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for today's Christian doctor

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

President John Wyatt MD FRSPCH
Chair Maggy Spence MB MRCGP
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Chief Executive Peter Saunders MB FRACS

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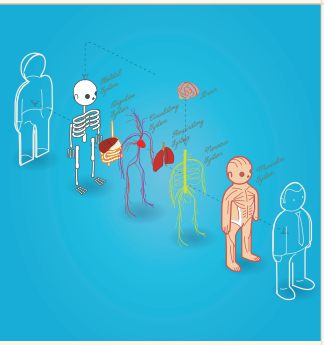
The divine image and the embodied soul

Restoring a theology of the body



What do the current drives for assisted suicide, abortion on demand, same-sex marriage, transgenderism, robot rights and presumed consent for organ donation have in common? They are certainly all backed by 'progressive' secularists who occupy the corridors of power. But more specifically they are all based on a sub-Christian view of the human body.

The body is central to the biblical world view and interest in it is being revived by two challenging new books, both written by evangelical Christian academics.[1,2]

Jesus Christ is God incarnate – the Word made flesh. He appears in Old Testament theophanies, such as the narrative of Sodom and Gomorrah.[3] He enters history as a baby, dwells among us and as an adult is crucified and dies. Furthermore, he is resurrected not as a disembodied spirit but with a real living body that can be seen and touched, that eats fish and lights fires on the beach, and yet it seems, can appear and disappear at will and enter locked rooms without using a door. Jesus's new body, unlike ours, is indestructible and no longer subject to 'death or crying or pain'.[4] But he promises that we will receive similar bodies after the resurrection.[5]

The Bible paints a high view of the body, encapsulated in two unparalleled short verses in the creation narrative.

'*So, God created mankind in his own image, in the image of God he created them; male and female he created them.*'[6]

The Bible is unashamedly binary – 'male and female'. We are 'created', not a cosmic accident but the product of intelligent design, made for a purpose.

'*Then the Lord God formed a man from the dust of the ground and breathed into his nostrils the breath of life, and the man became a living being.*'[7]

We are constructed from material elements – the dust of the ground – but we are more than just organised anatomy, physiology and biochemistry. We are animated by God's breath. We are neither disembodied souls nor soulless bodies. Rather we are embodied souls or ensouled bodies, an indivisible whole.

All sub-Christian ideologies distort these simple principles. Materialism denies the existence of anything beyond our senses, and like Plato's Protagoras makes man 'the measure of all things'.[8] It values human beings by their neurological capacity and dreams of one day creating human consciousness through technology.

Gnosticism denies the importance of our bodies, and hence what we choose to do with them. It is the soul that is ultimately important. Greek dualism values both body and soul but sees them as separate entities which part from each other at death. Eastern pantheism looks to the day when we will be free from the limitations of the body. Spiritism idealises the disembodied soul.

Such schemes provide a fertile seedbed for distorted ethical objectives. If human beings are to be valued, based on their capacity for communication, relationship or intellectual function, then those at the beginning or end of life, or disabled by disease or injury, are simply human 'non-persons' – biologically human but not beings with rights. It is this view that lies behind the idea that we can do things to embryos, fetuses and people with brain damage or dementia that we would not contemplate doing to healthy children or adults.

If gender is simply an arbitrary social construct, rather than the cultural expression of biological reality, and gender identity is determined by our thoughts rather than our chromosomes, then the use of 'therapeutic' puberty blockers, cross-sex hormones and 'gender reassignment surgery' is not problematic. If our bodies are not gifts of God, given to us by him to steward in accordance with his moral direction, then we can use them for any purpose we choose, whether it is in line with the function implied by their structural design or not, and others, even the State, can choose how to use them after our deaths.

By contrast, Christianity holds a high view of both body and soul and a high view of morality. Our bodies are temples of the Holy Spirit, instruments entrusted to our care. We are 'not our own'.[9] We are instead to worship God in our thoughts and actions, submitting our bodies to him as living sacrifices and honouring him in the way we use them.[10] From conception to death, each of us, as divine image bearers are worthy of the utmost love, respect, empathy and protection. Each part of our bodies, including our sexual organs, are designed for a specific purpose. Although marred by the effects of the Fall, we look forward to the day when we will be clothed again with imperishable bodies, constructed for life in a new heaven and new earth.[11,12]

As Christian doctors and nurses we are immensely privileged both to learn of the intricacies of our amazing bodies and to know from the Scriptures about their true nature and purpose. Sadly, many churches have lost a biblical theology of the body and this perhaps accounts for their moral uncertainty when it comes to responding to ethical views based on false ideologies.

From those to whom much has been given, much will be required.[13] Perhaps Christian doctors and nurses should be taking the lead in addressing this theological and moral confusion.

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

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news reviews

New BMA guidance on CANH

The devil is in the detail

Review by **Peter Saunders**
CMF Chief Executive

New draft guidance from the BMA allows doctors to withdraw food and fluids from non-imminently dying patients with dementia, stroke and brain injury, provided it is in their 'best interests'.[1,2]

It comes complete with a six-page executive summary, flow charts and tick box forms to smooth the decision-making process. Definitive guidance is due out in mid-November.

Who makes these decisions? If there is an advance directive for refusal of treatment (ADRT) then the patient does. If there is an appointed health and welfare attorney then they do, and if it's not the case that 'all parties agree' then it falls to the Court of Protection. But in the remainder of cases – the vast majority – it is 'usually a consultant or general practitioner'.

What are these best interests? It boils down to whether CANH (clinically assisted nutrition and hydration) can 'provide a quality of life the patient would find acceptable'. Otherwise, continuing to provide it is 'forcing them to continue a life they would not have wanted'.

So, by a subtle twist, providing basic sustenance to someone who 'would not have wanted' to be in this 'condition' is a form of abuse.

Quite how oversight or accountability will be possible is unclear, as the death certificate need not make any reference to the fact that the patient died from dehydration after a feeding tube was removed. Instead 'the original brain injury or medical condition should be given as the primary cause of death'.

What is largely disguised here, in a lengthy and turgid 77-page document that few doctors or carers will ever read, is a simple mechanism for ending the lives of brain damaged patients who could otherwise live for months, years or even decades.

There are conceivably tens of thousands of patients in England and Wales potentially caught in the net. It will be almost impossible to work out what has happened in a given case, and there are no legal mechanisms in place for bringing abusers to justice.

How did we get here? This whole process has transpired by a small series of steps – each following logically from the one before and endorsed in case law, statute law, regulations and guidelines. They stem back to the Law Lords' decision on Hillsborough victim Tony Bland, who was the first to die in this way. But this trickle could be about to become a flood.[3]

Once we accept that CANH is 'medical treatment', rather than basic care, then we are inviting professionals to devise a simple scheme whereby the starvation of large numbers of non-dying but expensive and 'burdensome' patients can be achieved simply and efficiently, and largely undetected, without involving the courts.

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Trivialising gender dysphoria

Government consultation simplifies complex issues

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

The Government's public consultation[1] on possible means to make it simpler and easier for people in England and Wales to change their legal gender concluded on 22 October 2018.

CMF made a submission. We oppose the move to a self-declaration model, not because we wish to endorse the current assessment model but because we believe the proposed changes would lead to a worse outcome.

We should take note of the accounts[2] of people seeking to 'de-transition' and re-identify with their birth gender. Self-declaration would make it both easier and quicker to change legal gender and thus encourage earlier medical transition. This would increase the possibility that people make choices they later come to regret.

There is evidence[3] that amongst those who present with gender dysphoria there is an elevated prevalence of co-morbid psychopathology, especially mood disorders, anxiety disorders and suicidality.[4] The proposed changes would deprive these people of contact with mental health professionals at the time when their assessment and advice could be crucial. This is of particular concern for teenagers struggling with the turbulent effects of puberty, social transition and identity issues in general. Pursuing legal gender transition may harmfully distract a young person from addressing issues such as anxiety and depression. There is a real risk that individuals who require psychological support will not receive it.

We believe a system of self-declaration would be harmful not only for individuals and their families, but for society as a whole. It would make gender identity simply a matter of a person's subjective feelings about themselves and changing legal gender simply a matter of personal choice. It would encourage the view that gender identity defines reality and that biological sex is but a social construct, something 'assigned' at birth. This new ideological dogma has no evidence-base in science, but self-declaration would appear to reinforce it as if proven fact.

The transgender community has moved away from a simple 'binary' view of gender, preferring to see gender identity as fluid – liable to change or fluctuate over time. It is difficult to imagine a legal process for gender change in such an environment that could be both fit for purpose and resistant to frivolous abuse. What is certain is that to remove all medical or social prerequisites for legal transition will trivialise what is a complex human developmental process.

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The myth of neutrality

The agenda behind 'value-free' sex education

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

The Department for Education has been consulting on draft guidance for schools on Relationships Education (RE) at primary school and Relationships and Sex Education (RSE) at secondary school.[1]

Sex education policy has been, and still is, largely driven by concerns about teenage pregnancy, STIs and the adequacy of 'consent'. Advice given on RSE by leading campaigners[2] is devoid of references to morality, marriage or family life and fidelity as the context for sex. This approach presumes that a young person can shape their own morality without being given any social values or world view to reason and act within.

The weakness of a 'value-free' approach that gives no moral guidance on saying 'no' to sexual activity is that choice then becomes the prime value, irrespective of what the choice actually is. A comment by a school nurse[3] illustrates this well: 'I don't consider I've failed if a girl gets pregnant as long as she's got pregnant because she knew where advice was and chose not to access it'.

Dr Olwyn Mark warns that reducing decision-making to just 'consent' in effect socialises and educates young people to sleep with strangers.[4] This cannot be in the best interests of youngsters who are left rudderless.

We have evidence now that current sex education programmes do not produce the results they aim for.

A 2016 Cochrane study[5,6] found that current sex education programmes do not reduce pregnancy and STIs among the young. In fact, they have no effect on adolescent pregnancy and STI rates. At the same time, STI rates have actually risen,[7] along with sexual harassment, sexting and online pornography.[8] A BMJ editorial by Dr Stammers draws similar conclusions on sex education policies.[9] Recent US research found that: '…comprehensive sex education has essentially been ineffective in US school classrooms and has produced a concerning number of negative outcomes.'[10]

Children's greatest need in RSE is not to reduce morality to consent, but is guidance in developing holistic relational values, healthy emotional development and moral teaching on the significance of sexual relationships. Dr Mark suggests they also need to be taught: 'the virtues of Christian love and chastity, dispositions which can enrich the moral discourse of SRE.'

To those fearful of speaking Christian values, she adds: 'The presumption that a religious voice is any less valid or rational within policy reasoning and formulation than, say, a naturalistic world view position is also a flawed position that must be challenged.'[11]

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World Medical Association under pressure

Moves to weaken ethical stance challenged by Christian doctors

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

When the World Medical Association (WMA) was formed in the 1940s, it was as an ethical bulwark against the extremes of Nazi medicine. It has subsequently maintained a strong support for freedom of conscience and active opposition to euthanasia and physician assisted suicide.[1]

However, at the WMA General Assembly in early October in Reykjavik, two motions were put forward that challenged this. The first was a move to effectively weaken its stance on conscientious objection to abortion by changing some key wording in its statement on abortion.[2] The second was a move brought forward by the Canadian and Royal Dutch Medical Associations (CMA and RDMA) to remove its opposition to assisted dying.[3]

The former came as part of a routine re-evaluation of its position statement, and was challenged by CMF's global umbrella body, the International Christian Medical and Dental Association (ICMDA) in an open letter calling on the General Assembly to not loosen its wording around protection of conscience.[4] Sadly, the clause was amended as originally proposed.[5]

However, in a strange turnaround of events, the CMA withdrew its proposal on assisted dying, and then resigned its membership of the WMA, citing the apparent plagiarism of large sections of the new Director General's acceptance speech to the General Assembly.[6] In the meantime, the German delegation offered a 'compromise' resolution, which was roundly opposed, but is to be further considered by the WMA in spring 2019.[7]

So, while freedom of conscience has yet again been subtly eroded, for now at least the global medical community has not weakened its opposition to all forms of euthanasia.

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Trevor Stammers argues for the importance of conscientious objection in good medical practice

CONSCIENCE WARS

key points

- Freedom of conscience has been under increasing assault by academic bioethicists and by recent assisted suicide legislation in Canada and New Zealand.
- However, far from hindering patient care, freedom of conscience has positive benefits for patients, healthcare institutions and the individual professional.
- It also ensures the beneficence of medical care – protecting against abuses by individual professionals and institutions.

There have been increasingly strident calls to see conscientious objection done away with in medicine for well over a decade now.[1] In a famous 2006 polemic published in the *BMJ*, an Oxford bioethicist asserted:

'A doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.'[2]

In his view, conscientious objection results in both inefficiency and inequity. However, whilst he is careful not to depict conscientious objection as an exclusively 'religious' problem, the reader is left in little doubt that he considers it to be primarily so.

> A world without conscientious objectors is like 'salt that has lost its saltiness'

The article's subheading begins 'Deeply held religious beliefs may conflict with some aspects of medical practice',[3] and at several points 'religious values' are unfavourably contrasted, explicitly and implicitly, with 'secular liberal values'. Even more explicitly, religious values 'corrupt' the delivery of healthcare and to allow conscientious objection on the basis of them is clearly discriminatory when 'other values can be as closely held and are as central to conceptions of the good life as religious values'.[4]

Doctors may have private religious convictions but as public servants they must conform to a shared set of secular values and practices, defined and regulated by law and governmental policy.

Those unable or unwilling to do this, thereby forfeit their ability to do their job: 'Doctors who compromise the delivery of medical services to patients on conscience grounds must be punished through removal of their licence to practise and other legal mechanisms'.[5]

Legal constraints on conscientious objection

More recently conscientious objection (hereafter for brevity CO) has also come under fire from lawyers as well as bioethicists. Munthe and Neilsen, two lawyers from Sweden in a recent paper claimed:

'that the notion of a legal right to conscientious refusal for any profession is either fundamentally incompatible with elementary legal ethical requirements, or implausible because it undermines the functioning of a related professional sector (healthcare) or even of society as a whole.'[6]

They explain their reasons for this claim by suggesting that advocates of CO 'might confuse *legal* rights to conscientious refusal for healthcare professionals with moral ones.'

They seek to substantiate this arguably rather patronising position by insisting that for any legal rule to be truly just, it must:

1. Apply uniformly and equally to all legal subjects of the jurisdiction.
2. The official reasons for the rule must not support another rule that applies more widely
3. Qualifications and clauses within the rule do not in any other way violate basic tenets of impartiality or non-discrimination

Therefore, a rule, for example, permitting CO only for healthcare professionals and only in the case of refusing assisted-suicide related activities, would fail to be just as its restricted applicability would violate all three of Munthe and Neilsen's requirements. It would cover only healthcare professionals, only apply to assisted suicide and only the particular content of a conscience related to opposing assisted suicide.

With reasoning such as this advocated by legal professionals, it is perhaps not so surprising that the New Zealand Parliament is currently considering a euthanasia bill[7] which, if passed unaltered, threatens to punish with up to three months imprisonment any doctors who refuse to refer for euthanasia. In Canada, which only legalised euthanasia in 2015, the Ontario Superior Court of Justice ruled earlier this year against the Canadian Christian Medical and Dental Society (CMDS),[8] stating that Canadian doctors *must* refer for Medical Aid in Dying (MAiD), thus affirming the CO restrictions imposed by the province's medical regulator. Justice Herman Wilton-Siegel in his ruling stated the Court considered that if CO were allowed, equitable access would be 'compromised or sacrificed in a variety of circumstances more often than not involving vulnerable members of society'.[9] I am not likely to be the only one who finds more than a hint of irony in the judge's inference that vulnerable members of society would be safer in a state that compels all doctors to refer them for euthanasia than in one that allows doctors to object.

The importance of conscientious objection

There are in my view, several powerful arguments in favour of not just grudgingly permitting CO but for embracing it as a generally positive good within healthcare.

The safety of patients

The first argument concerns public safety. Earlier this year, it was revealed that over the course of a decade, 456 patients had their lives cut short by being administered high doses of opiate painkiller after being admitted for non-terminal conditions to the War Memorial Hospital in Gosport.[10] Concerns were first raised as early as 1991 about patients' lives being ended prematurely, but they were ignored. Over the twelve years up to 2000, the doctor in charge had signed 854 death certificates for patients, 94% of whom had been administered opiates. Is a repeat of this scandal really less likely to occur in a state which compels all doctors to participate in administering lethal injections, albeit at least ostensibly at the patient's request?

Those whistleblowers whose concerns were initially dismissed at the start of the Gosport killings, exercised great courage in speaking out. There is arguably a close relationship between whistleblowing and CO.[11] If, as in Ontario, healthcare personnel are not permitted to exercise CO about medical killing, how much more difficult is it going to be for anyone to whistleblow when the ending of lives ceases to be restricted to those patients who have requested it?

Benefits to healthcare institutions

This brings me to my second argument in favour of CO – that is of its benefit to institutions. Far from CO bringing society to its knees, as the Ontario judge implied, the moral integrity facilitated by accommodating it holds society to account. A world without conscientious objectors is like 'salt that has lost its saltiness' which as Jesus said is 'no longer good for anything but to be thrown out' (Matthew 5:13). Magellson comments that professions which are of central importance to society depend on their practitioners having moral integrity. Medicine, he suggests, is such a moral activity and therefore should permit CO.

Rights of conscientious refusal benefit healthcare institutions by fostering the moral agency of healthcare professionals necessary for such institutions to run properly, and institutions benefit from having moral agents capable of engaging in critical dialogue internally, as well as vis-à-vis other

If... healthcare personnel are not permitted to exercise [conscientious objection] about medical killing, how much more difficult is it going to be for anyone to whistleblow when the ending of lives ceases to be restricted to those patients who have requested it?

institutions and the public. CO enables healthcare professionals to dissent when external pressures lead to wrong policies or procedures. Some readers may have inwardly baulked at my linking the Gosport scandal with CO, but it is relevant. CO as I have said has many parallels with whistleblowing, including the fact that managements that care more about reputation and public image than about transparency and justice will attempt to crush both.

The attempt to drive all expressions of moral or religious belief, practice, or conviction out of healthcare will also lead to a sharp decline in patient well-being. Patients too, have different moral or religious convictions to which we need to be sensitive. We should not steamroll over them with secular liberal values which they may not share. This is rightly recognised in the sensible advice of the 2008 General Medical Council (UK) guidelines: *Personal Beliefs and Medical Practice: Guidance for Doctors* which states in para 21:

'Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options.' [12]

How can the profession be sensitive to the moral and religious conviction of our patients if we drive out of the profession those of our own who have conscientious objections to some legal practices?

Promoting moral integrity and preventing moral distress

The third argument concerns moral integrity. Acknowledging the right to conscientious objection is not merely giving way to a whim or selfishness. Magelssen, [13] in his defence of CO writes:

'We all have deeply held convictions that we consider important to us… Having moral integrity means being faithful towards these deeply held considerations… When you act against your deeply held convictions the link between your principles and actions is severed.'

Refusing to participate in what one considers as ending innocent life prematurely is not just being awkward. To take part or collude in any practice despite one's beliefs is morally objectionable, is a form of self-betrayal and entails a loss of self-respect and moral distress which can be highly damaging, leading to feelings of 'I could not live with myself if I did that.'

Moral integrity, though not referred to as such, is clearly seen throughout the Bible as an essential component of human flourishing. 'Give me an undivided heart' cries out a morally distressed King David (Psalm 86:11) and the Apostle Paul speaks of the 'insincerity of liars whose consciences are seared' (I Timothy 4:2). If we don't practise what we believe to be right, then we do damage to ourselves. However, if society compels us to participate in actions we consider to be morally wrong, then society damages us. It is a form of moral torture.

Beneficence and the goals of medicine

My final argument is that if conscientious objection is outlawed, the whole purpose of medicine becomes distorted. This is a very wide topic but put simply, if the doctor merely does as the state or patient dictates, what place is there for professional judgement, clinical experience and the objects of medicine to cure sometimes, relieve often, but comfort (and I would add) care always? Of course, CO is not unbounded – it must be reasonable, and it must be objecting to particular actions or procedures *not* particular groups of people, but neither should the patient's demands always prevail with no limits.

A recent article against CO in cosmetic surgery illustrates this point well. Its author held:

'It seems reasonable to argue that what the patients believe to be in their best interests should be considered their best interest. This poses a *prima facie* obligation on cosmetic surgeons to perform the treatment they the patients want even when they disagree with their patients. It should not be left to the doctor to decide whether to perform them or not'. [14]

In a rigorous critique of such casuistry, Saad [15] dubs this attitude as patient preference absolutism (PPA) and points to several problems with such an approach.

It overlooks an important distinction in patient autonomy between the positive and negative. Patients may well he argues, have the right to refuse to take medication for a gouty toe but they do not have the right instead to demand a surgeon remove a gouty toe to relieve the pain. He also points out that PPA risks undermining both beneficence and expert clinical judgement. 'If beneficence is reducible to acquiescence, it is hard to see how it can ever have any continuing significance in ethics'.

Conclusion

CO is necessary for patient safety, and benefits healthcare institutions by reducing the risk of institutionalising unethical practice and enabling diversity in the workforce which matches the range of moral and religious beliefs among patients. It is also a defence against moral distress in healthcare staff and against the rise of patient preference absolutism, which if unchecked will undermine clinical expertise, professional judgement and make beneficence irrelevant.

Trevor Stammers *is Reader in Bioethics and Director of the Centre for Bioethics and Emerging Technologies at St Mary's University College, Twickenham*

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Steve Fouch looks at how we can bring the whole of CMF together to pray into the issues and needs of the day

PRAYING FOR CMF

'If my people, who are called by my name, will humble themselves and pray and seek my face and turn from their wicked ways, then I will hear from heaven, and I will forgive their sin and will heal their land.' [1]

There is great power in God's people coming together to pray. Whether that is in small prayer cells, churches or in dispersed groups, praying for the same needs and with the same heart, changes things. God works in and through his people when they pray together, and he calls us to pray in fellowship as much as in private. [2]

Christian Medical Fellowship is a community of people joined together by our common service to Christ and the healing and caring professions. While we are not a church, we are a community of people called by Christ to serve him in our professions, and as such we are called to pray on all occasions, by all means and for all needs. [3]

We know that medics, nurses, midwives and others working in healthcare face huge day-to-day stresses. The healthcare system in the UK and in many parts of the world is under unprecedented strain. We face ethical, professional and spiritual challenges like never before. Are we praying about these issues with others?

For some years, members have asked for CMF to be much more of a praying community across the country. We know that those of you in local CMF groups pray together regularly, raising personal and professional needs, the needs of your workplace and your city or town. We have not been so good at getting together to pray as a whole Fellowship.

In this edition you should have received the new CMF Prayer Diary. Our aim is very simple – to give our members some areas to pray about together across the breadth of CMF. It covers matters to do with CMF and its members, the British health system, global health and mission needs and other areas relevant to your work. This prayer diary is not static with lists to pray through rigidly. Jump around if it suits you better to pray for certain issues at different times from those we have suggested.

The prayer diary will also be available on the *PrayerMate* app (available at the *App Store* and *Google Play*) [4] and on our CMF Facebook prayer group, CMF Watchers. [5]

Furthermore, while we have compiled this prayer diary in the office, future prayer diaries we hope will be driven by you as members. Send prayer requests to the office at *prayer@cmf.org.uk* or post them on the CMF Watchers group on Facebook, and we will include them where appropriate.

You may want to use these means to inform your personal prayer life, to bring to a home group, a prayer triplet or a local CMF group or workplace fellowship. By whatever means these tools can help inform your prayers, we want them to be made available to you.

Nothing builds faith like the testimony of answered prayer, so please use the *prayer@cmf.org.uk* email address or use the CMF Watchers group to share answered prayer, and if appropriate and with your permission, we would love to share some of those stories more widely with the rest of the Fellowship.

Finally, we do not plan to send this prayer diary out to everyone in the Fellowship, but only to those who want it and will use it. Some of you may not feel the need for it, or you might prefer to use the *PrayerMate* app or social media. But we also think that many members might prefer a paper prayer diary. So if you want to receive it regularly either fill in the carrier sheet with this edition and post to us or email *prayer@cmf.org.uk* with your name and your membership number and we will make sure that you are put on the mailing list. Above all, keep praying! [6]

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

The **CMF Prayer Diary** will come out three times a year in paper and electronic formats for all those who request it. To receive the paper copy fill in the carrier sheet with this edition and post to CMF, or email *prayer@cmf.org.uk*. To receive it via the *PrayerMate* app visit *praynow4.org/christianmedicalfellowship*

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2. Matthew 18:19-20
3. Ephesians 6:18
4. *praynow4.org/christianmedicalfellowship*
5. *facebook.com/groups/CMF.Watchers*
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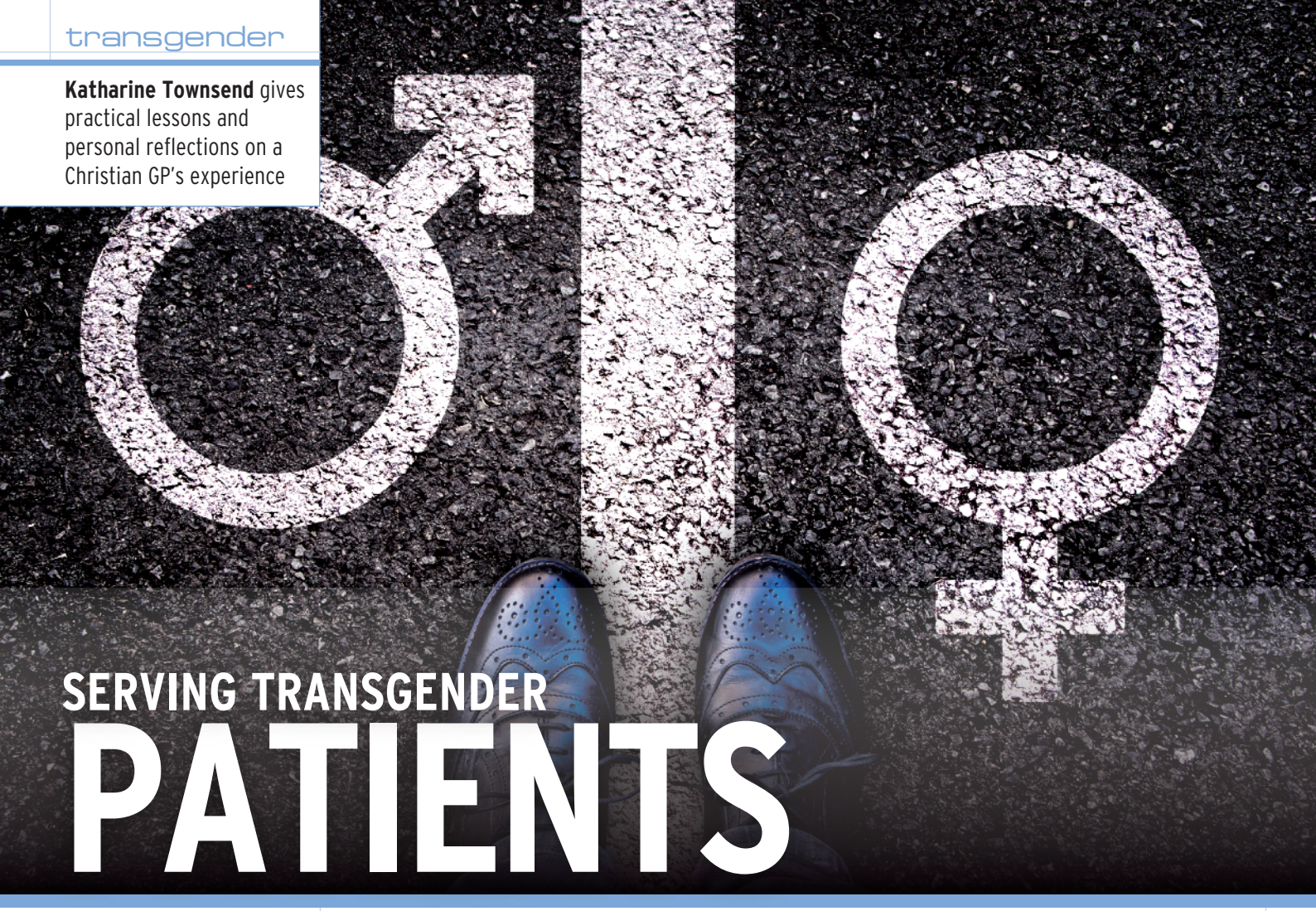
Katharine Townsend gives practical lessons and personal reflections on a Christian GP's experience



SERVING TRANSGENDER PATIENTS

key points

- The number of patients presenting as transgender has increased significantly in the last four years.
- Transgender covers a spectrum of gender identity issues, from non-clinical, alternative gender identities to those with severe distress and mental health issues.
- Care for transgender patients presents many challenges for GPs in particular but they do require compassion, non-judgmentalism and patience.

Background

I have worked as a salaried GP in a university town centre practice for 23 years. Until 2014, we could count on one hand the number of transgender patients on our list. Tragically, two of these (post-transition) have committed suicide. Since autumn 2014 we have experienced a sharp increase in the numbers of students asking for referral to a Gender Identity Clinic (GIC). Given our experience, it was essential we equipped ourselves to care for this growing group. This article summarises some of my lessons learned. I express views that may not be shared necessarily by my colleagues.

Time, time, time

It was truly heart-rending to hear the story of an individual who had, since they were six or seven, spent hours each day longing to be in the body of the opposite sex. They had hoped the feelings would settle with time, but realised with despair during puberty and after the teen years that this would not be the case.

However, for another group, who could be called 'gender variant', there was a less clear picture of long-term anguish. But they experienced a welter of complex issues and for a mixture of reasons had come to perceive medically supported adjustments in their gender appearance as a pathway to greater personal contentment and for some (though not all) to relieve distress.

Transgender is a catch-all term covering a diverse group of people who experience and/or live out their gender identities differently from people who feel comfortable with their biological sex. In contrast, Gender Dysphoria (GD) is characterised by experiencing distress with one's birth sex.

The GMC[1] strongly encourages swift referral to a GIC after presentation to GPs with GD, due to high rates of self-harm and suicidal behaviour. However, waiting times for GICs are upwards of two years. I now spend time getting to know my patient before referral (following suicide risk assessment). In practice several double appointments over several months at the end of a clinic (reducing time pressure) are necessary to get a thorough picture of their life, their emotional journey, when questions of gender occurred and how these have been expressed. Many have multiple comorbidities such as depression, autistic spectrum and personality disorders, and emotional turbulence from troubled family backgrounds.

Time with them helps me understand their complex issues and explore, and occasionally to challenge their thinking with respect to the wisdom of transitioning and the massive consequences that follow. Transitioning is a gradual process, not a single event. It may be simply name and attire that change, perhaps hormone treatment, perhaps 'top' surgery and/or 'bottom' surgery. A patient may choose some or all the possible options available. I explore the evidence base for medical treatment and impact on fertility.

On a foundation of a strong doctor/patient relationship a candid conversation is possible. Time at the outset enables a trusting relationship which will be a support along the difficult, and for many, lonely road ahead, as they face a host of complex decisions for years to come.

Vocabulary

Feelings of rejection, often justified, are commonplace among transgender patients. Using their preferred pronoun, I have found is an essential starting point: deliberately 'mis-gendering' is felt to be a form of rejection, insulting at worst and usually results in the patient seeing another GP.

Always remember the birth sex

There is a subtle, but elusive, difference in the way I interact with male and female patients. So, it took me a while to work out how to connect with my transgender patients. Internally, that is, in my core thinking and therefore subtly in my behaviour, I relate towards them as in their birth sex.

This is not articulated but I have consistently found this to be the most effective way of connecting, but they would never know my thoughts. I also recognise this may not work for everyone.

While obtaining a Gender Recognition Certificate for legal purposes takes a minimum of two years, changing gender on medical records[2] merely needs a letter of request signed and dated by the patient and takes weeks. Transgender patients requesting such a change come off all screening programmes associated with their birth sex and must take personal responsibility for having checks at appropriate times. Discussing gynaecological matters and breast issues is distressing for my trans-male patients.[3] Higher incidences of ovarian and cervical cancer occur in such patients due to their reluctance to be screened and fear of the physical examination, yet strong doctor/patient relationships can ease this.

It took me a while to grasp that a patient's gender identity has no bearing, whatsoever, on their sexual orientation or sexual practices. Many of our transgender patients have not had surgery and have heterosexual intercourse. Remember the birth sex and think; contraception, management of medical problems especially abdominal pain (could it be testicular torsion or an ectopic pregnancy?) and of disease prevalence.

Medicolegal issues

Adult GICs only accept a referral if the referrer agrees, at the outset, to prescribe any hormones the GIC may advise in the future after seeing the patient. However, with the exception of Sustanon, all hormones prescribed for gender dysphoria are unlicensed.

When I spoke to the MDU, they expressed surprise at the wording of the referral forms but added that GP prescribing, in this area, should follow written specialist advice. Since this advice would be deemed, 'best practice according to the knowledge and standards of the day,' GP prescribing, adhering to this, would be acceptable from a medicolegal perspective.

GICs give helpful and detailed guidance for monitoring those receiving hormones for adverse side effects, though quickly hand responsibility back to GPs for the initiation, administration of hormones and lifelong care.

The GMC[4] urges GPs to prescribe the GIC advised hormones but unlike other pharmaceutical products, there are few longitudinal studies demonstrating the effectiveness of treatment. Indeed, there is no agreed measure among GICs as to what constitutes successful medical treatment.[5]

My perception has been that some patients embarking on medical treatment reach a status quo and remain quietly contented. Others are delighted, at the outset, with the physical changes, but after six months to a year their mood deteriorates back to pre-treatment status occasionally becoming worse. These patients need much support in navigating the difficult road ahead.

Children

What of the capacity of children in early puberty to make life impacting decisions with respect to puberty blockers? I have many reservations concerning the impact on psychosocial development and fertility, but little experience at present. This is a relatively new treatment and in need of systematic research.[6]

Theological

I have tried to think about these issues from a theological perspective. Jesus teaches in Matthew 19 that we are created male and female: The Creator's basic pattern for humans is fundamental. However, Jesus goes on to talk about eunuchs (some born that way, some made that way by men) expressing a recognition that in a fallen world, people may not fit straightforwardly into the binary pattern of gender. The wonderful account of Philip and the Ethiopian eunuch[7] (the first Gentile convert after the resurrection) reminds us of Jesus's reaching out to all people whether or not their physical characteristics, or the cultural space inhabited by them, matches typical male or female patterns.

Jesus treats with absolute respect and kindness those rejected by society, people with leprosy, tax collectors, a woman with menorrhagia, a woman of ill repute, to name a few.[8] Many transgender patients feel rejected; I do not want to add to this.

Jesus urged his disciples, 'Do to others as you would have them do to you';[9] all medics embrace the principle 'Do no harm'. I am concerned that there has been a wholesale acceptance of medical treatments and protocols by the medical profession without adequate evidence to support such changes.

We have a duty of care to transgender patients to ensure that there are dispassionate long-term studies exploring the physical and psychological pros and cons of medical treatment. We must care for the needs of our transgender patients to the very best of our abilities. How that is done should vary from person to person but also as the medical evidence emerges.

***Katharine Townsend** is a GP in East Anglia*

Jesus treats with absolute respect and kindness those rejected by society... Many transgender patients feel rejected; I do not want to add to this

further reading

- CMF File 59 (2016) Gender Dysphoria *bit.ly/2OWFBgP*
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Paul Johnson looks at how to live abundantly in a busy life

THE BUSY MODERN DOCTOR

LIFE IN ALL ITS FULLNESS OR JUST A VERY FULL LIFE?

key points

- Doctors and nurses are notoriously busy people, and often feel caught on a treadmill and not experiencing the abundance of life in all its fullness.
- There are external and internal causes of 'busyness', what drives us and what choices we make (consciously and unconsciously).
- We learn to live in the fullness of life that Christ gives us as we re-evaluate our priorities and choices in the light of the gospel.

Defining the problem – the diagnosis

How would you describe last week at work? Would words such as fulfilling, peaceful, or joyous feature in your description? I suspect that for many of us routinely balancing multiple clinical and non-clinical commitments in an ever-changing NHS, the words busy, full, or frenetic would instead feature very highly. Indeed, nowadays, the reflex reply 'I am well, just very busy' seems to have become our universal response when someone asks us how we are!

Doctors and nurses have always been busy. The difference today is that we are expected to balance multiple responsibilities simultaneously in a culture of ever increasing deadlines and regulation. Such multi-tasking is compounded by the fact that many of our spouses also work long hours, our children have similarly full lives from the moment they enter pre-school (I was amused recently when a competitive mother proudly relayed that her newborn had been given a perfect Apgar score!), and when not working, we are balancing busy church, and social lives. Like those remarkable plate-spinning acrobats, metaphorically we are being asked to do this on a daily basis, constantly worrying that some of our 'plates' will start wobbling or even fall and break.

Our lives are certainly very 'full'. My personal assistant uses the term shoehorning as she tries to squeeze another appointment into an already overfilled calendar. Some of you may even identify with Ellen Goodman's description of the absurdities of 'normal' modern life: 'Normal is getting dressed in clothes that you buy for work, driving through traffic in a car that you are still paying for, in order to get to the job you need so that you can pay for the clothes, the car, and the house that you leave empty all day in order to afford to live in it'![1] And yet, when we read Jesus's words in John 10, we see

a stark contrast to today's 'treadmill' existence: 'The thief comes only to steal and kill and destroy: I have come that they might have life and have it to the full.'[2] I suspect that for some of us, we have continued to follow Christ faithfully in many ways, but have slipped into lives that are full in content, but that lack the true fullness that Christ offers.

Understanding the causes – the aetiology

Before considering the root causes of the problem, it is helpful to ask whether it is wrong to be busy per se? To answer this, we look to Jesus as our model. Throughout the gospels, we see that he was busy in terms of the number and intensity of activities that he engaged in. As Kevin De Young helpfully suggests: 'if Jesus were alive today, he'd get more emails than any of us. He'd have people calling his mobile all the time… If you love God and serve others, you will be busy too'.[3] However, De Young also makes the important point that 'He (Jesus) was busy, but never in a way that made him frantic, anxious, irritable, proud, or distracted by lesser things.' What then causes us to be so busy that we are easily robbed of the balance and fullness of life that Jesus demonstrated?

External causes

Do you start most days anxious, knowing that you are scheduled to do more than can possibly be achieved? Is your diary so full that there is no space for unplanned events? When with people, are you frequently thinking about your next commitment? Do you check and reply to emails as soon as you wake up and throughout the day until you go to bed? Do you eat lunch alone in your office most days while continuing to work? If you answered yes to these questions, you, like me, have a problem with extreme busyness and a condition Dr. Meyer Friedman termed 'hurry sickness'.[4]

Certainly, many aspects of busyness are inherent to being a modern doctor or nurse. The modern clinical workplace is a highly pressurised and regulated environment with intensive workloads and exacting deadlines, all undertaken in a highly emotionally charged setting. Combined with unrealistic performance targets being set in the context of decreasing resources, it is easy to understand why 'work-related stress' in the NHS is so high. Most of us have little control over our weekly timetables. The start times (and increasingly the composition) of our clinics and theatre lists are dictated by our managers, not by us. We find ourselves in that most stressful of situations, having high levels of responsibility, but relatively little control or autonomy. And yet, Jesus's promise of fullness of life was not given with a proviso that we don't work in the NHS or in the clinical academic arena! There must be ways that we can address the external causes of busyness, such that we can serve God faithfully in the modern medical workplace, while avoiding the dangers of 'hurry sickness'.

Internal causes

Whilst there are certainly external factors that lead to ungodly busyness, we need to examine ourselves as fallen creatures for any intrinsic drivers that lead to our predicament. Do we actually have more control over our busyness than we choose to exercise?

We practise medicine in a culture in which busyness is often considered as a surrogate for success or failure. If someone says that a colleague 'takes his or her work-life balance seriously', this is seldom a term of endearment and usually implies that the colleague is considered to be 'work-shy'. On the other hand, we often use long clinic lists, long operation waiting lists, high numbers of publications, and numerous speaking invitations, as evidence that someone is doing well. However, whilst such measures are partly understandable, ultimately such drivers can easily arise from and propagate pride in its different forms, including ambition, status, and power. Extreme busyness can also be driven by personal insecurity, expressing itself as a constant need to gain the approval of colleagues or patients, or by the chasing of insatiable wealth. As Jon Ortberg comments: 'Hurry is not just a disordered schedule. Hurry is a disordered heart.'[5] If I am honest, there are things that I regularly add to my already overpacked schedule that I really don't need to, and which, when God's light is shone on them, highlight subconscious motives and habits that need his transforming power. Rather than conclude therefore, that the causes of our predicament are all external and out of our control, we need to evaluate ourselves transparently, so that the 'treatment' can be appropriately targeted.

Finding a godly solution – the treatment

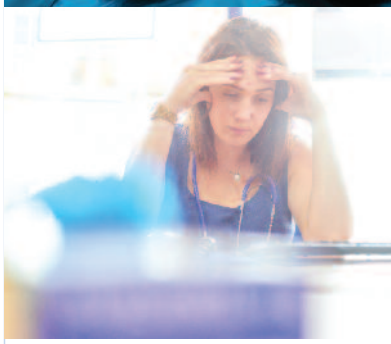
As I have attempted to address some of my own shortfalls in this area over the last few years, I have found a number of approaches helpful. I share these with you:

Examine your heart for what really drives you

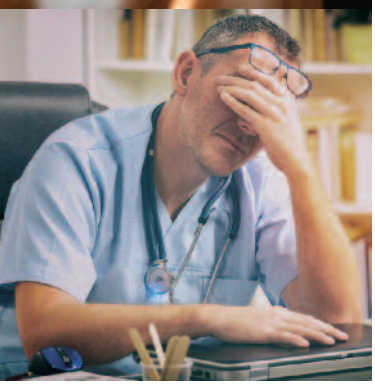
Based on the above, it is important to start by examining our hearts before our all-knowing God for what really propagates our busyness. We each need his help to discern between busyness that arises from a Christlike servanthood, and busyness that is driven by selfish ambition, hidden insecurities, or a disordered diary. In all that we do, we do well to heed John Wesley's advice to 'Hold loosely to all that is not eternal.'[6] We take comfort in the fact that we have an almighty God who forgives and restores.

Regularly review your commitments to ensure that they reflect God's unique calling for your life

As Christians, we believe that God has made us as individuals, and that he has a unique calling for



'Normal is getting dressed in clothes that you buy for work, driving through traffic in a car that you are still paying for, in order to get to the job you need so that you can pay for the clothes, the car, and the house that you leave empty all day in order to afford to live in it'.



In all that we do, we do well to heed John Wesley's advice to 'Hold loosely to all that is not eternal.'

each of our lives. However, modern medicine tends to encourage homogeneity. Do your diary and job plan reflect your uniqueness, or have you filled your schedule with activities that someone else should be doing? Before taking on any new commitment, consider it prayerfully in the light of what you are already doing and in the light of your God-given gifting and personal calling. Review your diary on a regular basis to ensure that you are living a life that is focussing on what your heavenly Father has called you to do (in all areas of your life), and where you are able to, be radical in removing things that are diluting your effectiveness. At the advice of a close friend, I now include in my annual appraisal a list of the invitations and activities that I have declined or dropped over the previous year, as well as those I have undertaken and achieved. I have found this a helpful discipline and would commend it to you.

Cultivate Christlike rhythms of work and rest

We have been reminded that Jesus lived a busy life while he was on earth, but that he avoided the pitfalls of 'hurry sickness'. Indeed, he demonstrated what it really means to have a perfect 'work-life' balance'. What do we learn from the way he lived? Jesus encompassed what is sometimes called the 'Discipline of Slowing'. This was not simply about him taking sufficient rest or leisure, although those things were and remain important. Within his rhythm of work and rest, he routinely spent times of quiet and solitude in order to be in his Father's presence. We too are called to spend time regularly 'being still and knowing that God is God' (Psalm 46:10). At the start of each day, we need to heed CS Lewis's wise counsel: 'The moment you wake up each morning, all your wishes and hopes for the day rush at you like wild animals. And the first job each morning consists in shoving it all back, in listening to that other voice, taking that other point of view, letting that other, larger, stronger, quieter life come flowing in.'[7] Jesus's rhythm of life, like his father before him, also emphasised the importance of maintaining a 'Sabbath rest' into the weekly schedule. Again, this is a rhythm of life that we are called to adopt, not as a legalistic ritual, but because this is how we function best as creatures made in God's image. Tim Chester puts it like this: 'the pinnacle of creation is not a person made to work, but a Sabbath made for the glory of God'.[8] Jesus also took time to think and reflect, something that modern busyness often prevents. In short, Jesus was 'living life in all its fullness', not 'merely existing'. He was busy, but with kingdom priorities. We are called to cultivate Christlike rhythms of work and rest into our lives and into those of our families.

Champion cultural change in your workplace

If we are truly to address the external causes of busyness in modern medicine, we need to champion a fundamental cultural change in the workplace. As leaders within the profession, we need to address unreasonable deadlines (such as major grant deadlines that always fall after the Christmas holidays!), depersonalisation in the workplace, measures of success that damage relationships, and rhythms of work that are fundamentally non-Christlike. We all need to promote a Christian counterculture in which relationships are prioritised over frenetic activity, and godly love for our patients and colleagues replaces mistrust and self-centred competition. We need to teach our medical students and trainees that there are more important things in life than endlessly building their CVs and encourage them to adopt rhythms of work and rest that still involve working hard, but that are driven by selfless giving of themselves to other people.

Prioritise relationships over activity

A sad consequence of busyness is that important relationships can become neglected or damaged. I will never forget the day when, as a busy paediatric surgical registrar, my seven-year-old daughter asked me why I spent so much time looking after 'all the other children' and so little time with her. Jesus's encounter with Martha and Mary reminds us of the importance of prioritising relationships: 'Mary has chosen what is better and it will not be taken away from her.'[9] In our busyness, we need to prioritise relationships over activity – relationships with our spouses and children, with our friends and colleagues, and most importantly with our Saviour. We need to ring fence quality time in which we can be totally present and giving of ourselves and keep sufficient flexibility in our schedules to be adaptable and available. We need to spend quality time in the presence of our Father, worshipping him above everything, and seeking his ongoing direction for our lives.

Nathan Foster highlights the impact of such a change in priorities: 'I cannot think of a greater way to bring about genuine transformation in the spiritual life of the Church than to become a people who say 'no' to busyness, hurry, and distraction, and willingly organise our lives in such a manner to be fully present to God and each other, living a life learning to love well...'[10] If we are to exchange a 'very full life' for the 'fullness of life' that we have been promised, we must prioritise our relationship with the One who came to give this. As Kevin De Young concludes: 'It's not wrong to be tired. It's not wrong to feel overwhelmed. It's not wrong to go through seasons of complete chaos. What is wrong – and heartbreakingly foolish and wonderfully avoidable – is to live life with more craziness than we want, because we have less Jesus than we need.'[11]

Professor Paul Johnson *is a Professor of Paediatric Surgery at the University of Oxford*

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TRAINING FOR SURGERY IN THE DEVELOPING WORLD

Gordon McFarlane explains how general surgical training in the Highlands and Islands of Scotland is ideal training for medical mission

2,500 years ago, a man with a good job, in a well-developed country heard a report about the great needs in Jerusalem, where there was oppression, economic hardship and low morale. He had probably never been there and was used to hearing of the problems of that land, but this report was different. God spoke to him and he wept.[1]

God continues to speak to medical personnel, calling them overseas into rural situations. But for those considering a surgical career, it may seem impossible to gain appropriate training and experience to deal with the wide ranging and often advanced conditions they will encounter.

UK surgical training has undergone major changes in the last 50 years. Back in the day, a senior registrar could deal with anything from a ruptured aneurysm in a 75-year-old to a pyloromyotomy in a six-week-old and from a wedge excision of an ear to a radical nephrectomy. These surgeons were not only the backbone of district hospitals in the UK, but with very little further training could operate anywhere in the world. But now, an ST8 trainee with a Certificate of Completion of Training (CCT) in colorectal surgery will be highly skilled in laparoscopic bowel resection but may never have worked in a urology unit, is unlikely to have any paediatric surgery experience, and will not expect to have to deal with any vascular or breast cases.

These problems have been recognised in the Greenaway report,[2] leading to the Royal College of Surgeons publishing the document: Improving Surgical Training.[3] The Joint Committee on Higher Surgical Training (JCHST) are finalising a new surgical training curriculum in response. The aim is to make all CCT holders more able to handle a surgical take in a large district general hospital or teaching hospital, but the new curriculum remains unlikely to equip most trainees with further operative experience in subspecialties such as urology or paediatric surgery and will certainly not cover orthopaedics or gynaecology and obstetrics.

So where does this leave students and Foundation Year doctors who are interested in serving God in a rural situation in a low or middle-income country? Is a career in surgery no longer a sensible choice? And where do surgeons train who want to work for other international organisations? The Lancet Commission on Global Surgery describes basic life-saving surgery that every district hospital in the world should be offering, including caesarean section, laparotomy and treatment of compound fractures (Bellwether procedures).[4] These have been chosen only as markers of the huge variety of surgery required in remote areas.

But where do surgeons who develop this sort of wide repertoire of surgical skills then fit back into the NHS? All general surgical consultant adverts in UK require a subspecialty interest, although an increasing number describe emergency surgery as making up a significant component of the job. While emergency surgery, with little or no elective work may suit some, it is not an ideal choice for a surgeon returning to the UK for their children's higher education. Nor does this type of job allow continued practice across the surgical specialties.

A solution closer to home?

A need for remote and rural surgeons has existed in the Highlands and Islands of Scotland for many years. Originally single handed surgical units, these included other areas of the UK such as Penzance, the Isle of Man, Arran, and rural areas of Northern Ireland. Six units remain in the UK and are now designated rural general hospitals, with up to three surgeons covering most aspects of general surgery.

To attract and equip surgeons to work in these posts, a post CCT fellowship in Remote and Rural Surgery based in Inverness or Aberdeen has been available for over 20 years. Senior surgical trainees, with a CCT in colorectal or upper GI surgery may spend one to two years rotating through urology and orthopaedics, with shorter attachments to other relevant surgical specialties.

Scottish core surgical trainees can spend six months in a rural general hospital where they are exposed to a wide variety of surgery and have one-to-one training with a consultant. The new Improving Surgical Training curriculum is yet to be launched but it is expected that it will include a four-month remote and rural module. Training for remote and rural surgery is recognised and supported by surgical colleges and other specialties[5] and international volunteering is being actively encouraged within the NHS.[6]

While the traditional pinnacle of surgical training remains in the realm of the subspecialist in a large teaching hospital, there is increasing support and recognition for the generalist. Surgical trainees with clear purpose, determination, and a good dose of humility for post CCT training in other specialties can achieve a God-given calling to serve in the developing world on a short or long-term basis. And if the time comes for a return to the UK, general surgical posts are still available in the Highlands and Islands.

Gordon McFarlane *is a consultant general surgeon in Shetland, Gilbert Bain Hospital. G.McFarlane@nhs.net*

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Stuart J Fergusson argues for the importance of a global perspective in healthcare

GLOBAL CITIZENSHIP

key points

- Christian health professionals need to have a global perspective as a God-inspired response to injustice, and in recognition of the inter-connectivity of health problems and solutions.
- There are many ways to cultivate this perspective – short and long-term overseas service, teaching and training roles, academia and institutional links.
- There is also a place for Christian health professionals to engage politically and campaign on global health issues.

The moral and theological argument for a global perspective on healthcare

In recent years, global citizenship has become a popular way of framing the concept and the attitude that our world's people and systems are interdependent, and that we have a responsibility to cross-cultural competence and engagement in cross-community problems. The phrase has grown particularly popular within educational circles and its dimensions generally coalesce around the ideas of social responsibility, global competence and global civic engagement.[1] A useful description of a global citizen is 'someone who understands interconnectedness, respects and values diversity, has the ability to challenge injustice, and takes action in personally meaningful ways.'[2]

To what extent should Christians regard themselves as 'global citizens'? 'Our citizenship is in heaven,' the apostle Paul told the Philippian Christians in the first century AD.[3] For Christian believers, the foremost recipient of our loyalty is neither a nation state or humankind in general, but God himself.

However, far from disconnecting us from human problems, a Christian world view provides an objective rationale for compassionate engagement with the problems and concerns of local and global communities. Uniquely amongst God's creations, human beings were created with 'the image of God',[4] a designation of multi-layered meaning, but which indicates at least in part a responsibility to represent God's character and will, over all creatures and environments in this world.

Scripture teaches us that God is neither remote nor indifferent to pain and suffering, being described by the psalmist David as 'a compassionate and gracious God, slow to anger, abounding in love and faithfulness'.[5] The incarnation itself serves as a demonstration par excellence of God's intimate, personal approach with the problems of a fallen world. When Jesus was on this earth, his priority was to preach and demonstrate the good news of the kingdom of God[6] – good news for broken souls, but also good news for broken bodies and relationships. Jesus's compassion was not limited to those who loved him or obeyed him, but was administered to all those in society, believers or not who sought his help. Jesus's parable of the faithful outsider (the good Samaritan) taught that the Scripture's admonition to 'love your neighbour' was a demanding instruction to meet human needs wherever we find them.[7] Jesus also taught that the response we make to physical and relational needs was a direct indicator of our salvation status; '"whatever you did for one of the least of these brothers and sisters of mine, you did for me."'[8] The key ideas of global citizenship thus find a robust theological underpinning in the Christian faith. Christians can be enthusiastic advocates for an outlook that understands our responsibilities

are not simply to family, friends and local communities, but to all people.

The idea of global citizenship should have strong resonance and significance for Christian healthcare professionals. Healthcare provision should be conceived of as a globally connected effort towards the reduction or alleviation of human suffering. The inequity in healthcare provision between high-income countries (HICs) and low/middle-income countries (LMICs) is well known.[9] This injustice should rankle with Christians. In response to the empty religiosity of Israel, God spoke through the prophet Isaiah: '"Is not this the kind of fasting I have chosen: to loose the chains of injustice and untie the cords of the yoke, to set the oppressed free and break every yoke?"'[10]

The mutuality of healthcare problems

The argument for a global perspective in healthcare is not just a moral or a theological one but is one of practical reality. Although the resources available for meeting health challenges varies greatly around the world, many healthcare challenges are inter-connected and share very similar characteristics. The Royal College of Physicians and Surgeons of Glasgow published a policy report in 2017 which evaluated the importance of global experience and perspective in the Scottish NHS.[11] Amongst this report's key findings were the following:

There is much commonality in the healthcare challenges faced by high-income countries (HICs) and low or middle-income countries (LMICs), such as in:

- **Infectious diseases**: disease epidemics and drug-resistant infections do not respect international boundaries and solutions require transnational ideas and cooperation.
- **Non-communicable diseases**: both HICs and LMICs face an increasing burden of cardiovascular and respiratory disease, cancer, diabetes and mental illness, and have similar challenges in prevention and chronic disease management.
- **Rising costs of care provision and competition for skilled care workers**: in many countries, populations are aging, use of technology is increasing and there is competition for skilled health service workers, making achievement of equitable, affordable care difficult.
- **Providing equitable services to remote and rural communities**: there are worldwide difficulties in recruiting and retaining staff for rural areas and providing health equity to these populations.

The mutuality of benefit from healthcare cooperation

Since many healthcare problems are inter-connected, so are the solutions. Cooperation between health systems takes many different forms, via international organisations such as the World Health Organization, through intergovernmental agreements, to institutional partnerships and often individual commitments.

It has been increasingly recognised that cooperation between personnel in HICs and LMICs can bring mutual benefits to both systems. It is essential that such cooperation occurs thoughtfully and ethically.[12]

From the LMIC perspective, there is limited empirical data as to the benefits they obtain from HIC healthcare worker involvement, but the available evidence does point to the following encouraging outputs:[11]

- reduced morbidity and mortality
- improved knowledge, skills and confidence of health workers
- improved quality of care and new services
- enhanced training and education capacity
- improved institutional governance, policy development and system change

There is also clear academic evidence that individuals and systems in HIC settings can derive a wide variety of benefits when HIC personnel undertake training, service delivery or development in a LMIC setting.[13,14] These individual benefits come in the form of both technical and non-technical skills development, and often include a sense of personal renewal and enhanced job satisfaction. Benefits for HIC healthcare systems can include enhancement of recruitment and retention, system learning and capacity building, professional development of the workforce, improved patient experience and reputational development.[15,16]

What now?

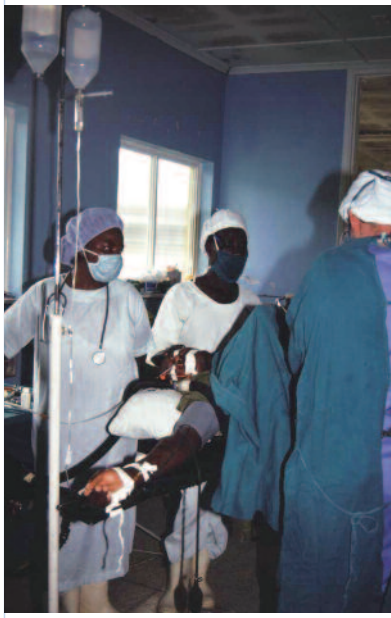
Christian healthcare professionals have opportunities to express their faith through action in different spheres:

- service provision in LMICs – short and long-term.
- teaching, training and personal development.
- campaigning and lobbying home governments, professional associations, and international organisations on issues that would improve equity of access and quality for neglected patients around the world.

Christians have a responsibility towards human needs in communities both local and global. Inequalities in the experience of health and healthcare around the world should provoke Christians to action.

We can be confident that engagement in the health problems of the developing world is not only a moral choice, but one that often provides a mutuality of benefit to both the high and low-income settings that they connect.

Stuart Fergusson *is a surgical trainee in Scotland. He was recently the co-author of a major policy report from the Royal College of Physicians and Surgeons of Glasgow on the value of international volunteering.*



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CMF members reflect on the 16th ICMDA World Congress in Hyderabad, India

ICMDA
WORLD CONGRESS REVIEW

About ICMDA

The International Christian Medical and Dental Association began in the '50s with informal meetings between different national Christian medical fellowships. In the late '60s the organisation was formally set up. It now has 84 member organisations and many other emerging fellowships and networks of Christian doctors and/or dentists in a number of other countries. ICMDA's vision is for a Christian witness through doctors and dentists in every community in every nation. See *icmda.net* for more information.

'In the Footsteps of the Great Servant Healer' was the theme for the 16th International Christian Medical & Dental Association (ICMDA) World Congress held in India at the end of August this year. 847 Christian doctors and dentists from 84 countries gathered for a week in Hyderabad, also known as 'The City of Pearls', and India's fifth largest city.

Several CMF members, volunteers and staff were at the Congress. We asked some of them to share their experiences with the rest of the Fellowship.

The programme started with the Students' and Graduates' Conference, led by talks from Dr Daniel Ho, who superbly kicked off the events with a talk based on exploring the hallmarks of the people of God. This set a great foundation for the rest of the conference by ensuring we had the knowledge of who we are as people of God, and the sense of purpose this places on our lives. [***Anne Huckstep***]

One of the highlights of the conference was seeing Ho's desire to make Christ known to everybody he met. Pastor Ho boldly shared Christ with those around him at every opportunity, irrespective of their profession or social status. His passion was inspirational and a much-needed reminder of how urgently the world needs to hear the good news. [***Bukola Ogunjinmi***]

Daily devotional talks set the tone for the Congress. Over three days, Raj Kumar focused on how as Christian doctors we can be *'a light to the nations'* [1] representing Christ to the many colleagues and patients that we meet. We are to walk in the knowledge that his divine power has given us everything we need for life and godliness. [2] Raj urged us to speak the truth in love, in the knowledge that God has equipped us and will enable us to step up and step out in faith. Charles Price encouraged us with Bible exposition, focusing on the 'Covenant God'. In Christ, we have a new righteousness, a new relationship and a new redemption – *'a covenant to the people'*. [3]

Another highlight of attending an ICMDA World Congress was the countless opportunities to meet Christian doctors from every corner of the globe. Different lives, different healthcare systems, different cultures in different countries, all working out God's purposes in the localities where they are placed. I heard inspiring stories reflecting God's provision, power and presence all over the world, as Christian doctors serve as the hands and feet of Christ. [***Matt Baines***]

Words cannot capture how incredible it was to have fellowship with brothers and sisters in the same profession from over 80 nations in the world – the bond of being one family in Christ far surpassed the fact that we were all previously unknown to one another. It was indeed a privileged glimpse of the 'multitude that no one could number, from every nation, from all tribes and peoples and languages, standing before the throne and before the Lamb'. [4] [***Felicia Wong***]

The meal times were another great opportunity to meet people from all over the world.

I remember talking to a Mexican couple over lunch who told us about their ministry tackling homelessness and poverty in Jalapa, Mexico. For dessert we were joined by a junior doctor from Niger who explained how few doctors there were in Niger, making our staff shortages in the NHS seem inconsequential in comparison. Over another meal, I heard about an oncology surgeon who had devised a Bible meditation programme through which she had seen many patients come to Christ and be healed from anxiety and psychosomatic illness! It was so encouraging to hear how God is working all over the world. [***Emma Pedlar***]

The Congress expanded my horizons about the global mission of the church. For example, I met the South African team preparing for a mission trip to Peru. It was so encouraging to see that God is always at work everywhere and uses people all over the world to expand his kingdom. I also met students and doctors from Europe. Together, we are planning to develop and strengthen the CMF movements in Central and Eastern Europe from where I originally come. [***Anna Pawlak***]

There is not enough space to capture all the stories and lives of Christian doctors from around the world that impacted me! Having spent some time in Papua New Guinea it was encouraging to hear the work of three Christian doctors in Port Moresby share some of their challenges and prayer requests. I was enthused by stories of doctors setting up prayer groups in a town in Uganda, the beginning of a prayer group in a city in Denmark and Christian doctors beginning to meet in a small town in Brazil. [***Matt Baines***]

It was immensely humbling to realise how privileged and blessed we are as a CMF in this country, when I came across many countries in which the Christian Medical and Dental Fellowship consists of only one or two volunteers trying to unite and equip colleagues. This calls me not only to be thankful but also urges me to pray for and consider how we might help to build up and encourage our colleagues in those countries. [***Felicia Wong***]

There were two international nights, each an opportunity for countries or regions to show off their talents. The student's and juniors' international night had a more comical flavour, with a dance number by Norway, a quiz from Oceania and stand up by the Netherland's very own Rick Paul! The UK felt the need to contribute to the main international night, so decided to teach the world to ceilidh! Unfortunately, we didn't bring a ceilidh band with us, so Cotton Eye Joe had to do. The sight of the whole auditorium filled with people 'Stripping the Willow' was a sight to behold! [***Emma Pedlar***]

We had dances, songs, hymns, stand-up comedy, and saw beautiful cultural attire, and so much more. We were having so much fun that a group of us continued praising and worshipping the Lord in song and dance afterward as we didn't want the night to end. [***Bukola Ogunjinmi***]

There were many breakout sessions to choose from during the day. These included workshops on bioethics, missions, understanding world views and mentoring. I attended a seminar on 'compassion fatigue and burnout'. We looked at how, in the busyness and demanding nature of work, we need to 'be still and know that he is God'.[5] A pastor from Delhi led a seminar on Christ-centred leadership. We explored how as Christian doctors in leadership our motivation should be to reflect Christ, recognising that the leader we become is often based on the leader we follow. We explored how God has given us the capacity to lead in the spheres into which he has called us. [***Matt Baines***]

The ICMDA World Congress afforded me a global perspective of what it looks like to be citizens of heaven but resident aliens in this world; to be medics living for Jesus in godless and increasingly hostile societies. I learned about the waves of assaults (some subtle and some more overt) against Christians in the medical profession, such as the persecution of anyone with any conscientious objection to sanctity of life issues including abortion and assisted suicide in Canada (see *News Review* p5), and even the move to deter anyone applying for the medical profession who might have any such objections (see *Conscience Wars* p6).

Incredible though some of this might appear to be, the issues in other countries only herald what will be coming to us soon in the UK.

It was a wake-up call for me as a UK medic, often with my 'head in the sand' and concerned only with my immediate circumstances, unaware that my freedom to practise as a Christian doctor is being subtly and systematically eroded.

I don't want to wake up one day to a 'new world' in which being a Christian and being a doctor are mutually exclusive and lament the fact that I did not stand up and speak out as a disciple of Jesus Christ because I did not know what was happening. [***Felicia Wong***]

My experience in India was remarkable. I departed with a greater understanding that although the Congress represented people from different cultures, traditions and healthcare systems, we all had one similarity; a calling to be Christ to those we care for and work with, and to embody grace in the areas in which we are called to serve. [***Matt Baines***]

I am grateful that I had the opportunity to go to the World Congress and I am already looking forward to the next one in Tanzania in 2022! [***Anna Pawlak***]

[we were] people from different cultures, traditions and healthcare systems [but] we all had one similarity; a calling to be Christ to those we care for and work with...

Anne Huckstep
is in her final year of medical school at UCL in London
Bukola Ogunjinmi
is a 4th year medical student at St. George's Hospital, University of London, Tooting
Matt Baines
is a GP partner in Coventry
Anna Pawlak
is a GPST1 in Stockton-on-Tees
Emma Pedlar
is a CT2 in plastic surgery in Manchester
Felicia Wong
is CMF's Head of Graduate Ministries and a former GP in south London

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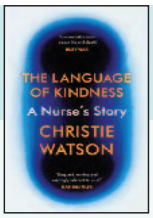
5. Psalm 46:10



The Language of Kindness:
A Nurse's Story
Christie Watson

- Chatto & Windus, 2018, £9.65, 336pp, ISBN: 9781784741976
- Reviewed by **Steve Fouch**, Head of Communications at CMF

Sometimes I forget what a huge privilege it was to be a nurse. Sitting with the dying, being there at the birth of a new life, helping people navigate through mental illness, disability and rehabilitation.

Then you read something like *The Language of Kindness*, and you get jolted out of the everyday and into the reality of what it means to be a part of this amazing profession.

Watson takes us through her story; stumbling into nursing almost by chance, discovering the reality of human suffering going on all around us, but hidden from most people's gaze. She takes us through all her training placements, her first staff jobs and on to her long-term career as a PICU nurse.

Littered with facts, figures and details to explain to the lay reader what is going on, the book explores the minutiae of life in the A&E, the dark sense of humour of the staff room, and the exhaustion of completing a third twelve-hour shift in a row. It lays bare the smells, the mess, the pain and despair, as well as the hope, joy, relief and the stories of human kindness in the midst of suffering with which each day confronts nurses.

This is not a Christian book – although Watson picks up on some biblical texts, especially around the issue of human dignity. You won't agree with all she says, but it moved me profoundly, reminding me of all that I loved (and hated) about being a nurse.

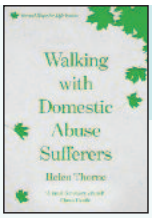
Dying Well
John Wyatt

- IVP, 2018, £9.99, 192pp, ISBN: 9781783594856
- Reviewed by **Steve Fouch**, Head of Communications at CMF

Increasingly hidden from public view, medicalised and privatised, death and the process of dying have been progressively removed from ordinary life. The health professions and the church have colluded with this according to the premise of this book. John Wyatt argues that this has been to our detriment, as dying can be a time of growth, healing and reconciliation and that in marginalising death we have lost so much.

Digging back into Scripture, to the ancient church tradition of *ars moriendi* and his own clinical experience, Wyatt's book is a much needed antidote to the modern marginalisation of this universal human experience. In actively engaging with impending death, we can deepen our faith, help others come to terms with our departure, and find fresh spiritual depth in our living.

Full of hope, practical advice, biblical depth and personal testimony, *Dying Well* is going to be indispensable to pastors, chaplains, medics, nurses and others involved in the care of the dying. But above all, it is something that every Christian needs to read and engage with as we look to our own future hope in Christ, and to coming to terms with our own mortality.



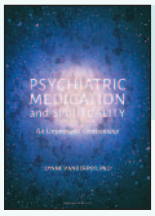
Walking with Domestic Abuse Sufferers
Helen Thorne

- Inter-Varsity Press, 2018, £7.99, 112pp, ISBN: 9781783595952
- Reviewed by **Claire Wilson** psychiatry trainee and MRC Clinical Research Fellow, King's College London

Taking readers through the journey of the domestic violence victim, from disclosure to recovery, this short book is written for those who may find them themselves supporting survivors of domestic abuse. It also discusses how to support perpetrators.

We will likely come in to contact with patients affected by domestic violence throughout our careers. Indeed, as a psychiatrist, my patients with mental disorders are disproportionately affected both in terms of victimisation and perpetration.

What should be our response as Christians? Thorne offers practical advice on how we can walk alongside all those affected. She helps the reader make sense of domestic violence within a biblical framework of suffering. She outlines the warning signs and ways in which victims may present, as well as some of the thought processes of victims and perpetrators. She then offers insights in to how to effectively support disclosure, escape from the abusive relationship and know ultimate healing. This is an essential read for all Christian health professionals.



Psychiatric Medication & Spirituality
An unforeseen relationship
Lynne Vanderpot

- Jessica Kingsley publishers, 2017, £14.43, 240pp, ISBN: 9781785921261
- Reviewed by **Stefan Gleeson**, Consultant Psychiatrist & Director of Medical Education in Hampshire

This book has received some positive reviews in the USA, where the pharmaceutical industry holds some sway over medical practice, raising questions of professional practice. Based on a qualitative study of 20 patients with mental disorders, identifying themselves as,' religious/ spiritual'. It is essentially a critique of the reductionist care of patients. There is a useful emphasis on narrative construction by patient and doctor; reflections on how medication impact on patients' spiritual development and disturbing examples of unacceptable practice.

If, as the author suggests, it is true that the majority of the American population is on some form of psychotropic medication, then the book is a timely warning against the pharma industry dictating what goes on in the consulting room. The training and practice of psychiatry in the UK is more predicated on Karl Jasper's emphasis on 'listening' to the patient and the bio-psycho-social (& spiritual) systems formulation than the author suggests.

Vanderpot states that she does not wish to make generalisations from such a small sample of patients. She seeks to present negative and positive narratives of patients' medication journeys, taken from a spiritual angle. However, I would guard against generalisations as she has not included the most acutely unwell in their social context, and just as not every doctor is correct, neither is every patient always correct in their interpretation. Still a useful, albeit disconcerting, read.

BOOK STORE

Mad or God?

Jesus, the healthiest mind of all
Pablo Martinez & Andrew Sims

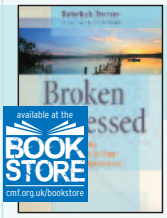
- IVP, 2018, £6.89, 208pp, ISBN: 9781783596058
- Reviewed by **Peter May**, a retired GP and author of *The Search for God*

This is an important and original book. Two psychiatrists have worked together to examine Christ's mental health. Taking their cue from CS Lewis' trilemma that Jesus was either mad, bad or God, they investigate Christ's life and behaviour with professional expertise.

Did this Man of Sorrows show signs of depression? Did his mood and character fluctuate? Is there any evidence that he was deluded? Ruling out major pathology, they then look for personality disorders, relationship difficulties and reactions under stress.

What did his teaching reveal of his intelligence and sanity? Was his life consistent? Did he practice what he preached? Was he volatile or unbalanced? Did he form good friendships? What did his conversations reveal? What impact did he have on others? Did he have any moral flaws? How should we rate his moral teaching? How did he relate to women? How did he cope with misfits, enemies, authorities, the weak and the scheming? And what was he like under pressure, facing false charges, torture and an agonising death?

Jesus actually presents us with a quadrilemma, for many believe he was really a myth. But this compelling figure was far beyond fictional imagination: he had the healthiest mind of all.



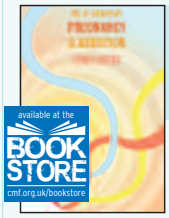
Broken but blessed

Journeying from pain to peace with unlikely guides
Rebekah Domer

- Plough Publishing, 2018, £10.56, 138pp, ISBN: 9780874867633
- Reviewed by **Janet Goodall**, retired consultant paediatrician based in Stoke-on-Trent

This little book contains the spiritual equivalent of clouds holding silver linings. The author is a hospice chaplain who structures her book around the eight beatitudes (Matthew 5: 1-12). Disabled herself, she enters into the sufferings of others in a sensitive way, concluding that suffering is intended to transform us by bringing us closer to Christ. It is Jesus's love that enriches the poor in spirit, comforts those who mourn, honours the humble and satisfies the spiritually hungry and thirsty. Those so blessed by his love will show mercy, approach God with purified hearts and convey his peace to others. Even those reviled and persecuted for their faith will be enabled to rejoice in the hope of a heavenly welcome ahead.

The 'unlikely guides' of this book range from a joyful sister with complicated Down's syndrome, through to those grieving over various kinds of dashed expectations, to a street pastor ministering to those hungry for healing and discovering the meaning of mercy. Each beatitude is appropriately illustrated by someone Domer has met. All of us are likely to suffer in some way; even if dented rather than broken we are still in need of healing. These stories encourage us to look for blessings around the bruises. Jesus provides the supreme example as he endured the cross for the joy set before him.



Pregnancy and Abortion

Your Choice
Dr Mark Houghton

- Malcolm Down publishing, 2018, £7.00, 208pp, ISBN: 9781910786802
- Reviewed by **Greg Gardner**, a GP in Smethwick

Attempting to be both easy to read and scholarly, this book succeeds in both objectives. Written in an easily accessible style and with short chapters, the first part of the book explores the way choices are made. Sections on parenting, adoption, abortion, teenage pregnancy, and 'men and abortion' fill in some of the detail.

Six chapters later, various long-term sequelae of abortion are presented. The ones on long-term maternal mortality, and mental health have helpful charts. There is a good review of abortion and the risk of subsequent preterm birth by John Wyatt. The book is well referenced. The author set himself a huge task by trying to cover as much medical ground as possible. There are 238 references in total with many primary sources.

The dedication page is 'to all pregnant women and their near relations.' The book would be good to recommend to pregnant women faced with difficult choices as well as pregnancy counsellors, GPs, obstetricians and trainees for those specialties, church leaders, researchers, journalists and politicians. It would be a helpful addition to any church or medical library.

If the material in this book is kept updated it could become a primary source of information for anyone trying to get deeper into this big subject.

eutychus

Loneliness epidemic

While Age UK warns of a looming epidemic of loneliness among the over 50s, a global poll by the BBC suggests that those in their teens and twenties are the loneliest group in society, and not just in the UK, but worldwide. Increased connectivity and the ability to travel have, it seems, exacerbated rather than diminished social isolation. The attendant physical and mental health problems have given policymakers reason for concern. Despite headlines about social prescribing by GPs and postal delivery workers (formerly 'postmen/women') checking in on the elderly on their rounds, a year into her tenure as the world's first Minister for Loneliness, MP Tracey Crouch must be wondering whether government really has a solution. *The Times* 13 September 2018 *bit.ly/2CRCBNR*

Transgender consultation ignores women

Women's rights groups have challenged the government's recent consultation on the right to gender self-identification, saying that it ignores the needs of women. MP Maria Caufield addressed a recent gathering of these groups at Westminster, saying that the parliamentary inquiry into transgender rights 'didn't really look at the implications for women as a whole...[and] was fundamentally flawed'. With a recent case of a 'trans-woman' sex offender being jailed in a women's prison only to assault four fellow prisoners, the room for abuse is obvious. Others are concerned that women are in danger of being effectively legislated out of existence if anyone could self-identify as a woman. The clashes between feminists and trans-activists have become an ugly feature of the current debate but show how the rights of one group so easily come at the cost of another. *The Guardian* 17 October 2018 *bit.ly/2R3gNRO*

Genetic genocide for mosquitos

The humble mozzie gets a bad press as insects go. Being a vector for many viral and parasitical diseases, the mosquito has been subject to repeated attempts at elimination. But where swamp drainage and DDT did not fully succeed, new genetic techniques to 'breed infertility' into the population have caused total collapse within two or three generations in the lab. But is wiping out a species tampering with ecology? It raises the ethical question about whether, as stewards of creation, humanity has the right to destroy an entire species. *BBC News* 24 September 2018 *bbc.in/2EvSCtK*

Opioid deaths increase organ transplants

It is no secret that the USA faces a major crisis from the abuse of opioids, with the number of related deaths doubling in the last decade. The ironic upside to this is that four times as many opioid users are registered organ donors now than in 2008. With the first drop in the size of the organ donor waiting list in 25 years of steady increases, the increased number of opioid user organ donors is being recognised as a major cause of this turnaround. Because the victims are often young, otherwise healthy and are regularly rushed to hospital and ventilated before being declared brain dead, they are ideal organ donors. While no one would choose this as a strategy for increasing organ donation, it is at least a silver lining to a very dark cloud. *Vox* 24 September 2018 *bit.ly/2QW2aAz*

Are too many GPs retiring too early?

Research has long shown that GPs who retire in their 50s outlive those who continue working to statutory retirement age, so the trend to early retirement is nothing new. However, it seems the pressures of being a modern GP are not only driving the vast majority to work only part-time, but increasingly to retire early. This at the very time when there is a struggle to attract junior doctors to train as GPs. Ironic, that our primary care model is one being exported around the world just as it falls further into crisis at home. *The Times* 28 September 2018 *bit.ly/2NQhEDp*

Making eggs and sperm from body cells

The latest research out of Japan on induced pluripotent stem cells (iPSCs) suggests that within the next decade or two, we may be able to create gametes out of somatic cells. Those with infertility problems would be offered the chance of healthy children. But it also means that anyone, of any age could in theory become a parent. It offers the potential for more genetic screening – making 'designer babies' more of an option, and even offers the disturbing prospect of so-called 'uniparents' – where one individual provides both sperm and egg to create a child. For now, this technology is still at animal laboratory test level, but in a decade or two we may have some very difficult ethical questions to wade through. *The Guardian* 14 October 2018 *bit.ly/2ykANsd*

Organ donor registration ad goes too far

The drive to increase organ donation is global. It also leads to some very questionable approaches. An Australian ad sought to 'lightheartedly' show how easy it is to go on the organ donor register by portraying two Roman guards persuading Jesus on the cross to sign up as a donor. Needless to say, the advert has caused much offence to Muslims and Christians. It is sad that such a tasteless approach was taken to such a serious topic. *The Drum* 16 October 2018 *bit.ly/2QZO4gq*

Wales to follow Scotland in alcohol pricing

If ever there was an argument for not decriminalising drugs, it would be the massive health and social toll caused by alcohol and tobacco. The strategy of the moment in dealing with the alcohol crisis is minimum per unit pricing (MPUP). Many hate the idea of taxes as a 'nudge policy' to reduce problem drinking, but the research is mounting from around the world to show that it works. So with Scotland having taken the plunge in 2012, the Welsh Government is following suit with a consultation on bringing in MPUP in, in the next couple of years. Public Health England is watching how this works out in Scotland and Wales before making its decision on MPUP. *The Guardian* 28 September 2018 *bit.ly/2InVAiq*

Contaminated blood scandal gets a full inquiry

Regarded as the worst scandal in the history of the NHS, the story of how contaminated blood and blood products, mainly from the US, were imported into the UK in the 70s and 80s, despite the risks being well known, is still shocking. Over 1,800 people with haemophilia were infected with HIV and thousands more with Hepatitis B and C. After many years of campaigning and several smaller scale inquiries, a full public inquiry has been launched by the British government. *The Guardian* 27 September 2018 *bit.ly/2CUhxFA*

Steve Fouch reflects on a simple yet dangerous prayer

'HERE I AM, LORD'

When God first spoke to him out of the burning bush, Moses' simple reply was 'Here I am' (Exodus 3:4). In Hebrew the word is הנני [*hineini*]. It is with the same word that a young Samuel responded when he thought that Eli, rather than God was calling him in the night;[1] it is the response of Isaiah when God asked who would go with his message.[2]

It is a simple word, but such a small basket carries some very weighty stones! Because when these prophets responded to God's voice, they weren't just saying where they were. They were saying 'I am available.'

The consequences of that simple, open prayer of availability were considerable – for Moses it meant leading Israel out of slavery to Sinai to receive The Law and on to the borders of the Promised Land; for Samuel, it led to him being the leader and kingmaker who chose the king who would be the ancestor of Jesus; and for Isaiah, it meant taking the message of God to the kings of Israel at great personal peril and prophesying the coming of the Messiah.

When we say 'Here I am' to God, are we ready for him to take us to where he wants us? Are we ready to make ourselves unconditionally available to him? It's a scary prayer, but it is one that opens the door to God doing mighty things in us and through us.

Hineini – 'I am here and ready for you, my Lord'.

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

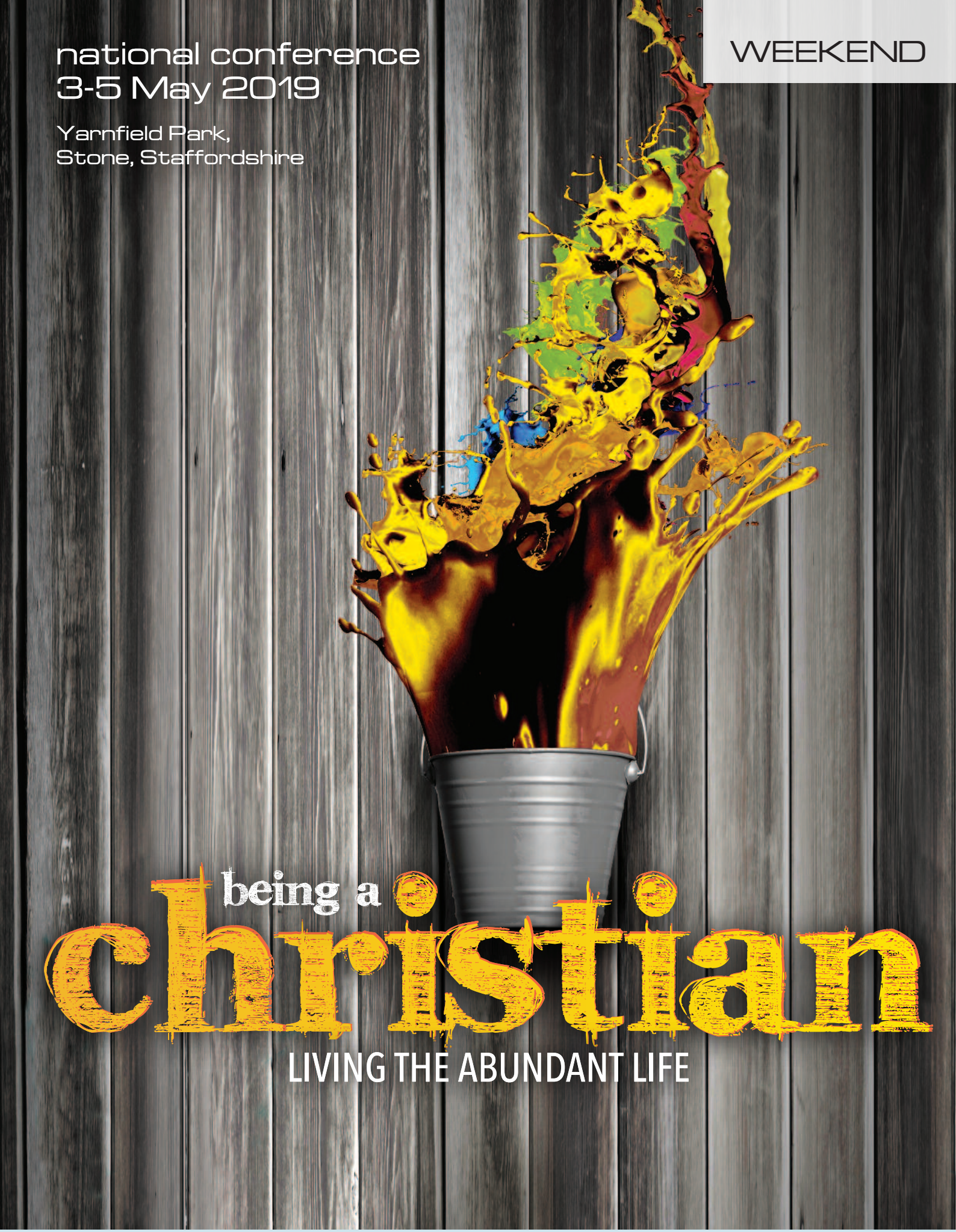
references

1. 1 Samuel 3:4-10
2. Isaiah 6:8

national conference
3-5 May 2019

Yarnfield Park,
Stone, Staffordshire

WEEKEND



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