Spring 2017

for today's Christian doctor

triple helix

faith at work

beginning of life; prayer; refugee & asylum seeker health; obesity

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.

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CMF
Christian Medical Fellowship

No. 68 Spring 2017

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Pharmacists' regulator's proposal to remove conscience rights

Unethical, unnecessary and quite possibly illegal

Should pharmacists be forced to dispense drugs for what they consider to be unethical practices – like emergency contraception, gender reassignment, abortion and assisted suicide? Or should they have the right to exercise freedom of conscience by either referring to a colleague or opting out?

The General Pharmaceutical Council (GPhC),[1] the independent British regulator for pharmacists, pharmacy technicians and pharmacy premises, is proposing to replace the current 'right to refer' with a 'duty to dispense' in what it admits represents 'a significant change from the present position'.

The Council frames this 'person-centred' care in terms of a universal right for clients to 'access' legally prescribed drugs and devices. Pharmacists would thereby be pressured to comply or risk disciplinary procedures and/or possible loss of employment. Potential trainees could be dissuaded from pursuing a career in pharmacy altogether. CMF has made a submission[2] to the consultation on the draft proposal, which closed on 7 March 2017. The Council is expected to report its conclusions in the next month or two.[3]

Pharmacists who believe that human life should be respected from the time of fertilisation will generally object to dispensing 'emergency contraceptives' like *levonelle* and *ellaOne*[4] that may act by preventing the implantation of an early embryo.[5] Highly contentious gender reassignment procedures, involving hormones to block puberty in children, or to aid transsexuals to 'transition' to the opposite gender, are another area where the new regulations will put pharmacists under pressure to comply. Assisted suicide, euthanasia and home abortion are currently not legal in Britain, but were they to become so, this would leave pharmacists further exposed.

Freedom of conscience has been a core ethical value, foundational to healthcare practice as a moral activity, from the Judeo-Christian ethic and Hippocratic Oath[6] to the General Medical Council's *Good Medical Practice*.[7] The right of conscientious objection is not a minor or peripheral issue. It goes to the heart of medical practice as a moral activity. It helps to preserve the moral integrity of the individual clinician, preserves the distinctive characteristics and reputation of medicine as a profession, acts as a safeguard against coercive state power, and provides protection from discrimination for those with minority ethical beliefs.[8]

Most people can understand and respect the right of health professionals not to be involved in activities which they regard as abhorrent – obvious examples in other jurisdictions where doctors have been complicit include female genital mutilation, punitive amputation, torture, capital punishment or organ harvesting from prisoners or street children. But equally we need to recognise that many healthcare professionals in Britain, not all Christian, regard practices such as abortion, assisted suicide, gender reassignment or embryo disposal or experimentation to be similarly morally wrong.

Pharmacists are healthcare professionals in their own right. They are not rubber stamps or vending machines. Accordingly they deserve to be treated by their regulators with the respect due to their professional status and should not be forced to do things they regard as clinically inappropriate or morally wrong.

There are better ways to ensure that freedom of conscience is respected whilst still enabling people to access services to which they have a legal right.

The GPhC could, for example, leave the current guidance, which grants a right to refer, unchanged. They already admit that only 'a *small number* of complaints' relating to 'fitness to practice' are received annually.[9] Second, they could follow the GMC, which permits doctors to 'opt out of providing a particular procedure because of [their] personal beliefs and values...'.[10] Third, they could adopt the approach of the pharmacists' professional body, the Royal Pharmaceutical Society (RPS), which proposed, in the event of assisted suicide being legalised, that those pharmacists willing to dispense lethal drugs should 'opt in' by placing their names on a register.[11]

If instead the GPhC presses ahead with imposing a 'duty to dispense' it will not only be running roughshod over the professional status of pharmacists, but could also be opening itself up to a legal challenge.

There is already a substantial body of law on conscience protection, not least Article 9(1) of the European Convention of Human Rights (ECHR), which provides a right to freedom of 'thought, conscience and religion'. Whilst this is not absolute, and needs to be balanced against other democratic rights, any intervention must be shown to be *both* necessary and proportionate. It is hard to see how this move by the GPhC fulfils either of these requirements.

The GPhC's proposal to remove pharmacists' conscience rights is disproportionate, unethical, unnecessary and quite possibly illegal. Let's ensure that we speak out in support of our pharmacist colleagues and pray that the GPhC chooses a more flexible, tolerant, respectful and sensible path.

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

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Sex and Relationships Education

Should it be compulsory in schools or not?

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

The Government has announced that Sex and Relationships Education will be made compulsory in all schools, from age four.

The drive to do so seems unstoppable given that 'the numbers of STI diagnoses in those aged 15 to 24 years has risen considerably'.[1] Supporters of relationship education believe it will also help protect children from cyber bullying, pornography, 'sexting' and other such challenges. But will compulsory SRE solve these problems?

First, the vast majority of pupils in school do receive sex and relationships education. Only in academies, independent and primary schools was it not compulsory, and the majority take this area of education seriously.

Yet, despite widespread SRE STIs among young people continue to increase, faster than any other group.[2] A recent, large, Cochrane study found that sex education programmes do not reduce pregnancy or STIs.[3] This does not suggest that teaching SRE in every school will improve things.

The key issue is the basis and thinking behind sex education. Organisations behind the long-term drive for compulsory sex education (the PSHE Association, Sex Education Forum etc) champion 'non-judgmental' sex education, devoid of context such as marriage, family life, fidelity or exclusivity. It is all about individual choice – with consent. Could this change under the new Government proposals?[4]

That said, there are a couple of welcome proposals. One is the name, it will be called RSE – relationships and sex education. While this is word games it does reveal priorities by putting relationships first and placing sex in context. Second, schools will be able to teach RSE in line with their faith.

However, while parental withdrawal will be maintained for secondary schools, there will be no opt out at all for primary school pupils. Even for secondary schools the opt out provisions will be limited (only for the 'sex' part) and probably only up to age 15.

Parental concerns about making sex education compulsory have partly stemmed from concerns that children will be exposed to unsuitable materials which sexualises them (see this example)[5] while approaches based on encouraging young people to exercise self-control or chastity, and encouraging parental involvement, have attracted very little support and often outright opposition. Moral confusion has resulted from abandoning moral absolutes. The relativistic approach advocated by campaigners for compulsory SRE can actually make it easier for vulnerable children to be exploited.

Sexual intimacy is something valuable and worthy of respect.[6] If this is taught under the new Government proposals then it will be a positive development, however more likely will be pressure for ever more explicit sex education. Sex education is an ideological battlefield that impacts children from a young age. The danger is that a Government-funded strategy of undermining parents and pulling down traditional moral standards may well prevail.

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Bullying and NHS culture

How we challenge it

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

It seems hard to credit that an organisation whose primary focus is the care of the sick should have an appalling reputation for bullying and intimidation of staff. However multiple surveys[1] of NHS staff show that at least 25-30% of respondents reported experiencing bullying from colleagues and managers at some point. Ten percent say that they have experienced discrimination in the workplace, and that figure doubles for black and ethnic minority staff members, and nearly as high for disabled employees.

Alarmingly, in a recent survey, over half of those who had experienced bullying reported that they felt it had been because they had raised concerns about care standards, patients' safety or had stood up for colleagues facing discrimination.[2]

Sometimes it may be the culture of a team that singles out those who don't fit in. This is particularly true where a culture of 'getting by' has developed because of staff 'burnout'. Any staff member who seeks to give their best shows everyone else up and becomes an obvious target. Ironically, those who seek to raise standards can find themselves accused of bullying.

Furthermore, the fact that so many colleagues just won't back up or support the bullied individual for fear of becoming a target exacerbates the situation. The culture of fear and intimidation leaves many of those facing bullying isolated and even ostracised by their colleagues. Bullying can be as much a sin of omission as one of commission.

Up to a third of those experiencing bullying have been forced to leave their jobs.[3] There is a strong correlation between bullying or 'disruptive behaviours' and the occurrence of adverse events and compromises in patient safety.[4]

Workplace culture plays a big part in shaping us as professionals – but culture is not static. It is not just managers who shape the culture, we all have a role.

Christians are meant to be salt and light[5] in our workplaces; challenging bullying culture, caring for those on the receiving end, leading by example.

We need to be caring for ourselves physically and spiritually, particularly finding others to pray with us and support us, either in our churches or with other Christians in our workplaces. We need also to find and work with likeminded colleagues (not just Christians) who share a common concern to create a better working environment.

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Lord Shinkwin's Abortion (Disability Equality) Bill

Protecting the most vulnerable

Review by **Rachel Owusu-Ankomah**
CMF Associate Staffworker and junior doctor

In May 2016, Lord Shinkwin's Private Member's Bill [1] sought the provision of equality within the 1967 Abortion Act, by changing the law to ensure that disability can no longer be given as a reason for termination at any gestation.

Lord Shinkwin and the 'We're All Equal' campaign cite the 1995 Disability Discrimination Act as a key base for their proposal, as statements on their website qualify:

'We're all equal. That's what the law says, isn't it? Wrong… legal and lethal discrimination on the grounds of disability have been a reality for almost 50 years…' [2]

Currently, under Section (1)(1)d pregnancies with 'physical or mental abnormalities causing serious handicap' can be terminated up until birth, whereas a limit of 24 weeks is set for 'able-bodied' babies. There were 3,216 abortions carried out on these grounds in England and Wales in 2015, including 1,046 over 20 weeks and 230 over 24 weeks. [3]

The Bill proposed by Lord Shinkwin is, however, not supported by the BMA, RCOG, the Faculty of Sexual and Reproductive Healthcare or the British Maternal and Fetal Medicine Society. The BMA cites that 'it would be inhuman – and risk psychological harm – to make a woman carry a pregnancy to term when the fetus will not survive, if she does not want to'.

Lord Shinkwin feels it is a 'modest and reasonable' amendment and if passed is likely to have very little impact on the status quo. Women will still be able to opt for abortion up to term under sections 1(1)b and 1(1)c of the Abortion Act. Lord Shinkwin explains that passing his Bill will mean that the 'principle of disability discrimination itself would no longer be enshrined in law'.

The Bill has reached the report stage in the Lords but will not be granted any further days of debate so will now fall.

Shinkwin's Bill follows the 'Don't Screen Us Out' campaign (DSUO) [4] that is calling for the government to halt the introduction of cell free fetal DNA, non invasive prenatal testing (cffDNA NIPT).

The 2013 National Down Syndrome Cytogenetic Register (NDSCR) report shows that 90% of babies who are prenatally diagnosed with Down's Syndrome are aborted. [5] DSUO argues that NIPT would enable increased selective elimination of children with Down's Syndrome. Rather, medical reforms in the areas of accommodation, inclusion and support for disability should be enacted prior to its implementation.

This all provides food for thought for healthcare professionals on both the provision of disability care in the UK and the rights of those with disabilities diagnosed prior to birth – as well as the age-old abortion debate, especially in view of Diana Johnson's new termination Bill. [6]

The outcomes of these will speak volumes as to how we see and protect the most vulnerable people in society, as well as how we live out Christ's example of laying his life down for the weak. [7]

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New light on the horizon for social care?

Opportunities for Christians

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

This winter has been bad for the NHS for many reasons, not least of which has been the lack of social care for those medically fit for discharge. In the last year alone, the number of care homes for the elderly in England has fallen by 1,500, or 8%. Local councils now spend more than 50% of their budget on social care, but they cannot keep pace with the rise in demand or the decrease in central government funding. Indeed, in 2015-16 up to £2bn of effective subsidies for community care came out of the NHS either directly or through delayed discharges. One in three of those in need get little or no care at all, one in eight fund it themselves, another third rely on friends and family and only about one in five get most of their support through local authorities. [1]

The causes are well known – rising life expectancy means we have more retired people and a smaller tax base of working people to fund care. Families are more dislocated and fragile, so family is often less able to provide care than in the past, but even where they can, it is now for much, much longer than in previous generations.

One key problem is funding. We do not have a system (private or nationalised) to save up money for our future care needs. Consequently, it falls on over stretched and underfunded local services or personal assets (including houses and life savings) to fund care. A national care insurance programme may be a long-term solution. [2] Integrated health and social care budgets and organisational structures may offer a quicker fix, although the evidence for this has yet to emerge. [3]

Another is to form new kinds of multi-generational households – not just consanguinal family, but other forms of shared households, such as the model pioneered by L'Arche. [4]

The Church and Christian organisations have a key role to play in all of this – from providing social support and community integration for vulnerable people and their families and carers, to running essential services and raising funds. Indeed, many already are at the cutting edge of meeting these needs. [5] This is an area where we have a lot to contribute as health professionals.

Whatever the way forward, it will require new thinking, new cooperation and leadership at all levels, from government to the local community.

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Philippa Taylor outlines some key areas for the coming year

BEGINNING OF LIFE ISSUES IN 2017

key points

- The 50th anniversary of the Abortion Act is likely to spark debate from both sides, particularly in Northern Ireland and the Isle of Man.
- Conscientious objection will be a big issue in 2017 as the General Pharmaceutical Council proposes to restrict significantly – possibly remove altogether – the right for pharmacists to object conscientiously to dispensing emergency contraceptives.
- The question of allowing abortion on the grounds of disability will continue with Lord Shinkwin's Abortion (Disability Equality) Bill, the 'We're All Equal' campaign and concerns that NIPT will have a negative impact on people with Down's Syndrome.

This year will be another busy and challenging year on beginning of life issues.

Abortion

October 2017 marks the 50th Anniversary of the 1967 Abortion Act. Throughout the year this significant anniversary will generate media publicity, events, stories from women and will fire up campaigns by those who want to see the laws tightened up (or at least adhered to) as well as those who want to relax the law on abortion even more. Already a Ten Minute Rule Bill has been debated in Parliament, seeking to decriminalise abortion and effectively legalise it, on demand, up to birth.[1]

We expect to see more focus this year on the operation of abortion clinics in the UK and Africa,[2] and new research on the link between abortion and preterm births. There will be ongoing debate on the discriminatory provision in the Act that permits abortion to term for disability, as a result of Lord Shinkwin's Abortion (Disability Equality) Bill and the 'We're All Equal' campaign that supports the Bill.

It will be fascinating to see what happens in the United States under the more overtly pro-life administration of Donald Trump. Already there has been media heat generated over the defunding of Planned Parenthood, the biggest abortion provider in the US, and over the President's nomination of Neil Gorsuch to the Supreme Court. Gorsuch has a strong record of protecting life and religious liberty.

Artificial gametes

Scientists have now created artificial mouse eggs,[3] using just a bit of mouse skin, and used these eggs to produce fertile pups. While it is unlikely that humans will be born via artificial eggs anytime soon, it is likely that we will see more teams developing artificial human gametes for research purposes. (In 2015 scientists from the UK and Israel created precursors to gametes from embryonic stem cells.)

Chimeras

Scientists are already creating human-animal chimeras in the United States and the National Institutes of Health (NIH) proposes to fund more experiments. Some research with chimeras is ethical; however newer forms of stem-cell-based chimera research involving the use of embryos means the human cells could become anything, including human eggs or sperm, and would increase human/non-human mixing.

Conscientious objection

2017 is a crucial year in the fight for freedom of conscience for Christians. The General Pharmaceutical Council is proposing significantly to change the conscience protection currently provided for pharmacists by removing any reference to referral and instead requiring pharmacists to participate directly in activities that they believe are morally wrong. If implemented, this would establish a precedent for overriding the consciences of doctors, nurses, other health professionals and more generally in society.[4]

Contraception

As noted above, there is pressure to significantly restrict – possibly remove altogether – the right for pharmacists to object conscientiously to dispensing emergency contraceptives.[5] CMF will publish a new booklet *Contraception: a guide to ethical use* – written specifically for Christians – so expect to see the publicity later this year.

Embryo research

Scientists in the UK have succeeded in growing human embryos in the laboratory for longer than ever achieved before, and are now pressing to go further, beyond the current legal limit of 14 days. Expect more publicity and vocal calls by scientists for extension to the legal research limit, but no actual legal change – yet. The race is also on to make artificial embryos in the lab, with announcements of some success in this by a British team in March this year.[6]

Gene editing

There have been tremendous advances in gene editing in the last two years, which will continue, primarily through the use of CRISPR-Cas9 and other similar techniques. They currently appear to offer novel and powerful approaches to modify genomic sequences and treat many human diseases, including HIV/AIDS, haemophilia, sickle cell anaemia and several forms of cancer. Expect further progress with therapies.

Gene editing of embryos

Gene editing of embryos is also proposed by UK scientists as a way to rid the human race of certain genetic conditions. Specific enzymes are added to the early embryo, to cut and replace particular DNA regions, creating changes that will pass down generations. New, more accurate enzymes have brought human gene editing closer to reality. Expect to see more advances in research on embryos, but not therapies yet.

Isle of Man

The present conservative Manx abortion law is likely to come under threat this year. HEAR (Humanity and Abortion Reform), a pro-life campaign group and CALM (Campaign for Abortion Law Modernisation) are two new groups that will be at the heart of public debates on abortion law reform in 2017.

Mitochondrial replacement research

The Human Fertilisation and Embryo Authority has recently permitted the creation of three-parent babies in the UK, so this will progress in 2017. The world's first 'three-parent baby' was born in Mexico in April 2016 using genetic material from two mothers and one father, a second one was born in the Ukraine this year,[7] and no doubt we will hear of others in 2017 in other unregulated environments. We may not hear so much about the failed attempts.

Non invasive prenatal testing

The Government is intending to implement cell-free DNA (cfDNA) screening, a technique that is able to detect disability more accurately in unborn children, into the NHS Fetal Anomaly Screening Programme in the next three years. This will likely be rolled out from 2018, but expect to see more publicity about the discriminatory effect of these tests, and their negative impact on people with Down's Syndrome, driven by the 'Don't Screen us Out' campaign. There are new tests in the pipeline, with improved accuracy, speed and ease of use, that will be able to screen babies in utero for single-gene disorders like muscular dystrophy or Huntington's disease.[8]

Northern Ireland

Despite the political uncertainly in Northern Ireland, it is still probable that there will be debates in the Assembly, in the media and public campaigns to change the law to allow for abortion for diagnoses of fatal fetal abnormality. If so, also expect Assembly debates on legislation to increase support for pregnant women receiving such a diagnosis. A new campaign, 'Both Lives Matter', has been launched to defend current laws on abortion and to support women with an unplanned pregnancy better.

Robotics

Alongside a significant rise in the use of robotics and nanotechnologies in medicine in the immediate future, robotics is already being utilised to improve the accuracy of 18–20 week ultrasound imaging and screening in pregnancy, searching for fetal anomalies.

Scotland

The devolution of abortion law as part of the Scotland Act 2016 will generate a campaign to remove some of the legal restrictions on abortion access and develop a Scottish approach to provision of abortion, which will be vigorously opposed by pro-life groups.

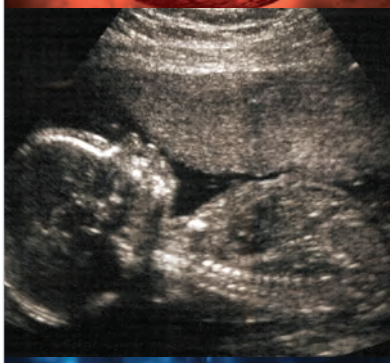
Surrogacy

There will be more concerted efforts to remove some of the legal restrictions in the UK on surrogacy to make surrogacy easier for any commissioning parent(s) and to remove some of the parental rights of surrogates, as well as making surrogacy contracts enforceable. The complexity of modern parental arrangements, driven by gamete donation, surrogacy and demand from infertile and same sex couples for children will generate more court cases to determine who is a 'parent'. In contrast, in Europe two developments this year have restricted surrogacy arrangements and strengthened the protection of children born to surrogates.[9] Perhaps one outcome of 'Brexit' is that Europe may be spared some of the pernicious influence of the UK's attitude to surrogacy – and perhaps also in some of the other areas where the UK leads the way in unethical research.

Blessed be the name of God forever and ever, for wisdom and might are his. And he changes the times and the seasons; he removes kings and raises up kings; he gives wisdom to the wise and knowledge to those who have understanding.[10]

Please pray for wisdom, knowledge and grace for the CMF Public Policy team in 2017!

***Philippa Taylor** is CMF Head of Public Policy.*



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Alice Gerth explores how Christian healthcare professionals can better approach the obesity epidemic

CHRISTIANS, THE CHURCH & 'FATTISM'

key points

- Struggles with 'body weight' can stretch to either extreme but our culture seems more judgmental of overweight people.
- As healthcare professionals we need to be supportive and non-judgmental in discussing patients' exercise and eating habits.
- In church a practical way we can support those trying to eat more healthily is to examine our catering. Most churches offer tea and cake after the service, how about a bowl of fruit alongside?

Obesity is not a new phenomenon, but it is increasingly on the secular agenda. Struggles with 'body weight' can stretch to either extreme – from restrictive 'clean' eating to morbid obesity. Yet it seems our culture is more judgmental of people who are overweight than underweight. Each of us should look to ourselves before we comment on friends or patients, removing the plank from our own eyes in order to see clearly to remove the speck of dust from others'.[1] As Christians it is easy to become self-righteous in our response, to describe obesity as a sin – a consequence of looking for satisfaction in food and an absence of self-control.

There are elements of truth in this. Culturally, gluttony and sloth are two of the seven deadly sins described in the fourth century, but we are all at risk of allowing food and exercise to rule us – whether through the guilt of too much food and not enough exercise or the idol of fitness and healthy living. I know that I swing between the two; collapsed on the sofa gorging on a bag of chocolates after a long day at work or else putting on my running kit, hitting the road and eating the latest 'superfood salad'; either looking to chocolate to feel better or to exercise in the hope that it will drive away the stress and negativity of work. Instead, in these things I should be thanking God for the good gifts that he has given me (chocolate and running), but not seek satisfaction in them. As doctors and nurses we are particularly at risk of making gods of health and exercise. We compete over our latest runs, cycles or fitness regimes. We admire health in others and look down on those who 'let themselves go'.

As doctors and nurses we are particularly at risk of making gods of health and exercise.

However we cannot ignore the consequences of being overweight, on a population or individual level. Estimates for 2012-2014 are that 66% of men and 58% of women in the UK are overweight and 25% of men and women are obese. These numbers continue to rise with the greatest rate of rise seen in those with severe obesity. Obesity rates are highest in the most deprived members of our society (28%) and reduce with socio-economic state to 20% in the least. The cost of obesity is thought to be £6.1bn to the NHS and £27bn per annum to the wider economy.[2] Individually, it increases your risk of diabetes, heart disease, cancer, liver disease and many other illnesses, with an average reduction in life expectancy of three years.[3] If we truly love our neighbours this is something we should want to help with.

Obesity is a complex condition affected by an individual's psychology, physiology, physical activity and diet. Not all of these are modifiable but we can help those who struggle with being overweight to do more exercise and improve their diet. But what does this look like practically in our church families and with our patients?

Patients

As a medical student I was taught that smoking and alcohol were essential parts of a patient's social history. Daily exercise and normal diet did not feature. But are they not equally important? Having discovered my patient smokes I am then meant to warn them of the dangers of smoking. Again, no such warning for being overweight. This culture needs to change, we need to be discussing patients' exercise and eating habits: in a supportive, non-judgmental manner. To do this we need to know what exercise and weight loss services are available locally and acknowledge that it is not easy. Arguably, obesity is harder to fix than smoking. A smoker can go cold turkey and count the number of cigarette-free days. Smoking is frowned upon in our culture, the temptation is hidden behind silver shutters at huge prices and smoking is prohibited in enclosed public spaces.

By contrast, it can take weeks to see the effects of a change in lifestyle. High calorie food is available and discounted in every supermarket and adverts saturate our televisions and billboards. The odds really are tipped against those trying to change. We need to engage with policy makers and vendors to make healthy choices more affordable, and reduce the prevalence of junk food adverts and outlets in our communities.

At work it is easy to become desensitised to unhelpful comments or thoughts about 'fat' patients, to curse them for your woes. Whether the surgeon struggling to find an appendix in and amongst the intra-abdominal fat; the F1 unable to find a vein under the subcutaneous fat; the ultra-sonographer unable to comment on the possible DVT due to poor quality images; the A&E trainee physically exhausted trying to do good quality chest compressions on the obese patient who barely fits on the trolley. We forget the person and only see the condition.

Resources

The condition makes our job harder, and utilises a disproportionate amount of resources both in terms of clinician time and financially. In an NHS that is struggling, these resources come at the expense of others who we may feel are more deserving – such as the frail elderly patient waiting for a cannula and her IV fluids or the possible cancer patient awaiting an ultrasound guided biopsy. By identifying this predisposition it helps us fight against any prejudices whilst acknowledging the challenges obese patients bring.

Friends, family & church

Weight, body image and self-confidence are emotive areas and as such I tread carefully, but I can't ignore the elephant in the room. Our churches are part of society and full of struggling sinners. Amongst those sinners are those who struggle with weight and body image, and yet rarely have I heard a sermon on the subject. If we chase after health with fitness and 'superfoods' we are seeking to control our own mortality. If we eat to excess and do not exercise sufficiently we are not caring for God's creation in ourselves. Going deeper we need to examine why we eat to excess. Are we looking for satisfaction in food rather than God?

At times in my life I have felt ruled by my stomach, fluctuating between over indulgence and dieting; all the time struggling with my self-worth as I looked for happiness and popularity in being slender and sporty. As a teenage girl I was particularly vulnerable. I can recall many a talk from my teenage years on lust and pornography but none on gluttony and body image. Why are we more comfortable talking about sex than being fat or anorexic? I wonder if this is partially because it is so visible. At school we knew who struggled with anorexia or bulimia, we could see it in their habitus and eating habits, and we knew who was fat. Speaking publicly on these issues requires grace as those struggling the most are visible to the whole congregation and, unless you belong to a tight-knit church, this may feel ostracising. In the same way broaching the subject on an individual level feels indiscreet and intrusive.

A practical way we can support those trying to live more healthily is to examine our catering. Most churches offer tea and cake after the service, how about a bowl of fruit alongside? When we hold events with a main meal perhaps spend a little more to allow options using fewer cheap carbohydrates and more vegetables and protein. Another is to meet for 1-2-1s by going for a walk, or activity, rather than coffee and cake. This brings other benefits – I have had some of my best conversations whilst walking round a park; silences seem more acceptable and so quick 'easy' answers are avoided.

Conclusion

Obesity isn't going away. It is a reflection of an overindulgent culture and it affects our church family. We cannot ignore it but when we engage with those struggling we must be gentle and wise. Its prevalence will continue to increase unless we change corporate, church and individual behaviour. At the same time we need to look at our own behaviour – are we overweight and unfit or chasing fitness and healthy eating? Anything that distracts us from seeking God is sinful, however 'good' it may seem.

Alice Gerth *is an ACCS trainee in Anaesthetics.*

Obesity isn't going away. It is a reflection of an overindulgent culture and it affects our church family. We cannot ignore it but when we engage with those struggling we must be gentle and wise.

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Aaron Poppleton
compares the parable of the Good Samaritan to healthcare today

CARING FOR REFUGEES & ASYLUM SEEKERS

key points

- The three main characters in the parable of the Good Samaritan each shed light on different dimensions of caring.
- The legal expert who questions Jesus may well reflect dilemmas faced by NHS managers puzzling about how to target limited resources.
- The Samaritan is a symbol of some of the issues which occur with care for vulnerable displaced persons where there are racial and cultural issues to be overcome.

What motivates us as Christian healthcare professionals to work with vulnerable individuals such as refugees and asylum seekers? The Bible has a lot to say on caring for those in need. The well-known parable of the Good Samaritan is a notable example:

On one occasion an expert in the law stood up to test Jesus. 'Teacher,' he asked, 'what must I do to inherit eternal life?' 'What is written in the Law?' he replied. 'How do you read it?' He answered, '"Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind"; and, "Love your neighbour as yourself"'. 'You have answered correctly,' Jesus replied. 'Do this and you will live'. But he wanted to justify himself, so he asked Jesus, 'And who is my neighbour?' In reply Jesus said: 'A man was going down from Jerusalem to Jericho, when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he travelled, came where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him. The next day he took out two denarii and gave them to the innkeeper. "Look after him," he said, "and when I return, I will reimburse you for any extra expense you may have". Which of these three do you think was a neighbour to the man who fell into the hands of robbers?' The expert in the law replied, 'The one who had mercy on him'. Jesus told him, 'Go and do likewise'.[1]

Care can be costly and challenging today in the UK. While providing comprehensive and largely high quality care, the NHS is rich in complex systems, limited in resources, and bound by cultural and legal frameworks.

Within this passage, we see three individuals who have quite different responses to the challenges of God's law.

Firstly there's the expert in the law. He stands up to test Jesus, asking what he must do to inherit eternal life. He knows what God's law says – that he should love God with all his heart, mind, soul, and strength, and to love his neighbour as himself. However, not wanting to be upstaged by Jesus, he requests a more specific answer. Who is his neighbour? Who is it that he should be seeking to

love? He wants to know how or where he should focus his efforts. Surely this is a man with NHS resource management at heart! Who should he concentrate his limited time and resources on? What criteria should he aim for in order to meet biblical NICE guidelines and to ensure a heavenly rating on his personal CQC outcome? Yet, Jesus has a different kind of loving care in mind, one that is much broader than the expert in the law had grasped. It's a new heart that Jesus requires of people, not knowledge. The question Jesus has in mind is not, 'who is my neighbour?', but 'how can I be a loving neighbour?'

The second person to focus on is the Samaritan. He's the third man to notice the injured individual by the roadside but the only one that shows compassion towards him. He is the one who puts salve on his wounds and dresses them. He goes on to transport the man using his own donkey, which implies that the man's injuries were too severe for him to walk. The Samaritan goes further still, taking the man to an inn and ensuring that he gets further medical attention and care. For a Samaritan to help a Jew was unthinkable. Thus, it is ironic that he is the unexpected saviour of a Jewish traveller who has been left for dead. All the more so when two ministers of God's law, a priest and a Levite, chose not to be associated with the Jewish man as it would make them 'unclean'. The loving care that the Samaritan provided was not conditional on the man's background or status. As the altruistic hero in the story, I wonder whether we would like to see ourselves in the Samaritan's shoes. I know I'd like to think that I wouldn't walk past a wounded individual at the roadside. However, what parallels can we make with our work or study as healthcare practitioners in 21st century Britain? There are many barriers and challenges to providing compassionate care to the patients attending our wards and clinics. Barriers such as time, 'I'm already running late for my next appointment, perhaps I won't address that issue now'; or culture, 'is it appropriate for me to talk about domestic violence or sexual health with my Muslim patient?'; or personal 'they weren't thankful for my efforts last time, why should I work above and beyond for them again?'

Finally there's the Jewish man on a journey, who is left for dead by the side of the road. It's not difficult to see similarities with the migrant situation in Europe today. The media reports on the thousands upon thousands of people who are risking their lives to reach Western and Northern Europe. The horrific trafficking process along the way can leave many physically and mentally traumatised, stripped, and left abandoned. We even hear of some who pay for their journeys with their lives, as they try to escape Syria, Afghanistan, and North Africa. However, unlike the media reports we hear, Jesus does not provide any details about the background of the man in the parable. We are told that the man was on a journey between Jerusalem and Jericho, and the parable assumes that he is Jewish. Beyond that we have no more information regarding his identity or the purpose of his journey. Interestingly, Jesus doesn't tell us how this man responded to the merciful care given to him by the Samaritan (if at all). We are left in the dark as to whether the man had any expectations of care; if suspicions or accusations were raised by others, such as the innkeeper, as to the Samaritan's motives; how the journeyman felt about being picked up by a Samaritan; or even if any gratitude was expressed by the man.

When we consider Jesus' purpose in telling this parable, the limited background information is fitting. Our neighbour is not decided based on ethnicity, religion, gender or any other discriminating characteristic. Equally, God saves, heals, and sanctifies us through Jesus not because of who we are, but because of who he is. His salvation to us through the cross is not a conditional transaction, but an unbridled, unbounded, and extreme unilateral act of his loving forgiveness and grace towards us. Refreshing ourselves daily through his Word, building a greater view of his character, reminding ourselves of what he has done and achieved for us – this will be a much more compelling factor for us in providing care for vulnerable people, than altruism, pity, or a sense of duty.

This is important; such care can be costly and challenging today in the UK. While providing comprehensive and largely high quality care, the NHS is rich in complex systems, limited in resources, and bound by cultural and legal frameworks. Furthermore, some of our patients can be difficult to love. They can be demanding in their expectations and have a different agenda to what we feel is best. Asylum seekers and refugees are by no means exceptions to this. Their limited finances, often difficult social situations, and uncertainty of residence can further heighten such tensions. Recognising God's forgiveness and ongoing patience towards us will give us patience in working for those who struggle even more than we do with the challenges associated with healthcare delivery in 21st century Britain.

It's not just knowledge we need to care for refugee and asylum seekers. As the parable shows, to use knowledge to provide compassionate and effective care we need to turn our hearts on a daily basis towards the great physician. Through Jesus' self-sacrificial love, shown on the cross, he forgives our sin and meets our deepest need.

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I know I'd like to think that I wouldn't walk past a wounded individual at the roadside. However, what parallels can we make with our work or study as healthcare practitioners in 21st century Britain?

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Alasdair Henderson
discusses what the law and professional guidance says about sharing your faith in the workplace

FAITH AT WORK

key points

- Christians still have a lot of freedom under the law to speak about Jesus in the workplace. An employer cannot simply restrict all religious speech.
- So long as you seek to share your faith in a biblical way – clearly and openly, in love and with gentleness and respect, and with wisdom and discernment – the law and professional guidance is largely on your side.

If you have been following the news over the past couple of years you may have got the impression that it is becoming harder for Christians to share their faith openly in the workplace. There has been high-profile reporting of several cases in which Christians have been disciplined, or even lost their jobs, for trying to say something about the gospel at work. A few of these cases have been in the NHS, and it can sometimes seem that the public sector, and the healthcare field in particular, is one of the more hostile spaces in which to try to talk about your beliefs.

If that is the impression you have got from the media, please do not get scared! Yes, there have been some Christians who have faced disciplinary action for evangelism in the workplace, but these cases are few and far between, and the specific facts are often more complex than newspaper reports would lead you to believe. Christians should affirm the work of organisations that defend people suffering injustices because of their witness. However, the reality is that, at least in terms of the law, Christians still have a lot of freedom to speak about Jesus in the workplace. Sadly what the law requires is not always fully appreciated by employers and fellow employees or put into practice as it should. Even when Christians adhere to what the law requires, following Jesus and faithfully proclaiming the gospel might mean persecution; there is a cost of discipleship. And the Bible does not promise that Christians will not suffer for their faith, just the opposite. But it is still important for Christians to understand their legal rights and stand up for both themselves and others when they face

It is still important for Christians to understand their legal rights and stand up for both themselves and others when they face any unlawful intimidation or marginalisation.

any unlawful intimidation or marginalisation in the workplace as a result of sharing their faith.

The danger is that excessive focus on stories about the rare cases where things have gone wrong leads to a 'chilling effect', causing many Christians to become unduly nervous about exercising their legal freedoms. This chilling effect is a serious problem as it hinders and restricts proclamation of the gospel. Somewhat ironically, it also raises the risk that our freedoms might be more curtailed in future. If we do not exercise our rights then we may actually lose them. If our employers and colleagues get the idea that most Christians do not really want or need to be able to be open about their faith at work, then those Christians who are still bold enough to speak up will be perceived as more extreme and limits on their freedom will begin to seem more reasonable.

The important and reassuring truth is that in the UK, so long as you seek to share your faith in a biblical way – clearly and openly, in love,[1] and with gentleness and respect,[2] and with wisdom and discernment[3] – the law and professional guidance is largely on your side.[4]

The two major pieces of law that apply to all workplaces are the European Convention on Human Rights (ECHR) and the Equality Act 2010. The ECHR gives everyone the right to freedom of conscience, thought and belief, and freedom of expression. These freedoms apply in the context of employment, as anywhere else. The rights are 'qualified', which means they can be limited in certain circumstances. However, the European Court of Human Rights has recently affirmed the importance of the freedom to be able to speak about faith in the workplace, so an employer cannot simply restrict all religious speech.

The Equality Act 2010 prohibits discrimination against employees on the grounds of various 'protected characteristics'. One of the protected characteristics is religion. Thus if a Christian doctor, nurse or other healthcare professional is treated differently, either directly or indirectly, because of his or her faith, that is unlawful. Similarly, if a Christian is harassed, ie subjected to unwanted conduct related to his or her faith that violates dignity or creates an intimidating, hostile or offensive working environment, that is unlawful.

Of course, the provisions of the ECHR and Equality Act 2010 also protect employees with other religious beliefs and employees who identify as homosexual, bisexual or transgender, amongst others. This could lead to a 'clash of rights' if, for instance, a gay employee takes offence at a Christian employee's opinion that marriage is solely between a man and a woman.

However, even on such controversial topics where people differ greatly in their views, Christians will generally be protected by the law if they share their beliefs, provided some basic principles are followed. All of these principles are actually both biblical and grounded in common sense.

1. **Pray**. It is always wise to ask God for good opportunities, wisdom and the right words to say. It is also usually appropriate to ask someone if you can pray for them (although more care must be taken with patients – see further below).

2. **Choose the most appropriate time and place**. Remember you are at work to work. We should work hard, in a manner pleasing to God and honouring to our employer.[5] This is an important part of our Christian witness, as well as actually speaking about the gospel. So look and pray for opportunities to speak of Jesus, but when they arise try to follow them up outside working hours or outside the workplace if possible. The more removed a conversation is from the workplace itself, the less concern it is for an employer, and the more relaxed and engaged the person you are talking to is likely to be.

3. **Be explicitly Christian**. Religious beliefs have greater protection in law than other beliefs. So do not be shy about saying how your faith informs your opinions. If you say 'as a Christian, I believe that…' or 'the Bible says that…' it is much more difficult for an employer to complain than if you simply express your view without making it clear it is based on your faith.

4. **Don't abuse your authority**. Abusing power in the workplace is wrong.[6] In general the law strongly protects your freedom to express your beliefs at work towards peers or those higher up in the organisation, but allows employers more scope to restrict such freedom in relation to subordinates or people who are vulnerable to pressure. So if you manage or supervise a colleague, be careful not to give any impression whatsoever that you are abusing your authority. For healthcare professionals, it is also very important always to be aware that patients are in a vulnerable position.

5. **Be gentle**. Even an employer who is personally antagonistic to Christianity will find it difficult to criticise a message delivered in reasonable language and a moderate tone. Dialogue is better than a lecture. Asking questions is better than only expressing your own opinion. Personal testimony is more persuasive than abstract truths. Ongoing discussions are better than isolated one-off conversations. We want to win souls for Christ, not just win arguments.

6. **Respect people's wishes**. The model of both Jesus and the disciples was to give everyone the opportunity to hear the gospel, but if people showed they were not open to the message, to move on elsewhere.[7] If a colleague or patient makes it clear that faith discussions are unwelcome, they should not be pursued.

Dialogue is better than a lecture. Asking questions is better than only expressing your own opinion.

resources

The Evangelical Alliance and Lawyers' Christian Fellowship have recently published a resource called *Speak Up* which deals with many of these issues in much more detail. It's written in accessible language, not legal jargon, and is available to download for free as both a 70-page booklet and a 16-page summary leaflet here: *bit.ly/2ofVaCN*

The Saline Solution is:

- a practical tool
- designed specifically for healthcare workers
- teaches how to share the love of Jesus with patients and colleagues with permission, sensitivity and respect
- delivered by healthcare workers
- one day course format
- encouraging, inspiring interaction with others in the healthcare field

See the CMF website for upcoming courses.

There are of course particular concerns that arise in the context of the doctor-patient relationship. However, the GMC has helpfully issued guidance which makes it very clear that doctors are able to talk about religious beliefs with patients, and indeed must take into account a patient's beliefs, so long as care is taken not to abuse the doctor's professional status.

The main code of conduct for doctors, *Good Medical Practice* (2013),[8] contains the following relevant principles:

- When assessing, diagnosing or treating a patient, a doctor must take account of the patient's full history, including spiritual factors, their views and values (paragraph 15).
- Doctors must treat patients fairly and with respect whatever their life choices and beliefs (paragraph 48).
- If a doctor has a conscientious objection to a particular procedure he or she must explain this to a patient, tell them about their right to see another doctor (and ensure they can exercise it), and avoid implying or expressing disapproval of the patient's lifestyle, choices and beliefs (paragraph 52).
- A doctor must not express his or her personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress (paragraph 54).
- A doctor must not refuse or delay treatment because he or she believes that a patient's actions or lifestyle have contributed to their condition (paragraph 57).
- Doctors must not unfairly discriminate against patients or colleagues by allowing their personal views to affect professional relationships or the treatment provided or arranged (paragraph 59).

The GMC has also provided more detailed *Guidance on Personal Beliefs and Medical Practice* (2013). In this the GMC emphasise that they do not wish to prevent doctors from practising in line with their beliefs and values, as long as they also follow the guidance in *Good Medical Practice*. Neither does the GMC wish to prevent patients from receiving care that is consistent with, or meets the requirements of, their beliefs and values (paragraph 3). The key thing is to ensure that patients are not treated unfairly, in a way that causes them distress or in a manner which denies them access to appropriate medical treatment or services (paragraph 4). In terms of talking to patients about personal beliefs, paragraphs 29-31 explain that in taking a history it may be appropriate to ask a patient about their personal beliefs. However, a doctor must not put pressure on a patient to discuss or justify their beliefs, or the absence of them. During a consultation, doctors should keep the discussion relevant to the patient's care and treatment. If a doctor does disclose any personal information to a patient, including talking to a patient about personal beliefs, he or she must be very careful not to breach the professional boundary that exists, which is essential to maintaining a relationship of trust between a doctor and a patient. Thus, a doctor may talk about his or her own personal beliefs only if a patient asks directly about them, or indicates they would welcome such a discussion. At no time should a doctor impose their beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.

The same broad principles will apply to nurses. The NMC Code requires nurses and midwives to 'make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way' (paragraph 20.7). Unlike the GMC, the NMC has not provided any further specific guidance, but it is important to note that the Code does not prohibit expression of personal beliefs in the course of carrying out nursing or midwifery duties; it simply requires that such expression is done appropriately. It also requires nurses and midwives to respect patients' choices (paragraph 1.3), and make sure that a patient's social and psychological needs are assessed and responded to (paragraph 3). This latter duty will require being attentive to any religious or spiritual needs.

However, one specific point which nurses and midwives should be aware of is that the NMC has produced Social Media Guidance which cautions against posting anything on social media that 'may be viewed as discriminatory' or 'does not recognise individual choice'. This is worded so vaguely that a nurse or midwife may be criticised for posting content on social media about controversial topics, for instance Christian views on same-sex sexual activity, even if these are expressed carefully and lovingly.

As long as healthcare professionals are sensible, compassionate and put patients' interests first, the law and professional guidance is clear that sharing your faith at work is entirely appropriate. If you have been worried by media reports to the contrary, then be reassured. And if you or a colleague face any pressure from managers as a result of exercising your freedoms, then gently but firmly draw the relevant legal principles to their attention.

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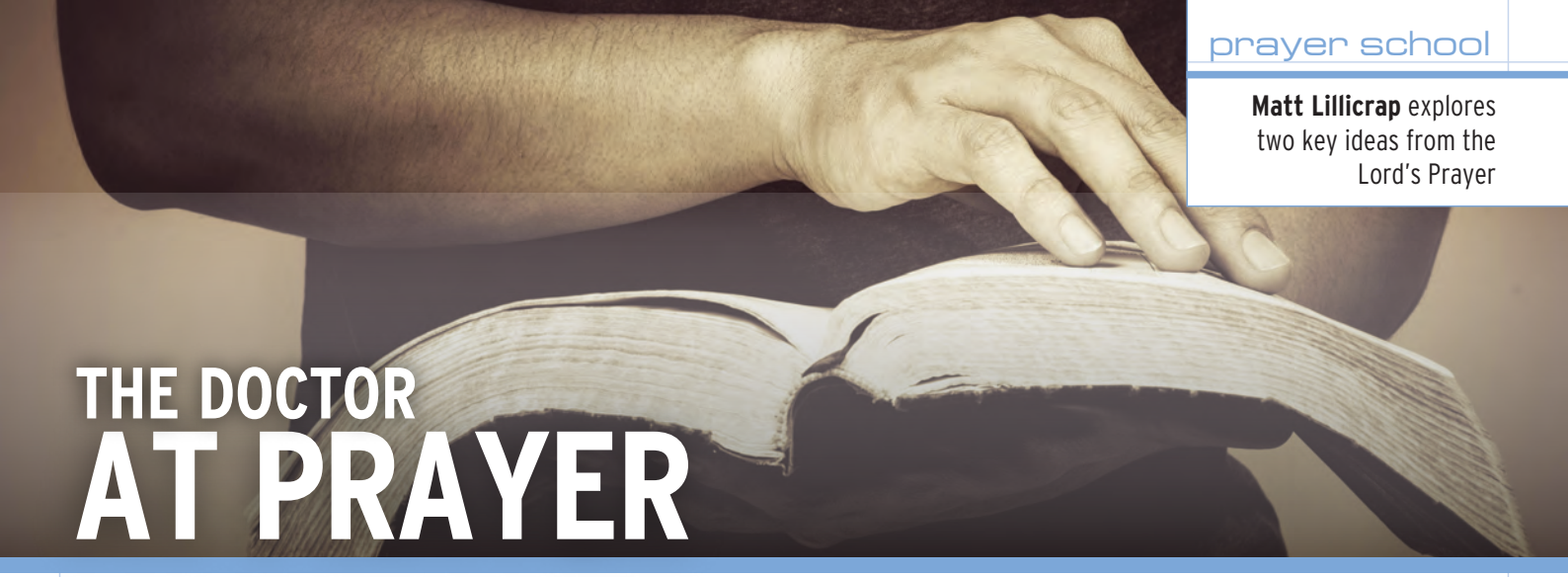
Matt Lillicrap explores two key ideas from the Lord's Prayer



THE DOCTOR AT PRAYER

When it comes to prayer, it's a relief to notice that Jesus didn't browbeat ('You! Pray more!') or offer a system. Instead, he gave us a prayer-model packed with unimaginable riches. The foundation of the Lord's Prayer will drive us to our knees and overcome the guilt-induced approach to prayer.[1] Every clause paints an astounding picture of God and those knelt before him. It gives us a deeper knowledge of both God and ourselves.

Knowing God: our Father the Holy King

Our Father in heaven,
hallowed be your name.[2]

There is a wonderful (probably apocryphal) story about Abraham Lincoln. He gave his son a pet goat (naturally), which he harnessed to a kitchen chair and regularly rode through the White House. One day, after Lincoln had been delayed over an hour for a meeting with his civil-war officials, the doors burst open and Lincoln Jr charged through the room, propelled by said goat. The President's response? He leapt from his chair, whooping with delight, chased him out of the room and didn't return for another hour.

This access of son to father lies behind Jesus' opening words. Just ride on in with your goat! The point is that God delights in his children. Yet, often we imagine our lives are insignificant. God may be generally interested, but details? What are my joys, troubles or struggles when there's a universe to run? Jesus, though, won't allow this – he insists we call God 'Father'. As we trust in Christ, his standing before God becomes ours. We are drawn into the life of the triune God as he gives us the Spirit of adoption so that we cry 'Abba',[3] calling the Son's father, 'our Father'.[4] This is prayer driven by our adoption as God's child. He is neither distant nor unpredictable, because he delights in us.[5] Will this vision of God draw you to your knees?

Pause here though. Hearing this can leave us imagining God on the same scale as us, a (super)human father, just bigger and better. If that's the case then prayer becomes talking to someone who, however powerful, is still a bit like us.

That might not sound like much of a problem. After all, doesn't prayer itself assume we can talk to him as we would anyone, anytime, anywhere? Again, Jesus won't allow this. After the astonishing opening, the first half of his prayer is saturated with God's 'otherness'. This is an unfashionable picture of God – God on a different scale entirely – the God whose name is to be hallowed. When we pray we tread on restricted-access hallowed turf. He is utterly holy, pure, even unapproachable. So we are praying that he be treated with the respect he deserves as Isaiah's thrice-holy God,[6] as John's exalted king.[7] He is not a bigger version of ourselves, into whose presence we may simply wander. He is the only being in the universe who depends on no one and nothing else, but on whom the whole of creation depends completely.

This bigger vision of God must fuel our prayers. Then combine this otherness with his fatherly nearness and the effect is breath-taking. This utterly-holy, entirely-independent, all-powerful, uncreated-creator of the universe… we call him 'Father'.

Knowing ourselves: dependent and forgiven

Give us today our daily bread.
And forgive our debts, as we also have forgiven our debtors.[8]

Right knowledge of God leading to right self-knowledge is the theme for the second half of the prayer.[9] While the camera has been zoomed in on God's majesty, now we zoom out a little and glimpse ourselves knelt before him.

It's a humbling picture for self-sufficient high achievers, as healthcare professionals tend to be. First, we are dependent creatures praying for daily bread, everything we need today, every day. This is easy to forget. We work hard, open savings accounts, invest in pensions, swallowing the illusion of self-sufficiency. But who enables it? Who gives 'life and breath and everything else?'[10] As we pray, we need a smaller vision of ourselves as dependent creatures.

Second, we are dependent debtors. We're all too familiar with debt nowadays; student debt, government debt, NHS debt; but the big question is, how much? When Jesus confronts us with this, do we really hear the depth of our spiritual bankruptcy? We owe God an unfathomable debt for our declaration of independence from our rightful Holy King, living as though we do not need him, but how can we repay? Everything we have and are is his in the first place.

Here, then, is the twofold vision that should drive our prayer; God, all-powerful, independent, approachable as Father; and us, dependent children, subjects of the Holy King, creatures of the uncreated-creator, sinners forgiven by the gracious Saviour.

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5. The language of 'father' can cause some to stumble. Where experience of a human father has been negative, this can colour these words in such a way as to make them difficult to hear
6. Isaiah 6
7. See Revelation 4 for John's vision of God's throne, almost inaccessible and encircled by thunder and lightning, angelic beings, and a vast sea
8. Matthew 6:12-13
9. This is the foundational point Calvin famously opens his Institutes with: Calvin's Institutes Book 1, Chapter 1, I and II
10. Acts 17:25

Niru Arulanantham identifies cross-cultural issues that surface in healthcare

CROSS-CULTURAL COMMUNICATION IN HEALTHCARE

key points

- Approximately 40% of medical practitioners in the NHS are classified as 'White British' out of a registered workforce of 273,000 doctors. Other big groups include those of Indian origin (11.8%), other White (10.5%), Pakistani (4.3%), African (2.7%), and Chinese (2.0%).
- East and West: there are fundamental differences of values and attitudes of people originating from non-Western cultures which health professionals need to respect.
- Christianity offers a bold vision and model of a new community.

Anyone working in the NHS cannot fail to notice the diverse cultures that make up staff and, in some areas, patients. Cultural issues surface not only when colleagues interact with one another, but also when patients from other cultures seek medical attention.

Culture has been described by the Oxford English dictionary as 'the ideas, customs and social behaviour of a particular people or society' or, more practically, as 'the way we do things around here'.[1] 'Culture' is derived from the Latin *colere*, which signified tilling or cultivating of the ground (as in agriculture), keeping bees (apiculture), fruitgrowing (horticulture) and a host of human enterprises. In Genesis we read that God placed Adam in the garden to 'dress' it.[2] Culture is the individual and corporate skills and experience we bring to living our lives and shaping community. Culture is dynamic, changing all the time.

Cultural differences mean that people see and experience things differently and this can easily create misunderstanding. Some of these differences reflect the breadth and wonder of the Creator-God, who made humans in his image. But it can also reflect how human rebellion against God has marred this image and distorted it so that relationships break down. The task of the healthcare professional in cross-cultural communication is where possible to try to overcome these differences and establish rapport.

Rapport between people is important for social cohesion, but difficult to define. We know when we have established rapport with someone; we also know when there is poor rapport. When resources are scarce, conflict between different departments (and even within the same department) is inevitable. Cross-cultural differences have the potential to make an already stressful situation more complicated. It is human nature that 'birds of

a feather flock together' and cultural differences can make working under stressful conditions worse.

The Bible offers profound examples of cross-cultural communication and Christian health professionals can learn from them. We have Paul's famous example: 'I have become all things to all people so that by all possible means I might save some'[3] as well as sermons in Acts where the presentation of the gospel is adapted to enable communication to different audiences.

Approximately 40% of medical practitioners in the NHS are classified as 'White British' out of a registered workforce of 273,000 doctors.[4] Other big groups include those of Indian origin (11.8%), other White (10.5%), Pakistani (4.3%), African (2.7%), and Chinese (2.0%). One in seven nurses (91,470) registered to work in the UK trained abroad.[5] Approximately one in five people in England and Wales have ethnic origins from outside the UK.[6] Like the NHS, Christians are a diverse group. Jesus told his followers to go and make disciples of 'all nations' and Jesus himself did not discriminate against people from different backgrounds (for example with the Samaritan woman in John 4). Therefore, as we work in a diverse health service, we can mirror Jesus' approach in spite of cultural differences.

There are wide variations in cultural norms within the same country. Cultural norms in London may not be the same as in rural Cumbria, for example. While there are various cultures in the world (eg African, Latin American), I will focus on some fundamental differences between 'Western' and 'Eastern' cultures, two cultures I am very familiar with.

- **Loyalty and obligation**: In Western cultures it is acceptable to say that something is inconvenient. In many Asian and oriental cultures people may avoid saying 'no' to avoid causing offence. They may later fail to turn up and offer profuse apologies. To a Westerner this seems rude, while the former approach may offend the Eastern person.
- **Privacy**: Western cultures place a great emphasis on privacy. Questions about family and money are considered normal in Asian culture.
- **Personal modesty**: Particularly with females there is a far greater concern about exposure and modesty in most Asian cultures – breast-feeding in public is rare.
- **Honesty and saving face**: In the UK it is considered good to be honest and upfront. In many countries this approach may lead to 'loss of face'. This difference in approach can lead to offence when swapping on calls etc. A 'no' response in an Asian setting is seen as far more than a simple difficulty in being able to help – it is a rejection of the individual and great offence can be taken. A person who agrees to undertake a task and then does not deliver is more likely to be forgiven as their intention was to help.
- **Displays of emotion**: In English culture, displays of emotion are generally viewed as 'bad form'. In large parts of the world, including Southern Europe, people may swing from calmness to loud arguments as part of a normal day!
- **Power and rank**: In large parts of the world power and status are extremely well demarcated and people are expected to know their place. In Western countries there is a greater egalitarianism and people may address the boss by their first name. People who cross cultures may struggle to understand the boundaries in a new setting.
- **Respect**: All people like to be respected. Humour can be a sign of affection in English culture. Doctors enjoy very high status in some countries (in the UK doctors are still considered among the most trusted people). Nurses in the UK are highly skilled professionals. Across the world a 'nurse' may undertake a variety of tasks. A lack of understanding of different roles can lead to conflict, especially when staff work in a different setting.

Many people have names that appear difficult to pronounce. In many cultures names have great significance and learning to say someone's name may help to build a good relationship. In the Old Testament people's names had tremendous significance (Abraham means father of many nations). As health professionals, there are many difficult drug names that we need to know and so learn how to pronounce. Telling someone their name is too difficult to pronounce may be honest, but perhaps not the best strategy to make a good impression.

Immigrants and refugees face unique and additional challenges. These include: lack of family and social support, language and employment issues and concerns back 'home'. Refugees may also have been tortured in the past. In contrast to many parts of the world, people in the UK enjoy many rights and privileges. Immigrants and refugees may either overreact to certain situations (eg demand a specialist opinion) or not be aware of their rights.

Christian doctors and nurses are called to be agents of God's ultimate purposes: breaking down barriers, so that a new humanity is 'brought near' to one another through the blood of Christ.[7]

Niru Arulanantham *is a Specialist Registrar based in Cumbria.*

The Bible offers profound examples of cross-cultural communication and Christian health professionals can learn from them.

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From a seminar given at the 2016 CMF National Conference.

Huw Morgan reflects on the vexed question of power relations in the life of the Christian doctor

MAKE IT YOUR AMBITION

When I joined CMF as a medical student in the early 1970s, the standard advice then to aspiring young Christian doctors was to get as far as possible in terms of seniority and prestige in the profession. The idea was you would be better able to exert Christian influence. This advice is laudable in many ways. Indeed, as a young doctor I became acquainted with some high-profile senior Christian doctors who were exemplary Christian role models, fulfilling their calling with graciousness, compassion and humility.

However, I was aware of others who, whilst enjoying similar levels of seniority and influence, did not display the same characteristics. They were savvy and experienced in the ways of the NHS workplace, but it seemed that they remained 'babes in the faith'. Their pursuit of professional excellence and prestige had been at the expense of Christian growth and character.

This observation made early on in my own journey as a Christian medic made me wonder if the advice referred to above really was as wise as it initially seems to sound. Further, it has led me to question the whole issue of how Christians approach the issue of power. It is easy to be sucked into what is actually a worldly perspective that says 'grab whatever power you can so you can use it for good'. Contrast this with Paul's words in 1 Corinthians:

But God chose the foolish things of the world to shame the wise; God chose the weak things of the world to shame the strong. God chose the lowly things of this world and the despised things – and the things that are not – to nullify the things that are, so that no one may boast before him.[1]

This is demonstrated in the life and ministry of Jesus. Although King of the Universe and ruling at the right hand of God the Father, he was born not in an emperor's palace but in a stable, his birth was announced to a group of Middle Eastern shepherds, social outcasts at that time. His earthly ministry focused on helping poor, marginalised and excluded people. He frequently challenged rulers, both religious and secular. He changed the hearts and lives of those who welcomed his loving touch and proclaimed that this is what the Kingdom of God is like. Finally, he submitted to an appalling criminal's death and the mocking of most who watched it. His resurrection showed that evil had been overcome not by power and force but by his love and sacrifice.

All this should prompt Christians to a radically different understanding of power and prestige from worldly values. So often in history it has been small, unobtrusive and even despised Christian people and groups who have been used by God to confront and change the unjust, oppressive and wrong structures; powers keeping people in darkness. In his book, *The Prophetic Imagination,*[2] Walter Brueggemann argues that as soon as God's people are identified with the power structures of the world, they lose their prophetic voice and role and become ineffective in their witness.

So what about Christian healthcare professionals? Does this mean that we should avoid positions of seniority and influence in order to preserve our Christian identity? Well, I think the answer may sometimes be yes. Our ambition should be to demonstrate Christ-like character in whatever position we find ourselves; not being over-concerned with how prestigious or otherwise it may be. Some of us may be called to significant high-profile senior roles. We should not undertake them unless we are sure that we can really trust God for the wisdom, humility and courage to fulfil them without compromising our Christian faith and witness.

Sadly, there often seems to be a curious blindness about misuse of power in Christian circles, in a way that there would not be about other sinful behaviour (sexual immorality, for example). I have lost count of the number of people I have listened to over the years who were wounded by the abuse of power by church leaders or leaders of Christian organisations. Sadly, this goes largely unchallenged. It does indeed seem to be true that 'power corrupts'. Christians are far from immune to its pull.

James, quoting Proverbs, reminds us: 'That is why Scripture says: "God opposes the proud but shows favour to the humble."'[3]

Being a doctor is in itself a powerful position. We have some power over the lives of patients and perhaps their relatives. We have influence with nurses, paramedics and other colleagues. We may, as we progress in the profession, have power on committees and working groups in institutions. It can extend to the careers of juniors, trainees and medical students. So we always need to take care to be humble and compassionate with whatever power we have, remembering who it is that we are serving. His example of selfless loving sacrifice used the weak and despised things of the earth to shame the strong.

'Make it your ambition to lead a quiet life: you should mind your own business and work with your hands', says Paul in 1 Thessalonians.[4] Here is an exhortation to unostentatious, conscientious pursuit of whatever work we may be called to, unconcerned with gaining power and influence. Do we want respectability, prestige and recognition in our profession? Or do we want to be a radical disciple – content to work at the margins, challenging the status quo where necessary, working for God's Kingdom?

As the psalmist put it, 'I would rather be a door-keeper in the house of my God than dwell in the tents of the wicked'.[5] Christian ambition is about desiring to be more like Christ in our character, actions and words, not seeking power and prestige in our profession or anywhere else.

Huw Morgan *is a retired GP involved in international training and based in Abergavenny.*

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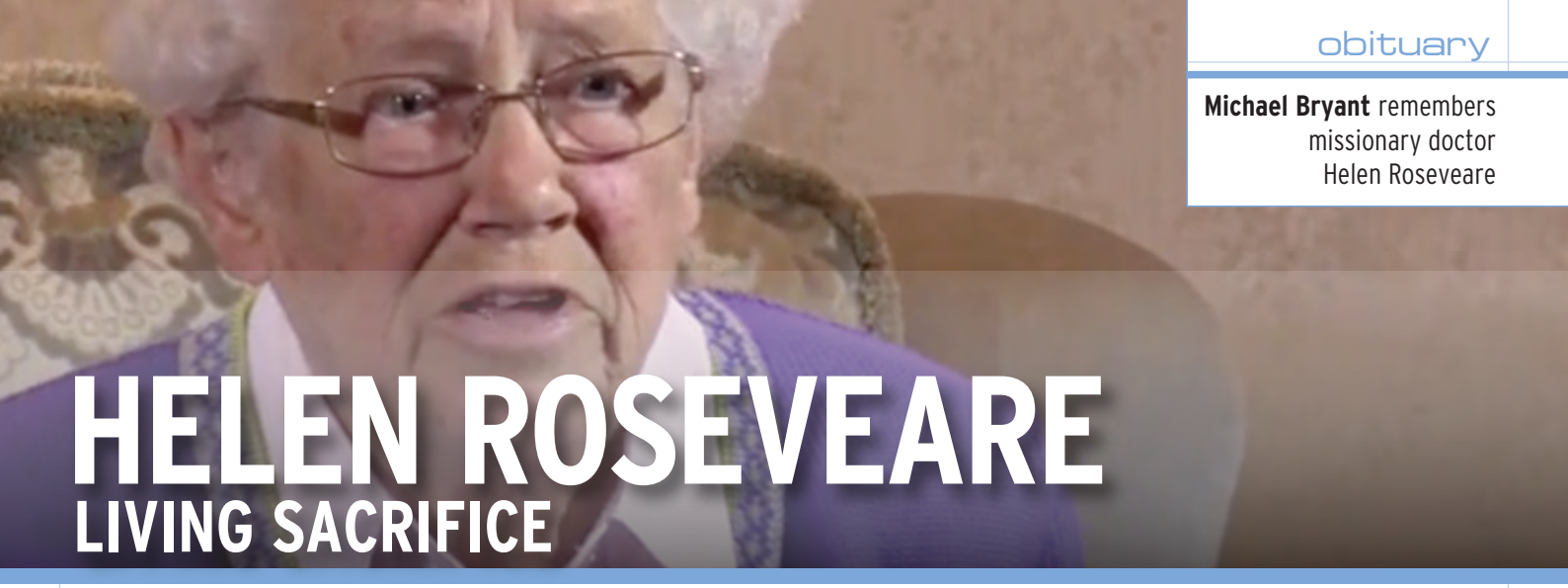
Michael Bryant remembers missionary doctor Helen Roseveare



HELEN ROSEVEARE
LIVING SACRIFICE

Growing up as a missionary kid to parents serving in Senegal with WEC International, I had the privilege of being exposed to countless godly women and men who served as missionaries in some of the world's most challenging places. But none stuck with me more than Dr Helen Roseveare, the humble and incredibly effective missionary doctor and educator who served in the Democratic Republic of Congo from 1953 to 1973, then as a missionary advocate until her death in December 2016.

Helen accepted Christ while at university in Cambridge, and publically declared her trust in Jesus, stating that she 'would go anywhere God wants me to, whatever the cost'. She was soon called to serve in North Eastern Congo to establish a hospital and training centre, initially in Ibambi then relocating to Nebobongo. The vast medical needs in this region were overwhelming and Helen soon realised that she could not accomplish much alone. Taking charge of an old leprosy camp, she established a training centre for nurses alongside the hospital.

The hospital grew rapidly and for a time she served in relative peace. However, this was short lived. As Congo gained independence in 1960, the country erupted into a brutal power struggle. Yet Helen remained and continued to work in the hospital, counting it a privilege to serve alongside her African Church family. Her example of perseverance in loving and forgiving enemies was remarkable and she continued to treat patients with ever-dwindling resources. She was given the name 'Mama Luka' after Luke, the biblical physician.

My own struggles and challenges of serving in Sierra Leone and living through a conflict in Senegal pale in comparison to the suffering Helen endured during the Simba uprising in 1964, where she was assaulted and brutally raped. For several months, she and many of her fellow missionaries were held at gunpoint, facing almost certain death while war raged around them. At times patients and staff from the hospital put their own lives at risk to protect her, having adopted her as 'our doctor'. Throughout this time, Helen often led prayers for their captors and was eventually rescued.

Incredibly, after a brief time back in the UK, she returned to a different part of Congo in order to continue with her work, again focusing on training local staff as nurses and doctors, continuing to show compassion despite her troubling memories. She was able to adapt to a country that had changed around her and encouraged many more students in their ambition to become doctors and nurses.

Despite her remarkable achievements, Dr Roseveare remained astonishingly humble. Her books are full of her honest struggles with pride, feelings of inadequacy and frustrations with her own impatience with the people around her. She remained honest throughout her life about her struggles, at times relating to other missionaries and seeking to put these right. She often learned through her mistakes the importance of prayer before and during clinics and surgical skills and ensuring that her own ego disappeared.

In our era, where medical mission to Africa so often consists of shorter trips, there is a danger of detachment from the people being served. Helen's life teaches us about the importance of genuine community and friendship across cultures. Helen was equally comfortable with her African friends as British ones, adapting her attitudes and absorbing the language. Despite working in a colonial and post-colonial era, Helen refused to patronise her African friends, seeking guidance and discipleship from local African pastors. She recognised the importance of partnerships and empowering local people with the knowledge needed to spread the work, but has frequently stated that she learned and grew more in her faith from the Africans in her local church whom she served amongst than she could ever teach.

Helen fixed her whole life on Christ, living out many of her quotes, viewing her sufferings as 'minor sacrifices in the light of the great sacrifice of Calvary, where Christ gave all for me'. Her life teaches us that to fix our eyes on Christ should not merely be a line in a hymn or an abstraction, but a precious calling giving freedom and peace in the midst of earthly pain. She would often describe vividly how she knew God's loving arms encircling her life despite, or perhaps because of, her sharing in Christ's sufferings.

Yet, above all, looking at her life teaches us never to place a limit on God's power perfected in our weakness. As a single woman she was initially not seen as a high priority by other missionaries, and often had decisions made around her. Her headstrong personality, often seen as a flaw, was mightily used by God to transform situations around her. Her initial feelings of shame after being sexually assaulted soon evaporated, and this experience was used to encourage others powerfully who had been through very similar assaults. Through her ministry, many found healing – both emotional and physical, but more importantly, spiritual. To this day, she is well-remembered as the woman who established hospitals and medical training but, more than that, as a woman who shared Jesus.

Other obituaries for Helen Roseveare can be found in *The Telegraph* and on *The Gospel Coalition blog*:

- *bit.ly/2ni49CQ*
- *bit.ly/2nGiwBR*

***Michael Bryant** is a GP and doctor of tropical medicine.*

further reading

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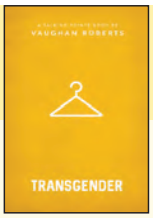


Transgender

Vaughan Roberts

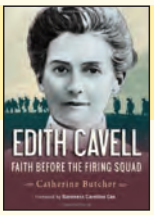
The Good Book Company, 2016, £2.99, 80pp, ISBN 9781784981952
Reviewed by **Rick Thomas**, CMF Public Policy Researcher

Transgender, how to understand it – as disobedience, dysphoria or deconstruction? Vaughan Roberts steers towards pastoral sensitivity and robust biblical clarity.

Roberts shows how gender identity has been dislocated from biological sex, assuming that we should seek to alter a person's body to conform to their sense of gender identity, and examines transgender through the biblical lenses of creation, fall, redemption and 'new' creation. He suggests that true authenticity is found only through living as we were intended to live – in relationship with our 'Maker'. The gospel is good news of rescue through Christ and ultimately of complete restoration of bodies and minds. Those who experience gender dysphoria need compassionate care, including encouragement to identify with their birth sex.

The final chapter is worth the cover price alone. It is full of practical help given as advice in a series of 'what if' scenarios.

What Roberts has done, and done well, is provide a read-in-one-sitting, tender-hearted but uncompromising introduction to transgender for Christians who find themselves wrestling with cultural trends or seeking to support friends or patients wrestling with gender identity issues.



Edith Cavell

Faith Before the Firing Squad
Catherine Butcher

Monarch Books, 2015, £8.99, 191pp, ISBN 9780857216571
Reviewed by **Steven Fouch**, CMF Head of Nursing

In the midst of commemorations of the centenary of the First World War, the story of a Christian nurse in Belgium, executed for treason, is not an obvious stand out. Yet the death of Edith Cavell became a global cause celebre.

Butcher paints a picture of this most unlikely patriot and martyr. Born to a believing family in Norfolk, Edith grew up regularly praying and reading the Bible. Her family also instilled in her the values of service of the poor, sick and vulnerable as part of her devotion to her Lord. So it was that she embarked on a career as a governess in Britain and Belgium, before undertaking nurse training as a second career in her early 30s.

Fluent in French, Cavell was approached to return to Belgium to set up the country's first nursing school in 1907. Thus, she found herself in Brussels as German troops marched in to occupy it in the autumn of 1914. During the next year, Cavell, along with various Belgium resistance fighters, ran a shelter for wounded allied troops, smuggling as many as a thousand soldiers and airmen back into allied territory.

The reader is taken into Cavell's personal correspondence and the reminiscences of her friends and colleagues. But above all, she shows how Cavell's faith in Christ inspired her service. As a result, when she was arrested and sentenced to death, she faced her final hours with forgiveness, faith and hope.

Virtually Human

Flourishing in a digital age
Ed Brooks & Pete Nicholas (ed)

IVP, 2015, £8.99, 176pp, ISBN 9781783593897
Reviewed by **Andrew Horton**, former CMF Media Producer

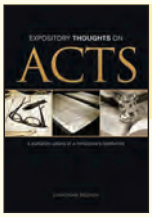
A book about our digital world has the potential to be irrelevant faster than you can say 'Google plus'. Thankfully, this book skillfully avoids this trap.

It begins with the theory and theology of technology, followed by practical applications and insights for us today. Theology isn't left behind, there's biblical insight and application from start to finish.

The story of technology is unpacked through the lens of the Bible, looking at its nature, purposes and potential. It's not technology itself that can be innately good or bad, and in fact we read that God knows the good in technology because its goodness comes from him. But we do need to be wise in our choice to say 'yes' or 'no' to the way we use technology. We're encouraged to praise God for technology because technology can display God's glory too.

Brooks and Nicholas don't leave you feeling either guilty or overwhelmed – you're more likely to feel strengthened in your battle to carve some Bible-time out of your social media treadmill.

Augmented and virtual reality devices may help us 'see the world better', but we'll always see it best through the lens of God's great plan for humanity. *Virtually Human* is essential reading for anyone who wants to know what it means to be an effective disciple in the digital age.



Expository Thoughts on Acts

A surgeon looks at a physician's narrative
Jonathan Redden

Christian Media Ritchie, 2015, £7.99, 200pp, ISBN 9781872734392
Reviewed by **Peter Pattisson**, retired GP

Older readers will probably be familiar with Bishop J C Ryle's *Expository Thoughts on the Gospels*. Surgeon Jonathan Redden's book is consciously modelled on those volumes. It covers the whole of Acts in about 70 short sections. The Bible text is printed, followed by one or two pages of comment.

The comment is strong on application. The necessary engagement with the text and context – the exegesis, awareness of critical issues and referral to mainstream commentaries – have all been done, but are in the background. The thoughts are expository in the truest sense of that word – they expose what is in the text and its implications for contemporary living, rather than imposing extraneous ideas or using the text as a springboard for unconnected thoughts.

Are you looking for something to stimulate your daily Bible reading? This would be an excellent start. In the 19th century Bishop Ryle wrote material specifically for use in family prayers. This present book could help couples to read Scripture together and, in some cases, could help families to engage with the Bible.

In a day when daily Bible reading is neglected or squeezed out, anything that could help us to a fresh start is to be welcomed.

The Search for God and the Path to Persuasion

Peter May

- Malcolm Down Publishing, 2016, £9.99, 254pp, ISBN 9781910786376
- Reviewed by **John Martin**, CMF Head of Communications

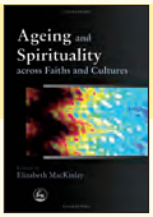
Peter May is a gifted evangelist whose insights and approaches have lasted. *The Search for God* is packed with useful outlines and worked examples for sharing the gospel.

Evangelism, he says, is primarily dialogue. Conversation is a skill to be cultivated and he offers copious insights on how.

He isn't terribly keen on the term 'apologetics'; cultivating the art of 'persuasion' is closer to the mark, with the onus on the Christian to be creative and engaging. Knowing the gospel is the essential foundation. He offers approaches readers can take to memorise or make their own. This can be delivered as a three minute version if someone asks what the Christian faith is all about. Equally it could be fleshed out in five talks.

Asking questions, he says, is more effective than stating propositions. He commends the example of Socrates the Athenian philosopher who posed questions and built skillfully on the implications of answers offered. Not every dialogue will lead to sharing the gospel, but once the process begins it can be resumed.

People today need to hear cogent reasons why the gospel makes sense. Here are helpful, practical resources to fulfil that need.



Ageing and Spirituality across Faiths and Cultures

Elizabeth MacKinley (ed)

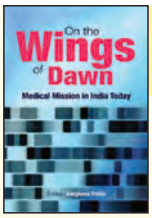
- Jessica Kingsley Publishers, 2010, £22.99, 272pp, ISBN 9781849050067
- Reviewed by **Cameron Swift**, Professor at King's College School of Medicine

Clarity about the concepts and interrelationships of 'ageing' and 'spirituality' is urgently needed for healthcare professionals.

Ageing (attitudinal perceptions and misperceptions, and their consequences) is explored against background demography and speculated across a range of religious and cultural contexts either formally (drawing on traditional teachings) or anecdotally (eg amongst Australian indigenous groups). Areas of common ideological ground include 'respect' for older people and 'duty of care' (a family imperative in Islam). In care provision, awareness and sensitivity are rightly emphasised, and some practical tools to assess 'spiritual need' are proposed.

Spirituality is widely represented as diverse, subjective, psycho-social, and culture-driven, and implicitly commended as pluralistic (versus 'fundamentalist'), with distinction drawn between 'internalised' spirituality and organised religious observance. An informative chapter usefully summarises basic Islamic teaching.

The cross-cultural insights are important and valuable. Refreshingly, one chapter on 'orthodox faith' deals not with Orthodoxy (eg Eastern or Greek) but explores (in the specific context of dementia) the core Christian understanding of spirituality as 'personhood' – every human being made in God's image – and its implications.



On the Wings of Dawn

Varghese Philip (ed)

- Evangelical Medical Fellowship of India, 2015, 256pp, ISBN 9789382759157
- Reviewed by **Deirdre Shawe**, a Rheumatologist with experience in General Practice

Aimed at people seriously considering medical mission in India, this book explains the complex history of healthcare in India and provides practical advice. The gems on its pages should be absorbed carefully as it is a unique study guide rather than a quick read. Each chapter has a different author and all bring their wisdom, advice and personal experience to the reader.

The healthcare system in India today can seem very confusing but in these pages the reader will find some clarity. There is a huge gap between the rich and poor in India, with 50% of the population having inadequate access to clean water and healthcare. An urban slum might be next to a state-of-the-art corporate hospital but have no access to it.

Post-independence, government-funded hospitals emerged, but due to the vast population they can only provide healthcare to 20% of the poor. There is therefore a huge gap, which charitable and mission hospitals can help to fill. Local Indian missionaries are starting to meet the demand, but they need help. There is a clear role for the Indian medical Diaspora, and also foreign missionaries, who can help with short and long-term placements, funding and play a vital role in research, teaching and training. The practice of medicine is a gift from God. The harvest is plenty but the workers are few. This book will prove an inspiration to those who are called to help.

Against the Flow

The inspiration of Daniel in an age of relativism

John Lennox

- Monarch, 2015, £12.99, 433pp, ISBN 9780857216212
- Reviewed by **Tom Roberts**, former CMF Communications Coordinator

John Lennox says that we live in a culture where 'God has lost his glory… holiness has degenerated into an exclusively negative concept'. Either Christianity is held to be worthless, or it is simply 'one choice' in the marketplace of ideas. In *Against the Flow*, he takes hold of the biblical book of Daniel as 'a clarion call to our generation… not to lose our nerve or allow the expression of our faith to be… squeezed out of the public sphere'.

Working through Daniel chapter by chapter, Lennox draws out essential lessons on topics such as God's role in human history, Christian identity, the importance of Government and the rule of law. He approaches Daniel with great care, and refrains from undue speculation about the meanings of Daniel's more cryptic visions.

At over 400 pages this is no light read, and at times is perhaps a little too exhaustive in detailing every aspect of the historical setting. Nonetheless, Lennox is a deep thinker with a first-rate mind, and his analysis here is well worth the effort. This is a vital book that will help Christians understand how we can stand firm in an increasingly secular age.

eutychus

Three score and ten?

Taking their cue from Psalm 90:10, Christians are apt to say mortals are allotted 70 years 'or 80, if our strength endures.' Imperial College London and the WHO's study of lifespans in 35 industrialised countries says life expectancy is set to rise, with women in South Korea to average 90 by 2030. Between 2015 and 2030, life expectancy in the UK is expected to go from 79 to 82 for men and from 83 to 85 for women. Here's a stern challenge for social care and pension planners. *BBC Health* 22 February 2017 *bbc.in/2kYBHkH*

Talking about mental health

Few employees, less than one in ten, feel comfortable telling employers about their mental health problems, says a Legal & General study. In contrast employers seem to have a perception that employees feel comfortable talking about them. The charity Wellbeing at Mind commented, 'Unfortunately there's still a taboo around talking about mental health at work, and a disparity between how well employees and employers think their organisation is doing when it comes to creating mentally healthy workplaces.' The cost of mental health to UK employers is approximately £30bn per year. *People Management* 20 February 2017 *bit.ly/2meHTWq0*

NIPT private providers criticised

Pregnant women are being urged to question private providers of a new test for Down's Syndrome. Women tend to receive too little advice and support, says the Nuffield Council on Bioethics. They often fail to make it clear that non invasive prenatal testing (NIPT) is not diagnostic. The Nuffield Council says advertising by some clinics fail to point out that NIPT can vary in its accuracy and may give a reading that turns out to be false with the NHS 'left to pick up the pieces' but not given sufficient follow-up. *BBC Health* 1 March 2017 *bbc.in/2mJ177Q*

When 'selfie' culture hurts

People tend to view 'selfies' as a bit of fun. But is that all? Does it stop there? Psychologist Linda Papadopoulos has warned that 'selfie culture' could cause harm to the mental health of young people. She thinks a rise in eating disorders and mental illness is linked to 'millennials' spending too much time analysing their social media image and treating themselves as a product. In her book, *Unfollow,* Papadopoulos urges people not to 'put all their self-esteem eggs in one basket' and not view beauty as the only desirable attribute. Well said. *Evening Standard* 17 February 2017 *bit.ly/2kSIvVB*

In praise of home cooking

Adults who never watch TV during family meals and eat mostly home-cooked food are less likely to be obese. The study of over 12,000 Ohio residents showed that eating at home, rather than out, and without the television on, was tied to lower obesity risk. Adults who cooked all family meals at home were 26 per cent less likely to be obese, compared to those who ate some or no home-cooked meals. Adults are likely to eat more food when watching TV. Meals that are not home-cooked may be less healthy, warn the researchers. *Reuters* 2 March 2017 *reut.rs/2mr2PNY*

Faith and the public square

Eutychus suspects only a minority of our readers troop off to church on Ash Wednesdays to have their foreheads 'ashed' with a sign of the cross. When Catholic MP Carol Monaghan appeared on television with a cross on her forehead *BBC Politics*' social media asked: 'Was it appropriate for an MP to work with a cross on her head?' We could ask: was it appropriate that @bbcpolitics should query a show of Christian faith in public? Was this a case of ignorance or hostility by our national broadcaster? *Daily Mail* 4 March 2017 *dailym.ai/2naCxMD*

Esther: case study in civil disobedience

The principle of natural law has largely been abandoned in our times, at a cost. It leaves the most vulnerable at risk, those at the beginning and end of life; those who depend on the more powerful to defend them. So what does the thinking believer do? Becoming more powerful is rarely an option. In *God and the Politics of Esther*, Yoram Hazony finds answers from Esther. He finds biblical warrant for civil disobedience in Esther's actions, subverting the will of a tyrant despite huge personal risk. *ABC Religion and Ethics* 2 March 2017 *ab.co/2mB4f8F*

Awful legacy for Romanian orphans

The plight of Romanian orphans certainly pulled at UK heartstrings in the early 1990s. Long-term studies of 165 of them show many still experience emotional and social problems, with only one in five unaffected by neglect experienced. Problems with concentration and attention levels continued into adulthood. Professor Edmund Sonuga-Barke from King's College London, said it was possible that 'something quite fundamental may have happened in the brains of those children, despite the families and schools they went to'. Getting children out of neglected situations as soon as possible was crucial. *BBC News* 4 February 2017 *bbc.in/2mxriRI*

Help in the barber's chair

People acknowledge how time in the hairdresser's chair can give you a lift. Now the Lions Barber Collective is joining forces with Public Health England to provide barbers with mental health training. Research has found that suicide is a leading cause of death in men under 45 and this triggered the initiative. One barber said that 'having a haircut provides men with precious time to offload and discuss problems in a friendly, non-clinical environment'. Eutychus knows barbers who have made their work a ministry. And there are stories how in some countries closed to the gospel, barbers engage in fruitful evangelism. *Daily Mail* 11 February 2017 *dailym.ai/2mbPsyy*

Miracle babies and the law

Professor John Wyatt has long pointed to the irony of how our society expends so much fighting for the survival of tiny premature babies while consenting to the killing of the unborn. The gap between capacity for tiny babies to survive and the 24-week abortion legal limit is closing. A case in point is the plethora of recent media reports tell the story of Abiageal, born at just 23 weeks gestation. Little wonder there is a growing groundswell opposed to terminations. See *CMF Blogs cmfblog.org.uk/2017/03/07* for a fuller treatment of this topic. *Guardian* 1 March 2017 *bit.ly/2mczuX4*

Ella Kim shares wisdom on God's sovereignty

IN GOD'S HANDS

'No! Please don't take my eye out!' The four-year-old boy desperately kicked and screamed as his worst nightmare was about to happen. It was the most unpleasant anaesthetic induction I had observed, as the small child was prepped for his enucleation. He was understandably terrified of his eye being gouged out. But his parents and the ophthalmologist knew that it was the best thing for him. The retinoblastoma would eventually kill him unless removed.

This case from my student elective led me to reflect on life as a Christian. Do we ever feel confused and afraid about what is going on in our lives? Why would God so cruelly take that precious something or someone away from me? Why would he let me fail that exam? Why would he take my health away from me? Sometimes we just don't understand why God would let these difficult, painful things happen.

But we are often short-sighted and forget the big picture. God doesn't promise our lives on this earth to be easy. But we have a God who cares for us; who is powerful; and who has a bigger eternal perspective. He knows where we are heading. He wants what is best for us, and what is most glorifying to him. And perhaps that terrible event actually turns out to be a good thing in the long run. There have been numerous events in my life that I didn't understand at the time, and I certainly wouldn't have chosen for myself. But months or years later God would show me why it was necessary, or how he would use it for good. He draws me closer to him through these events, shaping my character and strengthening my trust in him.

And some of these things I still don't understand, and perhaps won't until the new creation. But I know that for those who love God all things work for good,[1] and I am so grateful that I have a loving Heavenly Father who is much bigger and wiser than I am. I'm sure the little boy I met in the operating room will one day understand why his parents let him go through that horrific operation, and why it was actually the best thing for him in the long run.

Is there something going on in your life right now that you just don't understand but need to entrust into God's hands?

***Ella Kim** is a junior doctor in Ophthalmology and former Chair of the National Student Committee.*

references

1. Romans 8:28

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