is a small book, easy to hold in a weak hand and easy to read with a tired mind. The chapters are short and full of distilled wisdom. It is a little gem for anyone in hospital or for a hospital visitor.

John Piper has spent a couple of brief times in hospital, but long enough to write with insight. He first records ten beliefs he took in with him followed by ten things he learned there. He excuses patients too exhausted to get through the first ten, yet they will refresh those already sharing their faith and may draw others to it. Piper relies on God's Word, his goodness, omniscience and control. He outlines the story of salvation and the hope of heaven, where sickness will be no more. Satan may try to shake us but is not in control. God is able to bring gain from our pain. Piper encourages us to pray for, and perhaps with, neighbouring patients. Some may welcome talk about the hope we have in the love of Jesus. And pray too that God will use for his glory every part of the (sometimes humiliating) experience of being in a hospital bed.

Many will appreciate the lessons learned. A Christian friend in hospital has already found this a book worth sharing.



The Life you Never Expected

Thriving whilst parenting special needs children
Andrew and Rachel Wilson

- IVP, 2015, 154pp, ISBN 9781783593521
- Reviewed by **Mark Pickering**, Prison GP, husband to Rachael and father to wonderfully sweet and quirky autistic teenager Zoe

This book is packed full of useful insights. It never loses sight of how parenting special needs children can be both incredibly demoralising and hugely fulfilling. It also keeps returning to an uplifting view of God's purposes for parents and children.

The many short chapters are all perceptive and easily digested in moments of respite: learning to lament like the psalmist; the value of sleep; grieving for the dreams and expectations you may have had for your children that may now never be realised. We are reminded that, whilst all children can be exhausting and challenging, and those with special needs often more so, they are sources of great blessing, reminding us and others of God's love and faithfulness in unexpected and touching ways.

Andrew and Rachel Wilson have two young autistic children, both of whom have regressed from their previous levels of function with time. They are active in church leadership and write candidly about the effects their children's difficulties have had on their commitments outside the home, and the stresses it has placed on their marriage.

The book ends with the imagery of a ship – our journey is unpredictable (for all of us), our destination uncertain (even when we delude ourselves otherwise). Yet, our Captain journeys with us, and he sustains and guides both us and our children.

eutychus

Whoever pays the piper...

Before *Triple Helix* launched, CMF took an important decision. While we knew there would be plenty of businesses willing to pay high rates to reach 4,000+ doctors, accepting commercial advertising or sponsorship could compromise the integrity of the Fellowship. This came to mind recently on reading a report about the fizzy drinks industry. Surprise surprise, if funded by a corporation in the fizzy drinks industry, research nearly always finds no link between soda drinking and obesity, whereas research with no affiliation to the industry yields a mixed picture. *Reuters/Scientific American* 15 November 2016 *bit.ly/2fuTan0*

To vape or not

Is vaping a slippery slope to smoking? A study of American teens suggests that those who regularly vape are more likely to move on to tobacco than their non-vaping peers. The study is from the University of Southern California Keck School of Medicine and the University of Pennsylvania Perelman School of Medicine. It questioned 3,000 15-year-olds and found an association between frequent use of e-cigarettes at the start of the study and smoking tobacco at follow-up. E-cigarettes may be safer than tobacco but they do pose health risks. *Mail* 8 November 2016 *dailym.ai/2fYYuf5*

Yet another healthcare gap

Personal healthtech digital devices can monitor fitness, spot potential heart attacks, check glucose levels and blood pressure. Their availability grows exponentially and in future they will help people learn even more about their personal health and health in general. All these possibilities are great. 'But most of the available technologies are not designed with and for the users who could benefit most – the most vulnerable of society,' say Public Health researchers Quianta Moore and Rebecca Richards-Kortum from Rice University. *The Conversation* 18 October 2016 *bit.ly/2fliFxy*

Scouting and guiding... good for mental health

A research team from Edinburgh suggests that belonging to Scouts or Guides is good for mental health in later middle age. The team viewed data in a long-running study of just under 10,000 people across the UK, born in 1958. They found that 28% of the participants were involved in Scouts and Guides and these were 15% less likely to suffer from anxiety or mood disorders at the age of 50 than their non-participating peers. One implication is that learning self-reliance early on brings mental health benefits. *New Scientist* and *Press Association* 10 November 2016 *bit.ly/2fHcsAr*

Child cancer and quality of life

Cancer Research reports children diagnosed with cancer in the 1990s survive longer than those diagnosed in the 1970s. There is, however, a caveat. 'There hasn't been a reduction in long-term side effects or improvements in quality of life', says Cambridge-based Dr Saif Ahmad. The US study accessed data from the Childhood Cancer Survivor Study, with information on health status on 14,000 adult childhood cancer survivors treated between 1970 and 1999. The researchers anticipated that patients treated in the 70s would report worse overall long-term health than those treated in the 90s. *Cancer Research* 8 November 2016 *bit.ly/2fZ157v*

Vaccinating mosquitoes

In the 1950s Australia introduced Myxomatosis to see off a rabbit plague that threatened to decimate sheep and cattle pastures in the continent's inland areas. Now scientists in Brazil and Colombia have a similar idea. They want to release modified mosquitoes to see off carriers of mosquito-borne diseases such as Zika, dengue fever and chikungunya. Their mosquito army will be infected by a bug called Wolbachia, which is believed to reduce the ability of infected mosquitoes spreading these viruses to people. Donors include the Gates Foundation. *BBC News* 26 October 2016 *bbc.in/2eLsuef*

Dementia and worship

Hats off to the Church of England's Liturgical Commission: it's decided to focus on the needs of dementia sufferers by return to traditional language prayers, readings and hymns and utilising touch and handing around symbols. Bishop Robert Atwell, commission chairman, says: 'Journeying alongside those living with dementia is a costly business, but hugely important in our society where dementia is on the increase. Many find that the familiar words of worship and the singing of hymns reach into confusion and unlock the gates of memory.' *Daily Telegraph* 8 October 2016 *bit.ly/2eJTv4H*

Prisoners and mental health

Few will quibble with the thought that many UK prisons are in crisis. One indicator is a sharp rise in inmates with mental health problems. The *Guardian* reports the number of male prisoners transferred to hospital under the 1983 Mental Health Act grew by 20% between 2011 and 2014. A worry expressed by campaigners is that more people with mental health problems need to be sent to hospital instead of prison. But there has been a 25% fall in courts issuing hospital orders since 2011. Statistics for women are similar. *Guardian* 14 September 2016 *bit.ly/2cqty72*

Green space yields health benefits

A new study from the University of Exeter claims outdoor exercise delivers an estimated £2.2bn of health benefits to UK adults. Scientists calculated that more than eight million people each week took at least 30 minutes of 'green exercise'. Use of parks can help reverse the trend of rising obesity levels it observes. 'What we look at here is something that can be converted relatively simply into monetary values,' explained lead author Mathew White from the European Centre for Environment and Human Health at the University of Exeter. *BBC News* 20 September 2016 *bbc.in/2dfPXGe*

Mental health patients neglected

Government figures released in August indicate serious neglect of the needs of mental health patients in England. They are denied timely treatment promised by the government, figures reveal. The official target is intensive treatment within two weeks. But figures obtained by a Freedom of Information request suggest one in four of clinical commissioning groups are ignoring the target. For its part, NHS England says it is investing more to help meet demand. The waiting-time target is that patients aged 14 to 65 experiencing their first episode of psychosis should be treated within two weeks of referral. *BBC News* 10 August 2016 *bbc.in/2aKFCMQ*

Faith offers resources for dealing with emotion, as **Alice Gerth** discovered

A PATIENT I SHOULD HAVE CRIED OVER

Eight hours into my first weekend on-call, struggling to manage the workload, my jobs list getting longer as the day progressed and my bleep went off: 'Cardiac Arrest, Orthopaedic ward'. My heart sank. An hour later, I walked off the orthopaedic ward, Mr J having been pronounced dead.

Unfolding my jobs list and scrolling through the numerous bleeps I needed to return, I was struck by a wave of frustration and anger. I found myself thinking '*What a waste of time*'. However, wanting to be seen as professional and competent, I ignored the emotions and ploughed on. Not resting, not debriefing, and definitely not crying. My pride would not allow it, nor did anyone suggest it.

Once home, the anger returned; it felt like the anger was directed at Mr J. I wanted to blame him for causing me to fall so far behind at work, for the delay in Mrs B's analgesia, for an irritated family that had to wait to talk to me, and for my exhaustion. I was ashamed to be angry with a dead patient. Anger led to guilt and that led to self-pity.

Rested, and after talking to others, my emotions made more sense. Mr J was my first cardiac arrest. The resuscitation attempt was messy and prolonged. It should never have happened as he should have had a DNACPR in situ. There was the root of my anger: rightly frustrated with the way in which this man had died.

By contrast, Jesus' actions confront the way I was thinking. He cried in public and shared in others' emotions. Throughout his ministry he demonstrated the importance of a good support network, sending out disciples in groups and keeping them with him at times of need. He readily asked for help and others to pray for him, setting an example to his apostles.

We see the same in his apostles, Paul's letters are full of requests for prayer. How much more then should we ask others for support and prayer? As Christians we should set an example by sharing our weaknesses and empowering others to share theirs.

I now discuss this experience with final year medical students before they start work; it ignites an honest conversation. I hope that it also helps them to ask to debrief, empowers them to cry and defends against burnout. By being vulnerable we strengthen those around us and allow others to strengthen us.

Alice Gerth *is an ACCS trainee in Anaesthetics.*

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