Summer 2018

for today's Christian doctor

triple helix

global refugee crisis

the NHS at 70, gender confusion, doctors as patients, churches in social care, sharing faith with patients

ISSN 1460-2253

Triple Helix is the journal of the **Christian Medical Fellowship**

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

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

President John Wyatt MD FRSPCH
Chairman Maggy Spence MB MRCGP
Treasurer Philip Taylor MA (Oxon)
Chief Executive Peter Saunders MB FRACS

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

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

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

Editor Peter Saunders
Managing Editor John Martin
Head of Communications Steve Fouch
Editorial Assistant Oluwatosin Oyeniyi

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

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

Copyright Christian Medical Fellowship, London. All rights reserved. Except for a few copies for private study, no part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the Christian Medical Fellowship

Unless otherwise stated, Scripture quotations taken from The Holy Bible, New International Version Anglicised Copyright © 1979, 1984, 2011 Biblica. Used by permission of Hodder & Stoughton Publishers, an Hachette UK company. All rights reserved.
"NIV" is a registered trademark of Biblica. UK trademark number 1448790.

CMF
Christian Medical Fellowship

No. 72 Summer 2018

contents

Editorial 3
Legalising assisted suicide – *Peter Saunders*

News reviews 4
Changing gender – *Peter Saunders*
Medics on the frontline – *Steve Fouch*
Abortion momentum triggered by Irish vote – *Philippa Taylor*
NHS at 70 – *Steve Fouch*

NHS: 70 years old 6
Andrew Fergusson

Standing in the gap 8
Steve Fouch

When doctor turns patient 10
Adrian Warnock

RENDLE SHORT LECTURE:
Lessons from the refugee crisis 12
Bert Nanninga

When a Christian voice can be heard 16
Ruth Butlin

Sharing our faith in Jesus 18
Stephanie Moss

Book reviews 20

Eutychus 22

Final thought 23
Ruth Eardley

Legalising assisted suicide

British Courts and Parliaments remain firmly opposed

Assisting or encouraging suicide remains a crime in Britain under the Suicide Act 1961.[1] But over the last 15 years there has been relentless pressure to change this from well-resourced lobby groups backed by powerful celebrity voices and sections of the British media.

More than ten attempts to legalise assisted suicide (AS) were made through British parliaments between 2003 and 2015 – three each by Lord Joffe and Lord Falconer in the House of Lords, two in the Scottish parliament by Margo Macdonald and Patrick Harvie, one by Robert Marris via the House of Commons and one in each of Wales and the Isle of Man. These measures all failed and the most recent – the Marris bill – was defeated in the House of Commons by the huge margin of 330-118 on 11 September 2015.[2]

This is because there are also powerful forces defending the status quo – principally doctors, disabled people, faith groups and parliamentarians – all of whom share a concern about the consequences for public safety of licensing doctors to dispense lethal drugs.

Because of this failure to change the law through the legislature, lobbyists have now turned their attention to the courts. So far these court cases have also failed – Diane Pretty, Debbie Purdy, Tony Nicklinson, 'Martin' and Paul Lamb. But in 2018 we have seen two further serious attacks on the law – on the island of Guernsey and at the Court of Appeal.

Gavin St Pier and six other Guernsey parliamentary deputies filed a requête[3] on 26 April calling for a change in the law; but it came under strong criticism for its broad scope – allowing not just assisted suicide but also euthanasia, and seemingly leaving the door open for minors, non-residents, and those with mental illness. A conscience clause was also not guaranteed.

The proposal was subsequently revised several times to make it more acceptable but was eventually defeated by a 24-14 majority. Instead, deputies voted 37-1 in favour of a review of palliative and end of life care.[4]

Meanwhile the Court of Appeal has dismissed the Conway case. Noel Conway is a 68-year-old Shropshire man who had argued that the current blanket ban on assisted suicide under the Suicide Act was incompatible with his right to privacy under Article 8 of the European Convention on Human Rights.

The Divisional Court last year dismissed his case, arguing that it was legitimate for the legislature 'to lay down clear and defensible standards to provide guidance for society, to avoid distressing and difficult disputes at the end of life and to avoid creating a slippery slope leading to incremental expansion over time of the categories of people to whom similar assistance for suicide might have to [be] provided'.[5]

The Court of Appeal has now fully upheld this earlier judgement. Sir Terence Etherton (Master of the Rolls), Sir Brian Leveson (President of the Queen's Bench Division) and Lady Justice King heard the appeal in May this year and said that the conclusions of the Divisional Court could not be faulted.

Counsel for Mr Conway had secured permission to appeal on several grounds,[6] but the Court of Appeal delivered a clear repudiation of these, stating that the objectives of the ban on assisted suicide are not limited to the protection of the weak and vulnerable, but also include respect for the sanctity of life and the promotion of trust between patient and doctor in the care relationship.

The Appeal Court judgement[7] is well worth reading in its entirety as it provides a comprehensive summary of previous parliamentary debates and court cases on assisted suicide and summarises the position of all the major medical groups opposed to the practice, including the BMA, Royal Colleges of Physicians and General Practitioners, British Geriatric Society and Association for Palliative Medicine. It also stipulates that there is a 'clear objective line' morally and legally between withdrawal of treatment (meaning that the patient dies of his or her underlying illness) and assisting someone actively to end their own life.

The Care Not Killing Alliance, in which CMF plays a leading role, intervened in the case along with the disability rights group Not Dead Yet. Its evidence was referred to several times in the judgement. This sensible decision by the Court of Appeal yet again recognises that the safest law is the one we already have – a complete ban on assisted suicide and euthanasia based ultimately on the biblical principle of the sanctity of life.[8] Our current laws deter the exploitation, abuse and coercion of vulnerable people who, as we have seen in the US States of Oregon and Washington, often cite feeling they are a burden on others as the reason for ending their lives.

One would hope that those who have been campaigning to remove these important and universal protections from disabled and sick people would accept this ruling and focus their attention on securing equality of access to palliative care and mental health support, but Conway has already appealed to the Supreme Court and so we now await the outcome there.

Peter Saunders *is CMF Chief Executive*

references

1. Suicide Act 1961 *bit.ly/2u64nje*
2. Saunders P. Defeat of the Marris Assisted Dying Bill. *Christian Medical Comment*, 12 September 2015. *bit.ly/1084Q91*
3. The states of deliberation of the island of Guernsey requête: assisted dying *bit.ly/2KTO5Dv*
4. Guernsey rejects assisted suicide. *Care Not Killing*, 18 May 2018. *bit.ly/2rRneND*
5. High Court rules on Conway. *Care Not Killing*, 5 October 2017. *bit.ly/2znVZQT*
6. [2017] EWCA Civ 16 *bit.ly/2NB1kr2*
7. [2018] EWCA Civ 1431 *bit.ly/2u8mggY*
8. Genesis 9:6; Exodus 20:13

Changing gender

Fools rush in where angels fear to tread

Review by **Peter Saunders**
CMF Chief Executive

The government has launched a public consultation,[1] on how to make it easier for transgender people in England and Wales to change their legal gender on their birth certificates. A similar consultation closed in Scotland in March, but has not yet reported.[2]

Currently, under the Gender Recognition Act 2004 people need to be over 18, have been diagnosed with gender dysphoria, have lived in their new gender identity for two years and have obtained a certificate from a gender recognition panel before being able, legally, to change their gender.

However, a highly controversial 2016 report[3] by the Women and Equalities Committee of the House of Commons on Gender Equality, recommended reducing the age limit for hormone treatment and surgery to 16 and completely removing the process of gender recognition from its current medical and legal framework – basing gender change on self-declaration alone.

A consultation scheduled for autumn 2017 was first postponed but appeared to lose momentum[4] after chief proponent Justine Greening, then Equalities Minister, lost her cabinet post in a New Year reshuffle.

But the proposals have now reappeared under the watch of new Equalities Minister Penny Mordaunt and with the backing of Prime Minister Theresa May. May has said that she wants 'to see a process that is more streamlined and de-medicalised – because being trans should never be treated as an illness.'

The move is being justified by the results of the government's LGBT survey – the largest national survey of its kind, with over 108,000 participants – which showed that many trans people find the current process overly bureaucratic and expensive.

The key question behind these proposals is what gender dysphoria actually is. Is a 'trans woman' really a woman trapped in a man's body? Or is 'she' really just a man who has an unshakeable false belief that he is a woman? Is a biological male who has had female hormones and gender reassignment surgery really a woman, or is he just a feminised man?

As recently as 2013 this condition was called 'gender identity disorder'.[5] But it was renamed 'gender dysphoria' in the DSM-V and will be reclassified as 'gender incongruence' in the ICD-11 in 2020,[6] the implication being that it is only to be considered a mental disorder if it causes deep distress. This change appears to have been ideologically driven rather than evidence-based.

As Tom Goodfellow has written in a letter to *The Times*,[7] 'Gender transition, by its nature, is a medicalised process involving powerful drugs, hormones and ultimately extensive plastic surgery... So, the call for this process to be "de-medicalised" is clearly nonsense... Transgenderism is a complex issue and needs careful management. Simply legislating to allow individuals legally to self-identify will not meaningfully address any of the problems and could actually prove harmful.'

references

1. Reform of the Gender Recognition Act 2004 *bit.ly/2KGoASG*
2. Scottish Government Review of the Gender Recognition Act *bit.ly/2zMtCLR*
3. Transgender Equality Inquiry *bit.ly/2kVsY6Y*
4. Rethink over new law that would allow adults to swap gender without consulting a doctor after minister 'gets cold feet' *Daily Mail*, 25 December 2017. *dailym.ai/2MZDZy8*
5. Gender Identity Disorder *CMF File* 25, 2004. *bit.ly/2KLS2uR*
6. Transgender no longer listed as disorder by World Health Organisation. *Center for Family and Human Rights bit.ly/2KS7FN2*
7. Changing gender requires doctors. *The Times*, 11 March 2018. *bit.ly/2tDxtZ2*

Medics on the frontline

Medics are increasingly being targeted in war

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

Events in the Middle East over the last few years have challenged the long-held belief that medical services are neutrals and not to be attacked by either side. In Syria, as the civil war has headed towards its climax, bombing of hospitals has become alarmingly frequent.[1] In Yemen, a nation facing the worst humanitarian crisis in the world today according to the UN,[2] ports and facilities being used to get essential aid, food and medical supplies to the most vulnerable have been selectively targeted by forces trying to contain the insurgency.[3] In a more individual context, the killing of a Palestinian nurse Razan al-Najar in Gaza as she sought to help the injured has generated much anger around the world.[4]

Christian medics, nurses and other health professionals are often working in unstable countries, and facing this sort of danger is nothing new. Those working in mission hospitals in the Democratic Republic of Congo at the start of the civil war in the 90s are all too aware of how often Christian hospitals and health workers were brutally targeted by rebel forces. However, the latest violence has been increasingly at the hands of government forces, some of them from supposedly democratic, westernised nations.

The reality is that in war, especially one where a nation or a people perceive a real, existential threat, norms, conventions and niceties often get forgotten. We see human sinfulness at its most raw, particularly the willingness to sacrifice even deeply held values for the sake of security. A Christlike response in these situations is to continue to serve selflessly and to bear witness to the truth.

While we should protest against such flagrant disregard for the norms and international conventions that such attacks represent, we also need to pray for the many health workers, especially nationals, who do continue to offer the best care that they can in the face of such awful circumstances and threats to their own lives.

references

1. Syria conflict: Deadly strike on Save the Children maternity hospital. *BBC News*, 26 July 2016. *bbc.in/2LTkcQC*
2. Cocker M, Schmitt E. Humanitarian Crisis Worsens in Yemen After Attack on Port. *New York Times*, 13 June 2018. *nyti.ms/2t501Z5*
3. Leiberman A, Chadwick V. Battle for Hodeida puts local aid workers in the crosshairs. *Devex*, 14 June 2018. *bit.ly/2ygHL3M*
4. Unarmed Palestinian nurse shot dead by Israeli forces. *News.com.au* 7 June 2018. *bit.ly/2JEPEkN*

Abortion momentum triggered by Irish vote

Abortion liberalisation and decriminalisation

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

In the wake of the referendum vote to liberalise the abortion law in the Republic of Ireland in June, pro-abortion MPs in Westminster, led by Stella Creasy MP, have been campaigning hard to 'decriminalise' abortion in the UK and to extend permissive abortion legislation to Northern Ireland. The momentum created by the Irish 2-1 vote, and the current suspension of the Stormont Assembly, has encouraged the abortion lobby to argue that Westminster ought to impose a change in abortion laws applying in Northern Ireland.

An emergency debate was granted in the House of Commons on 5 June when the House considered the role of the UK Parliament in repealing sections 58 and 59 of the Offences Against the Person Act 1861.[1] These sections apply in all the UK aside from Scotland (which has its own criminal penalties for abortion under Scottish law). Many MPs argued for these penalties to be scrapped as outdated.

If sections 58 and 59 were to be repealed, abortion would be made entirely legal up to 28 weeks, and all restrictions and conscience protections in the Abortion Act 1967 would be voided in their application before that point in pregnancy. Data collection on abortion would also be affected.

The debate in the House of Commons did not affect or prompt any immediate change. The Government called on Northern Irish politicians to consider amending NI abortion laws but, thankfully, maintained that it is a devolved competency.

Meanwhile, the latest Government abortion statistics reveal yet another increase in abortions in England and Wales, a 2.3% rise from 2016 to 2017.[2] A total of 194,668 abortions in 2017 brings the number since 1967 to some 9,000,000 abortions. Approximately one every three minutes, 20 every hour, 600 every day.

It would seem that abortion is often being used as a form of contraception by a growing percentage of women. Over a third of women who had an abortion in 2017 (39%) had one or more previous abortions, so approximately 73,500 women were on their second – or more – abortion. 15,100 had two previous abortions, 3,700 had three while 72 women had eight or more previous abortions.

As with previous years, 98% of abortions were performed for (so-called) risk to the woman's mental health (185,448) which has become a catch-all phrase that usually means that the baby was perfectly healthy, and probably the mother too.

Which all fits with the goal of abortion providers and seasoned campaigners such as Anne Furedi of The British Pregnancy Advisory Service (BPAS). For years Furedi has made it clear that abortion should be regarded as another form of birth control and no more significant than buying a condom or taking the pill.[3] BPAS has been the main driver behind decriminalisation of the law.[4]

While these statistics are disheartening, at least the facts and figures are available, to highlight what is actually happening. If abortion were to be decriminalised, not only would abortion numbers inevitably increase further, data collection would go out with the current legal framework, leaving it to less effective regulations at best, and self-policing by the abortion industry at worst. We face very challenging times ahead.

references

1. *Hansard*. Vol 642. 5 June 2018. *bit.ly/2KVndmp*
2. Abortion Statistics, England and Wales: 2017. *Department of Health & Social Care* June 2018. *bit.ly/2kTo9Jt*
3. Doughty S. New boss of leading abortion provider says terminations should be regarded as 'just another type of birth control'. *Daily Mail*, 7 July 2017. *dailym.ai/2tYEVxx*
4. *wetrustwomen.org.uk*

NHS at 70

Are we ready and willing to pay for healthcare?

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

You can hardly have missed the coverage of the 70th birthday of Britain's National Health Service (NHS) in early July (unless you are not based in the UK, in which case, bear with us).[1]

As Andrew Fergusson explains in more detail in his article in this edition, the advent of the world's first national, universally accessible and free at the point of need healthcare system was a momentous step. Initially a source of anxiety and opposition, it is now an integral part of the British identity. Even if you don't work in it, you will have been treated in it. You were almost certainly born in the care of an NHS midwife and you will almost certainly die under the care of an NHS hospital or hospice.

But it is also a health system in crisis.[2] Since its start, demand has outstripped supply, but the situation is worse now than at any time in recent history. A winter crisis in early January 2018 shocked many into realising just how understaffed the NHS was in the face of the nation's health needs. Shortages of GPs and nurses[3] and the alarming attrition of junior doctors[4] are causing many to ask what is going wrong and if the NHS has got a future.

Increases in funding are being promised by devolved national governments across the UK. However, it is being recognised that this will come at the cost of increased taxation and possible charges for some services. Both will be contentious – the NHS's founder Nye Bevan quit the government over the introduction of prescription charges. And while polls suggest the public are willing to pay more taxes for the NHS,[5] it waits to be seen if this will be accepted in practice.

The NHS may not be perfect, but it has maintained a vital and popular role in British civic life. The question we must ask as a nation is how ready we are to pay for healthcare free at the point of delivery to all, on the basis of clinical need rather than wealth. The answer to this question in the coming years will reveal the sort of nation we are becoming.

references

1. The NHS at 70: A timeline in pictures. *BBC News*, 5 July 2018. *bbc.in/2L2tz04*
2. Triggle N. 10 charts that show why the NHS is in trouble. *BBC News*, 24 May 2018. *bbc.in/2J6fY6n*
3. Donnelly N. 96 per cent of hospitals have nurse shortages, official figures show. *Daily Telegraph*, 19 January 2017. *bit.ly/2L1VH3E*
4. Staffing crisis in NHS laid bare, as new BMA analysis shows that three quarters of medical specialities face shortage of doctors. *BMA*, 26 February 2018. *bit.ly/2uf7Zyv*
5. Evans H, Does the public see tax rises as the answer to NHS funding pressures? *The King's Fund*, 16 April 2018. *bit.ly/2L1V2iL*

Andrew Fergusson reflects on how the NHS promised care from 'cradle to grave' but is now in crisis.

NHS
70 YEARS OLD

key points

- Many of the major religions have medical traditions, but the ethical convictions of the church were radically different from most of the rest.
- The Beveridge Report created a blueprint for healthcare from 'cradle to grave' and 'free at the point of delivery', a system that relieved poor people of the cost of medical help.
- What Beveridge failed to foresee was the astonishing (and expensive) advances in scientific medicine, increasing expectations of the public, and the advances in longevity.

5 July commemorated 70 years of the UK's National Health Service. I briefly wrote for *Triple Helix* for the 50th anniversary [1] and the 60th, [2] so now want to reflect at greater length on Christianity's influence on medicine and the first 70 years of the NHS.

The first 1900 years since Christ

There had been strong medical traditions in the Buddhist, Jewish, Arab, Greek and Roman worlds but from the earliest days of the Christian church their radically different ethical approach was influential. The church began to change society's attitudes to the sick, disabled and dying. At the end of the first century Clement recorded in Rome how the Christians provided relief for widows; and during a second century plague in Carthage when pagans threw sufferers into the streets for their own protection, the bishop led Christians out into those streets to welcome sufferers into their own homes.

Constantine's Edict of Toleration in 311 gave Christians official sanction to express their convictions in public service. The Roman Emperor Julian who came to power in 355 was the last to try to reinstate paganism, but noted that to succeed the old religion would need to care for people better than the Christians did.

The 'Dark Ages' cover the period between the fall of Rome in 476 and circa 1000, but even so Charlemagne (742-814) decreed that every cathedral should have an attached hospital, monastery and school. Famous hospitals such as Barts and Thomas's were founded in the mediaeval period with a spirit of Christian service. The 18th century evangelical revival pioneered by the Wesleys and Whitefield led to a new age of hospitals, where the body was cared for as much as the soul. These institutions were mainly meant for the sick, the poor, and were supported by voluntary contributions. [3]

The 20th century

Medicine was beginning to become more respectable as a profession. Scientific advances started to resemble something we might recognise. The 1911 National Insurance Act underwrote general practice, the Great War (1914-18) reduced the numbers of men available. This began the very slow liberation of women. But the 1920s and 1930s were decades of great inequality with economic depression only beginning to lift in 1935. Even so, there were still over one million unemployed by the start of World War Two.

Professor Roy Porter (1946-2002) wrote: '*War is often good for medicine. It gives the medical profession ample opportunities to develop its skills and hone its*

practices. It can also create a post-war mood eager to beat swords into scalpels. The astonishing success of antibiotics used upon troops during the Second World War heightened expectations of wider public benefits. Only in Great Britain, however, was it followed by a dramatic reorganization of civilian medical services.' [4]

The concept of the National Health Service was blueprinted in the 1942 *Beveridge Report on Social Insurance and Allied Service* by civil servant Sir William Beveridge (1879-1963). It sought to take on the five giants perceived to threaten society: Want, Ignorance, Disease, Squalor and Idleness. Beveridge's 1942 slogan about comprehensive welfare provision 'from the cradle to the grave' summed up these ambitious aims.

Disease would be overcome by a new health service 'available to everyone according to need, free at the point of service, without payment or insurance contributions and irrespective of economic status. All means tests would be abolished.'

The landslide Labour Party victory in 1945's General Election allowed implementation. A bill introduced in April 1946 received royal assent in November and 5 July 1948 was the appointed day for its inauguration. Both municipal and charity hospitals were simply nationalised overnight and the Secretary of State for Health, Aneurin Bevan, became responsible for 1,143 voluntary hospitals with more than 90,000 beds and 1,545 municipal hospitals with 390,000 beds. [5]

There was much resistance from the medical profession about loss of private practice. Bevan boasted that he had 'won over the consultants by choking their mouths with gold'. GP fears of a full time salaried practitioner service were overcome by letting them remain separate from hospitals as independent contractors.

Christian doctors' concerns were about losing the freedom to work as Christians, but this never materialised, at least at that stage. There was great rejoicing about abandoning the need to extract payment from the poor.

Porter summed up the reorganisation as 'efficient and fairly equitable…powerful, popular and, by international standards, exceptionally cheap'. [6]

Where are we now?

We remain incredibly blessed by healthcare free at the point of need. It is indeed so popular that ten years ago former Chancellor Nigel Lawson described the NHS as 'the nearest thing the English have to a religion'. [7] However, we now realise the fundamental flaw of the thinking behind Beveridge: that if we are able to reduce inequalities and improve the general health of the population, we will spend less on treating patients.

Beveridge failed to predict the astonishing (and expensive) advances in scientific medicine, the increasing expectations of the public, and the advances in longevity that have caused many more to live many more years, though often with multi-morbidity. Social changes leading frequently to disintegration of the family, and diseases and disorders of unhealthy lifestyles have added to the mix. There is no need to dwell at length here on underfunding, too few beds, disconnect between health and social care, growing inequalities, issues of staff morale, and the possible effects of Brexit.

Is there hope for the NHS, or does the 3,000 year-old pronouncement of the Psalm of Moses apply? 'The length of our days is seventy years – or eighty, if we have the strength; yet their span is but trouble and sorrow, for they quickly pass, and we fly away.' [8] If 1948 was the cradle of the NHS, are we in 2018 digging its grave? There is an encouraging amount of optimism around. CEO of the King's Fund, Chris Ham wrote on 5 May of a cross party consensus that, 'Spending on the NHS and social care needs to increase by substantially more than inflation over the next 20 years and should be paid for by a dedicated tax... Survey evidence shows that the public is increasingly anxious about the state of the NHS and that there is support for tax rises to increase funding. Tax rises are now backed by a majority of supporters of all the main parties.

Ham also considers top priorities: mental health services, general practice, and improvements in cancer care, and emergency care. [9]A constant refrain across the political spectrum is 'the need for social care to receive additional funding as well as the NHS'. The Prime Minister's recent addition of social care to the then Health Secretary, Jeremy Hunt's job title may be significant. At the time of writing, the PM was expected to make an announcement on the scale of promised funding to mark the 70th anniversary. The thought of significantly more money and recognition of a cross party common sense consensus have led to hopes that 'the country has arrived at a second Beveridge moment'.

A personal view

Although later called out of clinical work, I loved my 14 years' clinical medicine. I had the privilege of being a GP throughout the 1980s, when the motto was, 'if it ain't bust, don't fix it'. Older patients told me of their fears about payment before the NHS came in. I'm glad I never had to ask for money.

A year in the USA where there is no universal health coverage confirmed why I have always been a fan of the NHS. I remain ardently committed to healthcare free at the point of need, and am ready to put more tax money where my mouth is. I would welcome a second Beveridge moment.

But there is 'too much medicine' now. Nobody seems to be allowed to die. We have forgotten that life has a natural end. Fears about dying are almost never discussed among health professionals and the public. Nobody appears to spend time any more preparing to meet their Maker. We desperately need to bring Christianity and medicine back together.

Andrew Fergusson *is a former GP and communicator at the interface of Christianity and medicine.*
In retirement he is active in local churches and in Christian publishing

We remain incredibly blessed by healthcare free at the point of need. It is indeed so popular that ten years ago former Chancellor Nigel Lawson described the NHS as 'the nearest thing the English have to a religion'

references

1. Fergusson A. Editorial: From the cradle to the grave. *Triple Helix* 1998; Summer: 3
2. Fergusson A. 'Diamond geezer' or ripe for retirement? The NHS at 60. *Triple Helix* 2008; Summer: 4
3. Beal-Preston R. The Christian Contribution to Medicine. *Triple Helix* 2000; Spring: 9-14
4. Porter R. The Greatest Benefit to Mankind. A medical history of humanity from antiquity to the present. London: Fontana, 1999:652
5. *Ibid*
6. *Ibid*:654
7. The English reformation - National Health Service. *The Economist*, 20 November 2014. *econ.st/2L1MV8R*
8. Psalm 90:10
9. Ham C. Cross party approach to NHS and social care, *BMJ* 2018; 361 (2 May)

Steve Fouch explores how Christians can fill gaps in NHS care.

STANDING IN THE GAP

key points

- For most of the history of the West health and social care has been the preserve of family, church and local community.
- As healthcare has become professionalised there has been a loss of social solidarity and the marginalisation of vocation.
- With the NHS facing a mounting crisis of resources, Christians are responding with new models of care.

Many fear that the ongoing reforms of the National Health Service (NHS) by the last two administrations are an attempt to 'privatise' the health service by stealth.[1] These anxieties, from both left-wing media and health professional bodies, stem from a concern that subcontracting out services to 'for profit' companies risks diluting or even destroying the NHS ethos of free care at the point of delivery to all according to need rather than ability to pay.[2] These voices argue that the profit motive leads to cut corners and compromises that do not benefit patients.

On the right, the concern is a growing bill for providing services in comparison to a new, more cost-efficient health service, with less bureaucracy. Market competition is far more efficient than state control, they argue, and will lead to a better service without compromising care. Furthermore, they maintain, patients should have the right to choose between providers and not just accept the services they are given.

> The provision of health and social care is an act of social solidarity that says all human lives and the quality of those lives matter

Both sides are right and wrong: right in their diagnosis, wrong in their prescription.

The state has an important role in coordinating and distributing essential services and resources, responding to and identifying needs at a macro level, through policy and infrastructure. But central planning is a blunt instrument and does not easily allow for innovation and creativity. It can fail to respond to the difference in needs and circumstances at a local level. But adaptability and responsiveness are at the heart of the way the private and voluntary sector operate.

Markets are effective media for products we buy

and sell; they ensure the price reflects the need for the product and the cost of its production and create incentives for innovation and adaptability. Health, however, is not a commodity – it is a fundamental aspect of human existence. The provision of health and social care is an act of social solidarity that says all human lives and the quality of those lives matter. However it is paid for, healthcare should be universally accessible and available to all as a common good; this is being increasingly accepted as the global baseline for which all nations should be aiming.[3]

There are other issues with the left/right approaches to healthcare. The German sociologist Ferdinand Tönnies pointed out that in pre-Enlightenment Europe mutual social solidarity was provided by the church, as a local, national and a supra national network and institution.[4] Societies looked after those in need in their community through a variety of institutions and networks, many founded in the church.[5] In many parts of this country, the church still fulfils this role.[6] After the tragedy of Grenfell Tower in 2017, local churches were the first responders after the emergency services.[7]

Whether we consider Alexandria in the sixth century[8] or Geneva in the sixteenth,[9] we can see strong examples of the church acting as a social support network, often in cooperation with the state.

Post Enlightenment, there was a move towards more secular networks and institutions to take up this role. This led to a shift from what Tönnies termed *Gemeinschaft* (community, mutuality, social responsibility, loyalty, friendship and love) towards *Gesellschaft* (a group of individuals bound together by utilitarian interests and necessity).[10] The profit motive in Gesellschaft removed the sense of mutual care, responsibility and social solidarity. In healthcare, career and profit became more central. The sense of vocation or calling to health or social care was diminished.[11]

Socialist and free market systems are both equally guilty of promoting *Gesellschaft* at the expense of *Gemeinschaft*. The barren nature of Soviet era healthcare in Eastern Europe showed this at its most stark – universal, technically competent (for the most part) but reducing people to machines to be fixed and put back to work. It ignored the complexity of the human beings it patched up, dismissing their hinterlands of faith, family, work and community.

The free market approach to healthcare in some Western nations displays a similar, bleak utilitarianism that ignores the social and spiritual nature of human beings. Left-wing utilitarianism and right-wing consumerism both fail the patient and diminish their humanity.

Is there another approach that bridges the gap between social solidarity and profit?

The NHS seems to hold these two ideas in tension with a measure of success. It maintains an ethos of service and social solidarity while operating a modern, professional pay and career structure. For many, the NHS is more than an employer; it is something they believe and value as good in itself, whatever its shortfalls.

Many social reformers of the 19th and 20th centuries including the father of the NHS, Aneurin Bevan saw the need for an ethos of service and solidarity tied to well-run, professional institutions. That most of these (with the exception of Bevan) were Christians should not surprise us!

Biblical roots are found in injunctions to serve the poor[12] and to set aside administrators and organisers for this purpose.[13] At the heart of this approach is to serve Christ[14] – whether tending the sick, organising the cleaning rota or creating a medical education programme. All work is God's work, and is to be done to the best of our ability.

In Manchester, health and social care budgets are being combined and commissioned jointly in a trial known as *DevoManc.*[15]

Community Interest Company (or CIC), Hope Citadel[16] was started by a medical student on an Oldham council estate who saw the lack of local GP services in her community. She challenged the local commissioning group about this. They got her to set up a practice to address the needs. The model of whole person care that the practice developed (drawn strongly from a Christian world view) involved working with local churches, community groups and others to address the social and healthcare needs of the people on the estate. It was so effective that Hope Citadel is now managing nine practices across Greater Manchester, specialising in providing health in areas of social deprivation.

This is one example of how a private company can be moved, not by profit, but by the ethos of care and compassion. It shows how small bodies can innovate in a way that larger organisations can sometimes struggle to do.

There are many innovations out there[17] that need to be part of the thinking behind health service reform. That many of these are faith-based should come as no surprise.[18] The church has owned the ethos of social solidarity since it began two thousand years ago; it is the natural outworking of the gospel.[19]

We need to move beyond the old ideas of the traditional left and right when it comes to healthcare. The church and Christian organisations have a huge role to play; it is one they are already playing! As the government decides what to do with its troubled kingdom of health and social services, it would do well to talk to those in the community who are re-imagining health and social care, in service of a much greater kingdom.

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

references

1. Johnston I. NHS privatisation exposed: Scale of treatment for paying patients at NHS hospitals revealed, *The Independent*, 30 September 2017.
2. Bodkin H. Government is deliberately creating a health crisis to privatise the NHS, doctors claim, *Daily Telegraph*, 24 July 2017.
3. Simpson B. Tedros Makes His Case for a Transformed WHO, *Global Health Now* 21 May 2018. *bit.ly/2wYezOh*
4. Tönnies T. *Gemeinschaft und Gesellschaft* Cambridge University Press, 2001 (originally published 1887)
5. Fergusson N. *Networks, Hierarchies and the Struggle for Global Power*, Allen Lane, London, 2017.
6. Pepinster C. How rural vicars became the last social workers in the countryside. *The Observer*, 7 January 2018.
7. Aitken J. The fourth emergency service. Faith communities in the Grenfell frontline, *UnHerd*, 19 July 2017. *bit.ly/2Kz6AJu*
8. Ferngen J. *Medicine and Health Care in Early Christianity*. Johns Hopkins University Press, Baltimore, 2009:87-95
9. Tame J, Tame L. Reimagining social welfare: Lessons from Geneva's transformation. *Cambridge Papers*, Jubilee Centre, January 2018.
10. Tönnies T. *Op Cit*
11. Bradshaw A. *Lighting the Lamp: Spiritual Dimension of Nursing Care*. Scutari Press, Harrow, 1994: 97-170
12. Matthew 25:31-46
13. Acts 6
14. Colossians 3:17
15. *www.gmhsc.org.uk*
16. *www.hopecitadel.org.uk*
17. Some examples can be found at: *bit.ly/2kdUcTW*
18. Fouch S. Time for new partnerships: the added value of Christian organisations in preventative health. *CMF Blogs*, 29 March 2017. *bit.ly/2oe9ufs*
19. Saunders P. The Reformation and Medicine. *CMF Blogs*, 4 November 2017. *bit.ly/2pg4PZy*

Adrian Warnock experiences life on the other side.

WHEN DOCTOR TURNS PATIENT

key points

- Doctors learn to be detached from their patients, but patients need to know that doctors care.
- Treatment without compassion misses the opportunity to serve like Jesus.
- Compassion is seen in small attention to detail, when looking after a patient.
- Doctors need to take time to rest well so they can show compassion.

Adrian Warnock graduated from Bart's and the London School of Medicine and Dentistry in 1995. He specialised in psychiatry before moving into pharmaceutical medicine. Adrian was diagnosed with chronic lymphocytic leukaemia in May 2017 and has had several inpatient admissions and two surgeries as a result. [1]

From the first experience of anatomy dissection as a medical student, our experiences as doctors gradually distance us from our patients. People who get sick are subtly viewed as 'other'. We are taught, quite rightly, to be professional, calm in a crisis, and to make objective decisions about clinical care.

If we experienced the same emotional impact concerning every dead or dying patient as the first one we saw, then we'd quickly become psychological wrecks. Certainly, when a patient is near death they wouldn't want a doctor or nurse who just sits on the bed crying about the direness of the situation. They would want one who can figure out what needs to be done and who does it.

This process of professionalism can ultimately lead us away from Jesus' desire that we be known for our love.[2] Busy on-calls, relentless demands, and increasing seniority can lead to an absence of any emotional involvement or humanity. One of the biggest challenges facing Christian health professionals is the battle to retain compassion.

Compassion is defined in the Miriam Webster Dictionary as 'sympathetic consciousness of others' distress together with a desire to alleviate it.' Compassion is when love moves beyond mere emotion and motivates us to action. Medicine must never become merely a career where our reason to work is simply to earn money, or just to get through the day.

Jesus experienced the pressures of dealing with crowds and their demands. However busy A&E is on a Friday night, there won't be 5,000 people there thronging around a single healer and hanging on

their every word. When Jesus looked at the crowds he didn't see a faceless multitude but suffering individuals, made in his image, who he had come to make the ultimate sacrifice to save. On one occasion we are told Jesus 'saw a great crowd, and he had compassion on them and healed their sick' (Matthew 14:14). Perhaps the greatest privilege of being a doctor or other health professional is that we are called to show compassion like Jesus and be involved in his healing work.

We rightly speak a lot about ethical issues at CMF. But if we also forget to emphasise Christian love, we will miss the mark as much as those who compromise biblical truth in a misguided attempt to be loving. As John Stott put it, 'Truth becomes hard if it is not softened by love; love becomes soft if it is not strengthened by truth'.[3]

Having been a doctor since 1995, I am now on the receiving end of treatment. I am very grateful for the care I receive. However, some things happen in a pressurised NHS which never should. Some of these are unavoidable. Others would never happen if health staff always remembered compassion.

I was told on the phone by a haematologist that I 'almost certainly' had chronic lymphocytic leukaemia a few days after my first A & E visit. Such news should only ever be given face-to-face. By then I was an inpatient at a different hospital with pneumonia. The local haematologist refused to meet me for several weeks. When he got the results of the definitive test, he wouldn't even tell the doctors treating my pneumonia they had an immune compromised patient on their hands. I finally got a private doctor to confirm my diagnosis. That night I was crying on a phone helpline with a compassionate nurse, who suggested I get myself referred to a specialist hospital.

When I was admitted to hospital a couple of days later, I was beginning to develop sepsis despite weeks of various antibiotics. At that moment I needed a doctor who could dispassionately work out what needed to happen and do it. As I think back on the many health professionals that have helped me through my admissions and clinic visits, the compassionate ones stand out.

The dilemma faced by all health professionals is how to deal with extreme challenges; balancing the need to be rational, while retaining compassion, which at its core is an emotion. Too much and too little emotion is a problem. A journalist explained this dichotomy well:

'Doctors, of course, have to be compassionate and dispassionate at the same time. A doctor who was completely indifferent to the sufferings of others would be a public menace; but a doctor who felt every patient's suffering as his own would have a short and miserable career.'[4]

Compassion is not about time. It isn't what is said, but the way it's said. It's about remembering you are treating a person made in the image of God. It is about understanding the emotions your patient and their family are feeling.

Compassion is the nurse who pauses and comforts you at a difficult moment during an admission. It's the doctor who appreciates the emotional impact of a diagnosis and gently explains the implications, rather than assuming you understand. You might be overly familiar with the illness you are treating, but to them it may feel like a tsunami threatening to destroy their whole family.

Sometimes the smallest things like managing expectations make all the difference. I remember being told by a receptionist that unfortunately they didn't yet have any radioactive material in the department so there would be a long wait for my PET-CT scan. Many NHS employees wouldn't have explained this, but it was so much better to be told than to be left waiting clueless.

Fellow CMF member Mary Wren described a similar experience during a hospital admission:

'What I really noticed was that some people really cared and others didn't. All did the job OK. But some didn't look me in the eye, smile, squeeze my hand, or give time. I noticed the one nurse who asked the elderly lady next to me how her husband was getting on at home – it only took two minutes but made all the difference.

That hand squeeze, the compassionate look, acknowledgement of the person inside, two minutes to listen... it can make the patient feel good, peaceful, hopeful, valued, warm inside. The doctor who came and looked me in the eye and squeezed my hand as she told me all about what they found inside, made me cry. Good crying. That was real, complete care of me the person, as well as my body.

I wonder how much difference that art of medicine, that soft immeasurable care, makes to the recovery of the person. I wonder if that hug or hand-squeeze would result in less pain relief being needed, less pressing of buzzers, patients getting home quicker.'[5]

How do you retain humanity and compassion in a busy clinical setting? Surely the answer is to consider the words of Jesus, 'Do to others what you would have them do to you.'[6]

If you are about to say or do something that is not how you would want to be treated yourself, it is time to have a rethink.

As much as we like to ignore this, sickness will one day affect every family. When it does, we would like ourselves or our family members to be on the receiving end of compassion.

Let us unashamedly show the love of God in our workplaces, whilst not forgetting to look after ourselves. Even Jesus needed to rest. He withdrew often from the crowds to quiet places to pray and reflect.[7] Too many doctors forget how to really take a break. One clue: true rest requires a pause from looking at any screens.

Be kind to yourself so that you can be refreshed to be kind to others. Remind yourself often why you first became a health professional. Never lose that sense of vocation. Remember, you really are doing God's work of showing love and healing.

***Adrian Warnock** is a previous editor of the student publication* Nucleus. *He serves as the CMF local link for North East London.*

Compassion is when love moves beyond mere emotion and motivates us to action

The dilemma faced by all health professionals is how to deal with extreme challenges; balancing the need to be rational, while retaining compassion

references

1. Adrian's journey with CLL and the effect it had on his faith is described more here: *bit.ly/2xTFmvG*
2. John 13:35
3. Stott J. *The Message of Ephesians: God's New Society*. London: IVP, 1991:172
4. Dalrymple T. Doctors must not care too much. *The Telegraph* 10 August 2003. *bit.ly/2kWOkkc*
5. Wren M. When the doctor went to hospital. *Triple Helix* Summer 2013. *bit.ly/2xTkapt*
6. Matthew 7:12
7. Luke 5:16

Bert Nanninga asks, 'Is there light at either end of the Euro-tunnel?'

LESSONS FROM THE REFUGEE CRISIS

key points

- Migration is traumatic. People do not give up the security of home and support systems for no good reasons.
- Migration is characterised by the liminal phase – it marks a transition into a new identity. Effort is required to be a neighbour to those in need in a changing culture.
- Christian physicians need to be culturally competent. We need to understand people coming from another culture are different. They cannot just do a course and train to become a European or British citizen.
- Living in a post-Christian culture means Christians too must now adjust to living in a new liminal phase within a society that has detached itself from its traditional spiritual moorings.

The people of the land practise extortion and commit robbery; they oppress the poor and needy and mistreat the foreigner, denying them justice. I looked for someone among them who would build up the wall and stand before me in the gap on behalf of the land so that I would not have to destroy it, but I found no one. [1]

In post-Christian Europe, we unfortunately have a tendency of doing the very same thing when we consider our attitude towards refugees on our doorstep. I will present some views on the migration issue and include lessons derived from my personal experience of culture shock and reverse culture shock.

I lived as a missionary in an upside-down world. I worked as a director in two mission hospitals, often being the only MD available. In 1998, a centre for HIV and orphan care in a rural part in the northern region of Malawi [2] was established. I experienced culture shock, and on return to the Netherlands, 18 years later, a reverse culture shock. The second was worst than the first; I can say that it took almost five years to experience the Netherlands as 'being home' again.

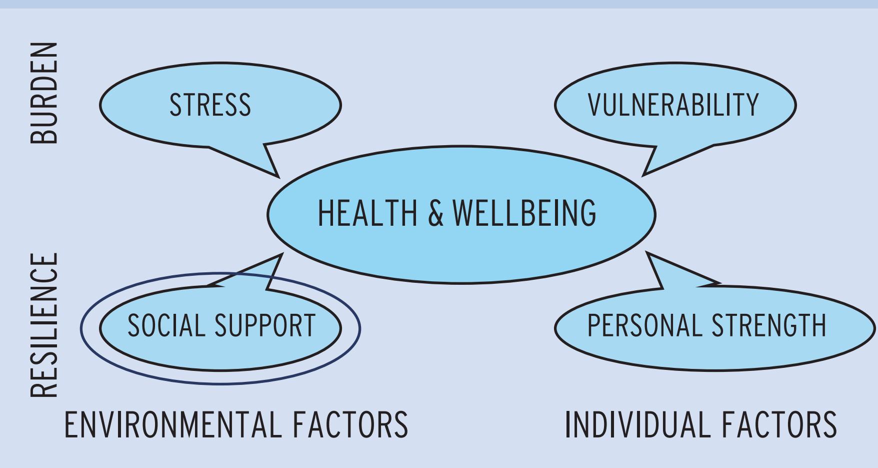
One of the well-researched risk factors of schizophrenia is experience prior to migration. So as I felt like a stranger during my reverse culture shock, I have been pondering these questions. Feeling detached and out of place creates considerable psychological stress. At the time, a consultant psychiatrist described my status as: *'Bert has not yet touched down'*. My mind was still somewhere in Africa, where I established a lot, had really enjoyed the work, and where I was concerned if all was well – it was hard to leave it behind.

The morbidity and mortality rates that I found on return were quite different from what I was used to, doing public health in Malawi. The average age of deceased people in the mortuary of St John's Hospital (Mzuzu, Malawi) in 1996 was 22 years of age. Of course this was because of HIV/AIDS, before the time that anti-retrovirals were widely available. This infectious disease was affecting mainly young people. The under fives were threatened by the same HIV, as well as malaria and diarrhoea.

When I came back to the Netherlands infectious diseases were hardly a major health problem (apart from avian flu and a new spirit of reluctance against

immunisation among young parents). Yet the morbidity and mortality figures on mental health in the West were in my observation increasingly shocking. In 2017, in North America, the first reason for death among young adults was opioid abuse; in Russia, alcohol abuse and in Asia, suicide. In Europe, the highest death rates in this age group are due to suicide and drug abuse. The risk that your adolescent child may die of a terror attack, something we all believe is a dangerous reality nowadays, is in fact much lower than your child may die committing suicide or of drug abuse. It should be a concern to us all.

FIGURE 1: Stress, strength, support, weaknesses and resilience model, (after De Jonghe F, et al. 1997)



The migration crisis

António Guterres, former United Nations High Commissioner for Refugees and since 2015, UN Secretary General, has described the global refugee crisis as follows: '*We are witnessing a paradigm change, an unchecked slide into an era in which the scale of global forced displacement as well as the response required is now clearly dwarfing anything seen before*.' (UNHCR report 2014 World at War).[3]

The UNHCR counted, at that time 42,500 new refugees being added to the total number each day, more than 60 million worldwide. It meant that every two seconds, there was someone who decided to leave home in order to find a safer place. 2015 was the year of Europe's refugee crisis.

Having a passport is something to cherish. When I started my duties in the psychiatric unit for asylum seekers, I was asked by the members of my new department to introduce myself; they had suggested that I present two items that were important to me. I brought my passport and my Bible and briefly explained why they were precious.

We have passed bills in Europe where we can declare people as being illegal when they don't carry a valid passport. Being illegal means they are deprived of all sorts of privileges, such as healthcare and legal protection. We tend to treat them as less human and have de-humanised strangers by giving them a so called 'illegal status'. The UK Parliament passed the UK Immigration Act in 2014 providing limited access to healthcare for illegal immigrants.[4]

Migration can be a trauma in itself. When people leave their own country against their will, their possessions, home, dear ones... they don't just do that because they want to experience Europe and have a better life. When refugees are displaced they are in misery. Nobody willingly gives up a place of safety, calm, familiarity, attachment and belonging. Nor do they give up a place where dreams have been cherished, and where life has been predictable as part of a community that has the same values, norms, and language. These are all primary resources that migrants have lost. When access to a new place of living is perpetually being denied to someone with an illegal status, his threshold to a safe haven will become a never-ending tunnel of desperation and eventually affect his mental health and identity.

Vignette: being illegal

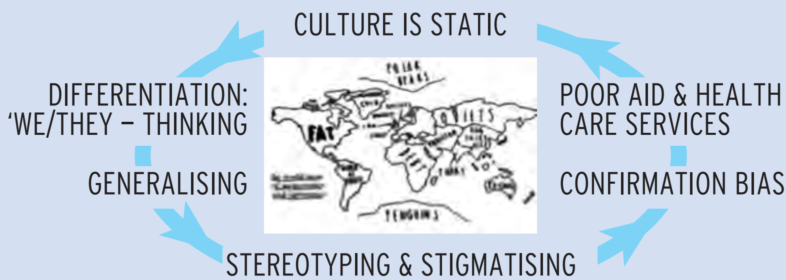
Ahmed, was a 32-year-old man whom I met when he came as a patient to see me. He had left Iran at the age of 21 when he was a promising engineering student who had run into political conflict with the Shiite regime. Upon arrival, he requested asylum in the Netherlands, only to hear within a month that his request was rejected. As a result, all of the European Union countries were closed to him; he had no access to freedom and he did not dare go back. He decided to survive on the streets, living undercover, offering himself as cheap labour in restaurants. He tried Sweden but was forced to return. He tried again, moving up and down between Sweden and Holland. As his fingerprints were taken and shared between border authorities, he was unable to escape. Three times he ended up in detention, of which he said, 'Those were my darkest days. That was truly horrible. I will never again talk about that time of my life.' He experienced nightmares and panic attacks. He could not share this without crying. As a young, intelligent man he must have had an attractive appearance, but he now looked like he was 40-years-old. He was anxious, depressed, tired, easily crying, very alert and agitated. He was a lonely young man, detached from his cultural, social and even personal identity. He felt very much ashamed and he literally cried to me, saying, 'Doctor, please help me. I have forgotten who I am.' He had lost all his primary resources, he had nothing to hold on to, he had been denied a new home and in the process he had lost himself. This is what migration can do to any of us, especially when this happens against our will and we're forced to go to another place where in due course we are not accepted. Only extremely resilient people can cope with this alone. As figure 1 shows: social support is a key factor in resilience. You may have personal strength, but when there is a tremendous amount of stress, social support is needed and should not be denied, as it was in this case.

Fort Europe

As Europeans, there is a growing tendency to reduce social support to those in need. We have

In 2014, there was a new refugee, every two seconds

FIGURE 2: Risk of poor health care delivery when observing culture as static (after: Shalid WA. 1988: Mechanistic Interaction Model of Aid-Services)



When refugees are displaced, they are in misery. Nobody willingly gives up a place of safety, calm, familiarity, attachment and belonging

built and continue to build Fort Europe, even finding pride in this. Like any other culture we are biased and ethnocentric; the present neo-liberal stand is simply this: 'Our culture is better.' These words came from the former Dutch Minister of Health Mrs Edith Schippers in 2016.[5] This is egalitarian neo-liberal ethnocentrism. However, there is a gap between what is so perfect on paper. In Malawi, I was often surprised that Malawian healthcare was being presented as if it was the best system in the world. Yet the realities I faced were quite the opposite. On the outside and on paper, it all seemed pretty well organised, but on the inside there was no power to do what was needed.

Cultural competence

When we say that our culture is better than another culture we are actually saying that culture is static. A static view of culture causes us to think in terms of 'we' versus 'they'. We generalise, stereotype, stigmatise, and build up a confirmation bias (figure 2). As a result our healthcare delivery will be biased and poor. Rather, we need to look at culture as dynamic: cultures are continuously changing. Culture is a process through which ordinary activities and conditions take on an emotional tone and a moral meaning for its participants.[6]

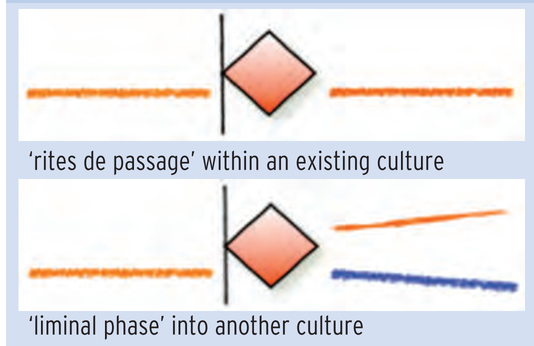
As Christian physicians, we need to be culturally competent. We need to understand people coming from another culture are different. They cannot just do a course and train to become a European or British citizen. We need to make the effort to understand people who come to us with their problems, not only being as quick as possible to find a reliable diagnosis, but to understand the illness as the patient understands it. Only then will we get close to the patient, build trust and find a solution together. Doctors need to be good communicators and good collaborators. In trans-cultural practice we have a fine opportunity to build this cultural competency.

The Apostle Paul was very intentional and culturally competent. He knew how to align, how to make contact with Jews, becoming like a Jew to those under the law.[7] The challenge is not to expect strangers in need to adopt our systems. It is whether we are willing to become their neighbours by practising adequate cultural competence.

Understanding migration: liminal phase

We have already noticed that migration can be experienced as trauma. I would like to highlight here the liminal phase of migration. The term liminality comes from two anthropologists who studied social transition processes. Arthur van Gennep researched initiation rituals among young men and women in central Africa and called them *rites de passage*, in which the liminal phase was the key transition phase.[8] Victor Turner characterised the liminal phase as a space where the individual ends 'being betwixt and between'.[9] He called it an anti-structure, where the previous and familiar structure has completely disappeared. There's nothing to hold on to, nothing is any longer the same. Only after the participants have gone through that phase, can they be introduced into the new phase.[10] A liminal space is not intended to last forever. Turner applies the concept of liminality to a number of transition processes, including migration.

FIGURE 3: post liminal phases within an existing culture, vs into another culture



'rites de passage' within an existing culture

'liminal phase' into another culture

In figure 3, I try to demonstrate the difference and similarity between the liminal phase as a *rites de passage* in an existing culture, where the individual goes back into the same culture, but now as a different person with a different identity versus the transition of the migrant. Only by memory does the migrant carry his cultural identity with him, but he has to adopt an entirely new culture. If he gets the opportunity and autonomy to make choices with respect to his future development he may succeed well in this transition and he will eventually integrate and feel at home in his new country, having a new (often) bi-cultural identity. It must be mentioned here that this process will not go without grieving: the lost culture is dear to the very self and the migrant often experiences sadness and a sense of loss. Migrating is indeed a mental health risk.

Not all migrants integrate well. Berry identifies four patterns.[11] There are those who prefer their original culture and being ethnocentric they stay separated, and often live in their own community where they fail to appreciate the new culture and from where it is even more complicated to be accepted by the receiving culture. Behind their front doors, their homes are as if they are still in Somalia or Pakistan. During times when they go out and try to adapt, they often experience shame. There is also

FIGURE 4: integration patterns (after Berry JW, 1992: Acculturation and Adaptation in a New Society, International Migration)

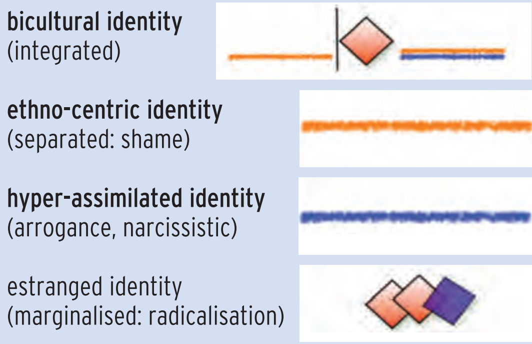
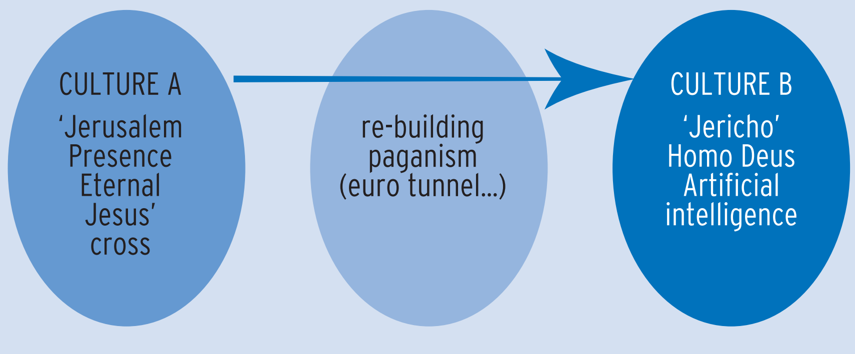


FIGURE 6: Living in a liminal phase after separating from a Christian era in Europe



a pattern of the migrant who completely forgets and ignores his previous culture: he idealises the new culture and at all costs presents himself as being part of it. He risks becoming arrogant like the proselytes in the New Testament times who had become more Jewish-like than the Jews themselves. Often they have an underlying narcissistic pathology, being easily offended. Lastly, there is a pattern of marginalisation leading to an estranged identity – that's what I described in the vignette of Ahmed, who lost his cultural identity and never got entry into a new culture.

Vignette

The identified problem with Ahmed as mentioned earlier, was that he was denied access. He was not accommodated in Europe, and therefore his liminal phase became a permanent state. He had no access to a new cultural and social identity – it was denied to him, and as this lasted for so many years he eventually got detached from himself. He had grown up as a young man in a healthy family, but all that was no longer of value. By God's grace I can add however, that – while in prison – he came to know Christ and in the end he even got a permit to stay legally in Europe. He is now on his way to re-finding his identity as a disciple and citizen of heaven.

Liminality in present day Europe

FIGURE 5: Atrium of a church building: example of liminal spaces

I would propose that the post-Christian culture we are part of is in a liminal space as well. It is quite astonishing to realise how fast we have moved from a predominantly Christian society into a post-Christian, secular society. It appears that almost within one generation we have abandoned these roots completely, even believing these roots historically were more a bother to society than that faith made a significant contribution to science and development.

Paul warns us in Romans 1, 'For although they knew God, they neither glorified him as God nor gave thanks to him, but their thinking became futile and their foolish hearts were darkened... and exchanged the glory of the immortal God for images made to look like mortal man and birds and animals and reptiles.' [12] When we say bye-bye to the creator God, who created us in his very image, we risk losing our identity. If we neglect worshipping him, we will develop an identity crisis. Indeed, we need to find our identity again in the Eternal.

Psalm 84 is an interesting passage to have in mind when you think of refugees and people coming to us from other cultures: 'Blessed are those whose strength is in you.' [13] In other words, resilience comes when you find strength in the Lord. 'Better is one day in your courts than a thousand elsewhere; I would rather be a doorkeeper in the house of my God than dwell in the tents of the wicked.' [14]

Staying close to Jesus and abiding in his presence is what we need; it is what we need to offer to those around us. We need to find and live out our identity in Christ. We are not shaped by our culture, but we, by living out our identity in Christ, shape the culture around us. 'Therefore, come out from them and be separate, says the Lord. Touch no unclean thing and I will receive you. And I will be a Father to you, and you will be my sons and daughters, says the Lord Almighty.' [15] That's a great promise: when we seek him, he will then call us his sons and daughters. Therefore, if we, as Christian medical practitioners seek and practice his presence, especially to those who have nothing to identify themselves with, there will be light at both ends of the Euro tunnel.

Migration is a very risky exercise. Liminal spaces are universal and colour all cultures. Migration is characterised by the liminal phase – it marks a transition into a new identity. Effort is required to be a neighbour to those in need in a changing culture.

And the righteous will answer that day in surprise, '"Lord... when did we see you a stranger and invite you in?"' [16] We are all called to stand in the gap!

Bert Nanninga *is a transcultural consultant psychiatrist based in The Netherlands. This article is based on his Rendle Short Lecture at the 2018 National Conference*

> As Europeans, there is a growing tendency to reduce social support to those in need. We have built and continue to build Fort Europe

references

1. Ezekiel 22:29-30
2. Matunkha Development Trust *www.matunkha.com*
3. UNHCR. World at War: UNHCR Global Trends Forced displacement in 2014. *UNHCR*, 18 June 2015. *bit.ly/1TKpnTo*
4. Immigration Act 2014. *bit.ly/1wEMql5*
5. Schippers' speech: stand up for freedom, against radical political Islam. *Dutch News.nl*, 6 September 2016. *bit.ly/2zttSQn*
6. Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine* 2006; 3(10): e294. *bit.ly/2xICHEZ*
7. 1 Corinthians 9:19-23
8. Gennep A. 1909. Les rites de passage: *étude systématique*. Paris: Uitgeverij. Nourry E. 1981.
9. Turner V. *Betwixt and between: the liminal period in rites de passage. Forest of symbols: aspects of the Ndembu ritual. Ithaca*: Cornell University Press, 1967:23-59
10. Turner V. 1969. *The ritual process: structure and anti-structure*. New York, de Gruyter 1997.
11. Berry JW. Acculturation and Adaptation in a New Society. *International Migration* 1992;30:69-86.
12. Romans 1:21-23
13. Psalm 84:5
14. Psalm 84:10
15. 2 Corinthians 6:17-18
16. Matthew 25:38

Ruth Butlin shares experience of voluntary work with NHS agencies.

WHEN A CHRISTIAN VOICE CAN BE HEARD

key points

- Service on Regional Ethics Research committees present unique opportunities for Christians to be a gracious influence.
- Committees try to ensure that resources are not wasted and patients are not unduly burdened by onerous tests and procedures.
- No particular qualifications are needed for appointment to a committee: what matters are qualities of character.
- Associate hospital managers have an important role in hearings under the Mental Health Act where vulnerable patients are at risk of being wrongly detained.

As Christians, we have a responsibility to use our God-given abilities for the good of society.[1,2] This applies not only to 'spiritual gifts' and 'natural talents' (such as musical aptitude), but also to the skills and knowledge we have acquired in the course of our professional lives. There are many opportunities to use our abilities within church-related settings, however to be influential in wider society, some of us Christians must be out in the secular arenas where ethical dilemmas are being addressed. Christian healthcare professionals can use their gifts through voluntary opportunities within the NHS.

Protecting participants in research

Within the NHS a huge amount of medical research is being conducted. Some of it is to fulfil requirements for an educational project (an MSc, a PhD or an MD). Research has potential to produce sound evidence on which good clinical decision-making or policy-making can be predicated. It also has the potential – if not properly regulated – to waste resources, to burden subjects with onerous tests and procedures, to invade people's privacy, or to cause actual harm out of proportion to the likely benefit.

All research conducted within the NHS has to be approved by, and is overseen by, The Health Research Authority (a statutory body). To consider applications for medical research projects numerous regional Research Ethics Committees, composed of volunteers recruited from the general public, operate under the auspices of the HRA. There has to be a mixture of 'laymen' and 'experts' in each committee, but some of those labelled as lay people (those not medically qualified) bring expertise from their own professional fields, such as pharmacology, psychology or statistics.

No particular qualifications are needed for appointment to a committee: what matters are qualities of character, such as integrity, and the ability conscientiously to study lengthy documents. Necessary training is given (legal requirements and a basic understanding of research methodologies). After that, it is a question of using one's God-given powers of reasoning and insight to identify the ethical issues and weigh them appropriately,[3] then articulating one's opinion clearly and concisely. In committee meetings all members contribute, so respectful consideration of others' viewpoints is crucial to finding a consensus.

The ethical issues which frequently arise are matters of balancing *actual* risks and burdens to individual participants against *likely* benefits to society, and the protection of vulnerable people from exploitation by professionals.[4] When patients are conscious of being dependent on a clinician for their treatment, it can be too easy for the clinician to persuade them to participate in a clinical trial. It can

happen without the patient fully exercising personal responsibility for making an informed decision. Distinguishing between procedures which are part of routine clinical care and those which are being done purely for a research project, can be difficult for patients.

One area which presents problems is the study design: if it is not appropriate (including sample size and selection) then the study cannot be expected to produce useful results and hence is intrinsically unethical. Another area which requires a well-informed (albeit subjective) judgement is the level of remuneration offered to participants: it should not tempt one to consent against other considerations.

A Christian voice in Research Ethics Committees is an important contribution to maintaining godly standards for the rights and dignity of individuals who – by reason of their illness or disability – are in a vulnerable situation when requested to participate in a research study.[2] The necessity for independent ethical review prior to conducting research means that scientists and health professionals safely carry out their studies without infringing the rights of people seeking treatment in the context of a national health service. As a Christian speaking in a committee meeting, it is not so much a question of proclaiming one's faith: it is being guided by the Holy Spirit to make a right assessment of an application and to discuss it graciously with fellow members.[5]

Protecting patients detained under the Mental Health Act

The ability to assess written arguments and to judge the merits of a case is also required for another type of voluntary work in the NHS, the implementation of the Mental Health Act (2007). This Act allows – in specified circumstances – people who are not criminals to be detained against their will in a particular place (and to be administered medical treatment without their consent). This power in the hands of professionals could be misused through carelessness or misunderstanding or, conceivably, by malicious intent or for ulterior motives.

Any person compulsorily detained under the Mental Health Act has legal rights of appeal and of independent review of his/her detention when it is extended. A next of kin also has limited rights to discharge a patient from detention. Those with serious mental illness are often unable coherently to defend themselves. To ensure they do not suffer injustice, independent people are appointed to undertake hearings for appeals or to review extensions. These people are commonly called 'Associate Hospital Managers,' since they fulfil the role given in law to managers of hospitals where the patients are detained. They also have the responsibility of ensuring that the professionals' power of detention under the Mental Health Act is used only in a legal and humane manner. In some places they are called Associate Mental Health Act Managers.

Since the small number of people who are so seriously ill as to need detention are often so socially-marginalised as to be largely invisible to the general public, their sufferings (or their disappearance into a psychiatric hospital) may go unnoticed. They may have no friend to speak up for them. Defending vulnerable people and the rights of the weak is a Christian duty:[6] it is a privilege to exercise this duty as an Associate Hospital Manager in the context of the Mental Health Act.

As a Christian in this role, one has to weigh evidence carefully and make a formal decision; all this is done prayerfully as one quietly seeks the Spirit's guidance.[7] Going home after a hearing, one might continue to pray for the patient. Through prayer, I believe we may introduce something extra, something of God's gracious healing love, into the patient's tragic life.

Patients detained under the Mental Health Act are entitled to speak for themselves, but often are unable to do so. The law provides access to an 'Independent Mental Health Advocate' (IMHA), who helps them to understand their rights and to present their point of view. Some IMHAs are employed by charities for this function, while others are volunteers. This is another role which could be taken on by a concerned Christian.[8]

It is unusual for Associate Hospital Managers to find any professional has wrongfully used his/her power of detention. When the Act is used carefully it is because of the precautions which are in place, such as the power of Associate Hospital Managers to discharge a patient from detention if they find that the criteria are not fulfilled. We must be thankful UK law, based as it is on Christian principles, contains such provisions to protect the vulnerable.

Protecting Christian values in NHS trusts

Though our National Health Service may appear to be run by professional administrators according to policies determined by politicians, wherever there is a foundation trust the public can influence some aspects of the decision-making. Anyone can become a member of a foundation trust, and can then speak and vote at meetings. For greater influence, one may stand for election as a governor (an honorary post).

It must be a good thing to have such positions held by Christians with experience in healthcare (such as CMF members). It is one way we can fulfil our duty to contribute as educated citizens of a worldly democracy, to good administration of the National Health Service. As Spirit-filled citizens of the kingdom of God, we can extend his kingdom into the far reaches of the NHS.[9] There are many avenues for Christians with some free time to undertake voluntary work of an intellectually-satisfying and often personally-challenging nature. Their Spirit-led contribution will help to preserve the highest ethical standards. One might see it as a way of 'being salt' in the world.[10]

***Ruth Butlin** is a retired medical missionary who worked with Leprosy Mission International*

A Christian voice in the research ethics committees is an important contribution to maintaining godly standards

references

1. 1 Peter 4:10
2. Acts 20:35
3. Colossians 3:23
4. Leviticus 25:17
5. Colossians 4:6
6. Psalm 82:3
7. Exodus 23:6
8. Isaiah 1:17
9. James 1:27
10. Matthew 5:13

Stephanie Moss shares stories of face to face encounters and tools that work.

SHARING OUR FAITH IN JESUS

key points

- Faith has an important place in healthcare and there are more opportunities to share faith than we realise.
- When we take opportunities to open up questions of faith we may find ourselves surprised to find that God is already at work in the life of that patient.
- Faith in Jesus is life-changing and peace with God is the deepest need of every patient.

Two sisters attended our surgery in a predominantly Asian part of town. They always came together and came often. They had various complaints and mostly different symptoms. But no sooner was one thing better than another complaint presented itself. I was the only female GP and they mostly came to see me. They were British-born Pakistanis, in their twenties and usually cheerful. They never felt a burden to me.

One day, I asked them if they knew of any reason why they seemed to have so many health concerns. I was expecting them to tell me about family stresses. Or that they had lost a relative to cancer and feared they might overlook an early sign of the same disease. However, they matter-of-factly told me, 'We have been cursed. There is a curse on our family.' They went on to explain that they were saving up to pay a lady in a street less than a mile from our surgery to have the curse removed. The cost would be several thousand pounds.

> We should all be pretty good at asking routine questions. But once we have spirituality on our radar, we can add in relevant questions, often with surprising answers.

I worked at that time with two fairly secular Sikh doctors and an English atheist. I brought this case to a practice meeting and asked what they would do in this situation. One told me he could never imagine finding this out as he would never ask that question. I asked again, 'What would you do?' and the atheist said he would refer the girls to a psychiatrist. This confirmed to me that a doctor with faith is much more likely to open up conversations about faith than a secular doctor. And that my colleague genuinely meant he would not know how to respond to a declaration of faith.

A way forward

Saline Solution is a day course on faith and healthcare, that can be accessed by individuals on tablets or laptops.[1] It teaches that faith is more important in healthcare than many of us realise and that many doctors underestimate the value their patients put on their faith. It explores the opportunities and barriers to sharing faith and offers tools to help us play our part in following God's call to be salt and light in our workplace.

For me personally, learning through the Saline course how to ask questions which open up conversations has been one of the most useful tools. We should all be pretty good at asking routine questions. But once we have spirituality on our radar, we can add in relevant questions, often with surprising answers. Since good medical practice includes caring for our patients' spiritual well-being,[2] we should never be afraid to ask questions.

A cannabis user came to tell me about his stress. He told me, using very unpleasant language, how angry he was with his mother, how messed up he was with his girlfriend and what a bad deal he'd had in life. I listened for a bit and asked him to tone down his swearing. Then I said something like, 'It seems you feel very hard done-by. How do you get strength to carry on? Do you have a faith to lean on?' He told me about his Christian upbringing. I then asked, 'When God looks at you, what do you think he sees?' He said, 'I think he sees a very special creation.' Now that was not what I was expecting.

On another occasion, I had offered to add a patient to my prayer list and she told me, 'My sister-in-law would be pleased if you did. She gave me a Good News Bible last year.' This encounter reminded me that God is already at work in the lives of our patients. Knowing this gives us more confidence to ask questions and seek out any spiritual agenda on our patients' minds. Saline points us to numerous studies which show how any religious faith has positive outcomes in healthcare[3,4,5] and it supports us if we have to defend our faith to questioning and sceptical colleagues.

Biblical teaching

The Bible clearly shows us that faith in Jesus is life changing[6] and everyone's deepest need is for peace with God. What a great tool prayer is: we can pray for our patients whether we tell them or not. We can pray for ourselves to be filled with the compassion of Jesus. We can pray for insight and help to ask the right questions. This is therefore another way we can share faith, our faith in Jesus as he works through us.

I feel that we need to have a very clear sense for when the Holy Spirit is guiding us during our encounters with patients and colleagues. We need to be sensitive to the Spirit.

I distinctly remember a Jewish female patient with whom I had had interesting conversations about bringing up children to have faith in a very secular world. She wanted to share her faith with me and took me to a service at her synagogue. But once, when I felt I wanted to talk to her about Jesus, I had a very clear sense that this was not the right time. However, when another patient told me about her grandmother's voodoo practices and asked me if I had a prayer against black magic, I felt very confident to tell her to call on the name of Jesus.

One afternoon a couple from Afghanistan came to see me, the husband interpreting for his wife who had just had her second stillbirth, having also had a late miscarriage. His wife had only a slim chance of a successful pregnancy because of consanguinity. The previous night we had been studying Psalm 56 in our home group and had been asked to choose a verse which spoke to us. I had chosen verse 16, 'Record my lament; list my tears on your scroll'.

I asked the husband to tell me how his wife was doing and he said: 'She is fine'. I said: 'Please ask her now and tell me what she says.' He did and told me she said, 'I cry a lot when I am on my own'. I then understood that Psalm 56:16 was for her. I told them about the Psalms which is Hebrew poetry written by the prophet David. I explained the verse and how I thought God wanted her to know that he had seen all her tears even if they were in private.

It was such a privilege to listen as the husband relayed these words to his wife and to watch her face. It was as if I was passing across a gift from God to her. She went on to have a healthy child the next year and called her son Daoud (David). A lovely ending. They have remained on my prayer list even though I have moved to another surgery. Maybe they will all meet Jesus through someone else some day.

At the moment, I work mostly with Muslim and Sikh patients and they are very happy to discuss faith and are especially glad if I offer to pray for them. I usually add them to my prayer list but rarely pray for them while they are with me.

Wherever we work in the NHS, our colleagues see us for many hours at a time when we share difficult and often stressful shifts. God is at work among our colleagues as well as our patients.

The Saline Solution stresses that we do everything with sensitivity and respect and that we ask for permission to proceed so that we follow the patient's agenda on matters of faith.

I would very much recommend to you a Saline course if you want to learn valuable skills and gain confidence sharing your faith.

Stephanie Moss *is the CMF Associate Staffworker for Workplace Evangelism*

saline solution

Saline courses equip health professionals to share their faith in ways that come naturally in the course of conversation and are not intrusive or threatening.

They teach a range of strategies for faith sharing, including:

- Taking a spiritual history
- Planting faith flags
- Asking penetrating but non-threatening, open ended questions
- Dealing with sceptical colleagues

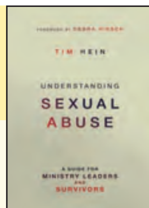
For information about courses near you or to find out how you can organise one in your area, email *info@cmf.uk.org*

> What a great tool prayer is: we can pray for our patients whether we tell them or not

references

1. Saline Process. *spot.ihsglobal.org*
2. Personal beliefs and medical practice. General Medical Council 2013
3. Craigie FC, Larson DB, Liul Y. References to religion in The Journal of Family Practise. Dimensions and valence of spirituality. *Journal of Family Practice* 1990; April:447-480
4. Levin JS, Vanderpool HY. Is frequent religious attendance really conducive to better health? Toward an epidemiology of religion. *Social Science & Medicine* 1987;24(7):589-600
5. McBride JL, Arthur G, Brooks R, Pilkington L. The Relationship between a Patient's Spirituality and Health Experiences. *Family Medicine Journal* 1998;30(2):122-126
6. John 10:10

reviews



Understanding sexual abuse

A guide for ministry leaders and survivors

Tim Hein

- IVP 2018, £12.00, 158pp, ISBN 9781910012475
- Reviewed by **Hilary Johnson**, consultant in child and adolescent psychiatry in Buckinghamshire

Tim Hein writes as a Christian leader and from his personal perspective and experience as a survivor of sexual abuse. Tim writes with sensitivity to support survivors who may be exploring and developing an understanding of their own situation for the first time. Additionally, he aims to equip churches to support survivors with compassion, care, confidence and knowledge. He acknowledges that he does not write as a psychologist or a therapist, but clearly draws from his own experience of therapy.

Hein offers support to the reader throughout the book, whether survivor or listener, gently introducing various topics with reassurances that the content will not be traumatic to read. However, he advises that any book written on this subject is likely to be a challenge for anyone who has suffered abuse themselves.

The chapter on forgiveness is particularly insightful, both for those who preach forgiveness and those who practise it.

The book contains well informed advice and explanations using personal examples. It is well written with the authority of a survivor, in a challenging but hopeful style, which will equip anyone working in pastoral care.

The robots are coming

Us, them and God

Nigel Cameron

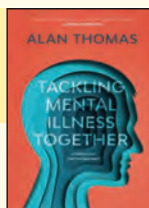
- Care, 2017, 148pp, ISBN 978090519530
- Review by **Claire Wilson**, psychiatry trainee and MRC Clinical Research Fellow, King's College London

The rise of artificial intelligence (AI) is relevant to us as Christians and also as doctors. Cameron effectively offers a biblical perspective on the issue in this short and easy to read book. He provides an accessible introduction to this rapidly developing field, which at times can seem a bit daunting to explore.

Cameron discusses the opportunities and challenges posed by AI to many aspects of life, such as employment and leisure time. But many books on the topic do this. What makes this book really worth reading is the uniquely Christian view that the author brings: artificial intelligence challenges what it means for us to be human, created in God's image.

What makes us unique? This idea is further explored as Cameron unpacks the nature of our human relationships but also our potential relationships in the future with robots and machines. How should we treat them? This exposes a raft of ethical dilemmas. Cameron provides a historical account of AI development with frequent reference to Scripture. There are also frequent questions posed which allow the reader to reflect as an individual or to facilitate group discussion.

While he touches on the implications of AI for healthcare, there is certainly a niche for another book exclusively on this issue for Christian doctors.



Tackling mental illness together

A biblical and practical approach

Alan Thomas

- SPCK, 2017, £7.00, 200pp, ISBN 9781783595594
- Reviewed by **Felicia Wong**, CMF Head of Graduate Ministries

Mental illness is now in the public domain more than ever before. Moreover, in our churches we are coming face-to-face with brothers and sisters struggling with mental illness. Unfortunately, some are doing so alone and in silence.

This easy-to-read book is written by a psychiatrist to help those involved in church ministry. Its aim is to help readers understand what mental illness is, the range of conditions, causes and treatments. Alan Thomas, does this by using a medical and biblical framework with case studies to bring to life various situations. He handles the difficult issue of mental illness and personal responsibility well.

An interesting read, this is a good, comprehensive resource for Christians looking for something accessible that explains mental illness. It covers the history of mental health therapies, the culture and changing attitudes around mental illness, diagnosis, management and other resources. It is helpful in getting church leaders and members thinking about how they can best support others struggling with mental illness, from showing understanding and compassion to when to seek professional help.

John Stott and The Hookses

David Cranston

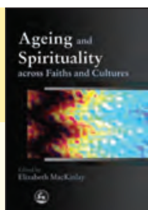
- Words by Design, 2017, £15.00, 86pp, ISBN 9781909075542
- Reviewed by **Chris Lavy**, consultant orthopaedic surgeon based in Oxford

David Cranston is a man of many talents. Still operating as one of Oxford's favourite urologists, he finds time to think, paint and write. This latest book, illustrated by Cranston's own watercolours and many old photographs, takes a quirky look at one aspect of the life of John Stott.

For many of us John Stott is remembered and loved as one of God's greatest gifts to the church. A man whose talks and writings opened the Scriptures to us and whose clear, explanations of theology flooded truth into our lives.

One of the resources that kept John Stott's mind so fresh and relevant was his time away with nature and with God. He bought a small cottage in Pembrokeshire, Wales in 1954 that looked over West Dale Bay and beyond that to the open Atlantic. It was here that John Stott came regularly for the next 50 years, to be still, to listen to God, to think, to write, to watch birds, and to spend time with close friends.

David Cranston had the great honour to know John personally and tells the story of the cottage and how it developed. He also includes inspiring chapters written by key Christian leaders whose lives were enriched by their time at The Hookses.



Ageing and spirituality across faiths and cultures

Elizabeth MacKinley (ed)

- Jessica Kingsley, 2010, 272pp, ISBN 9781849050067
- Reviewed by **Cameron Swift**, Professor at Kings College, London, specialising in geriatrics

Clarity about the concepts and inter-relationships of 'ageing' and 'spirituality' is urgently needed. This is firstly because of demographic change and secondly, because of an escalating need to balance biotechnical progress with 'whole person' value.

Ageing is explored against background demography and across religious and cultural contexts. But an evidence-based clinical/biomedical perspective is missing. Areas of common ideological ground include 'respect' for older people and 'duty of care' (a family imperative in Islam). In care provision, awareness and sensitivity are rightly emphasised, and some practical tools to assess 'spiritual need' are proposed.

Spirituality is widely represented as diverse, subjective, psycho-social, and culture-driven, and implicitly commended as pluralistic (versus 'fundamentalist'), with distinction drawn between 'internalised' spirituality and organised religious observance. An informative chapter usefully summarises basic Islamic teaching. Those looking for an integrated scriptural Christian /scientific lead on this important topic will not find it in this compilation, but the cross-cultural insights are important.

In my view, it's this understanding that together with transparent evidence from the contemporary sciences (biological, clinical and social) on ageing, which comprises the necessary forward rationale for ethical practice, attitudes and service progress.

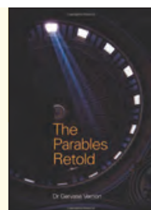
The 'conscience of Europe'? *Navigating shifting tides at the European Court of Human Rights*

Robert Clarke (ed)

- Kairos, 2017, £18.00, 235pp, ISBN 9783950385137
- Reviewed by **Trevor Stammers**, Reader in Bioethics, St Mary's University

A book primarily for lawyers by lawyers affiliated to ADF international – an advocacy group 'to protect and promote religious freedom'. The first part is a critique of the 'evolutive approach' of the European Court of Human Rights (ECtHR) to the European Convention on Human Rights (ECHR). The shorter, second part of the book gives details on the workings of the ECtHR, such as how its judges are elected and how to engage with the Court.

The chapters on abortion, euthanasia, assisted reproduction, surrogacy and conscience will be of interest to CMF members, especially those engaged with bioethics and public policy. I was surprised to learn how many of ECtHR's judgments in these areas had been quite restrictive in these areas compared with UK law. However, the Court's willingness to allow countries room for manoeuvre, when adjudicating on challenges to decisions on bioethical matters by conservative jurisdictions, is being increasingly criticised. It currently offers some possibility of redress against decisions overruling the right of conscientious objection in the UK.



The parables retold

Gervase Vernon

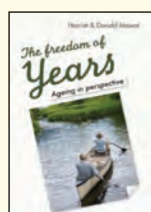
- CreateSpace, 2017, £5.00, 92pp, ISBN 9781548706746
- Reviewed by **Julian Churcher**, Associate Head of Graduate Ministries

The author takes 30 of Jesus' parables or sayings (mostly from Luke's gospel, with a few from Matthew's), bracketed by a verse from John's gospel and two poems (by Seamus Heaney and George Herbert). From these he has written an attractively produced collection of short stories set in the present day, the recent past or (in one instance) the future.

Some are based in true history (with helpful links to source information) but most are of course fictional, ranging worldwide through countries and cultures. Dedications at the beginning of some left me wanting to learn more about each individual's connection with the story: biographical subject or creative inspiration for example? Typos are distracting, especially when applied to famous names (eg 'Sachs' for 'Sacks', 'Ghandi' for Gandhi') and I felt that detailed scene-setting was at times unnecessarily complicated.

I was left with deepened admiration for the ingenuity of the original parables, containing every time just enough 'scenery' to engage the audience, and enable the events and exchanges within them to convey memorably the core message intended.

As he writes in the preface this is 'a book to dip into', and royalties go to an Essex charity addressing homelessness; this is a suitable book especially for enquirers into the gospel.



The freedom of the years

Ageing in perspective

Harriet & Donald Mowat

- Bible Reading Fellowship, 2018, £8.99, 192pp, ISBN 9780857465061
- Reviewed by **Peter May**, an author and retired GP in Southampton

I enjoyed this book. It gave me the opportunity to reflect on the varied processes of ageing – physical, mental, social and spiritual. By the age of 60, most of us can recite a litany of minor physical ailments, which become increasingly tiresome. We look forward in retirement to read all those books we have neglected, only to be frustrated by eye strain and the tendency to fall asleep as soon as we sit comfortably in our favourite chair. Family circumstances change unpredictably. Tasks we have laboured over for many years come to an end, or are given over, often reluctantly, to others. How then should we fill our days meaningfully? What new roles might we take on that seem cut out for us? These insights should help us redeem our days and also to care for other ageing people with greater understanding, sensitivity and sympathy.

This jointly authored book is written by a married couple, who have exceptional credentials for the task. He is a retired GP and consultant in Old Age Psychiatry, while his wife is a social scientist and gerontologist. They bring the issues down to earth by following the ageing process in the lives of two very different semi-fictional characters. The book concludes with eight practical tasks for the reader to focus on.

eutychus

Jeremy Hunt the great survivor

Being Health Secretary is a poisoned chalice. Even so Jeremy Hunt, survivor of many political storms, has eclipsed Aneurin Bevan and Norman Fowler to become Britain's longest-serving minister in that post: five years and 274 days to be exact (Monday 4 June 2018). A tweet Hunt sent marking the anniversary had an irenic tone: 'Thanks #NHS for being extraordinary in so many ways: much more impressive than a long Health Sec are the staff who have devoted 10, 15, or 20+ yrs to patients'. With the 70th anniversary of the NHS coming, what can we expect next? *The Guardian* 5 June 2018. *bit.ly/2kUMRJw*

Health deficits

The healthcare funding crisis deepens. NHS trusts in England have reported a combined financial deficit that was nearly twice the amount planned. There was a deficit of £960m in the last financial year compared with the £496m they had planned for, according to the regulator NHS Improvement. Acute hospitals were largely responsible, mainly because of increased patient demand. All other providers, including ambulance and mental health trusts, had collectively underspent, it added. The latest reported deficit is reached after taking account of extra financial support provided by the government. *BBC News* 31 May 2018. *bbc.in/2M4PB3o*

Churches, health and social care

A report from the Cinnamon Network has put a cash value on the contribution of churches to health and social care: £3 billion a year. Some 3,500 churches and 200,000 volunteers are working in health and social care initiatives. The report profiles ten examples of church-led projects. The Bishop of London Sarah Mullally commented: 'The Church's impact on health and care research is an important contribution to understanding how the voluntary sector and specifically the church and faith-based projects can promote health and create community. *LocalGov* 31 May 2018. *bit.ly/2sKhPHH*

Heading off Ebola

It's back. The Ebola virus has struck the Democratic Republic of Congo. It's notoriously hard to predict where it might appear next. The 2014-18 West African epidemic took 11,000 lives and infected another 28,000. So are we in for a repeat of this terrible health catastrophe? Not likely, says Dr Charlie Weller, Head of Vaccines at the Welcome Trust. 'A swift and well-co-ordinated response can ensure disease is contained early on, so as few people as possible become ill and die,' he said. *BBC News* 14 May 2018. *bbc.in/2sB7LS1*

Universities and mental health

Mental illness is the 'single biggest public health issue for universities,' says Head of Bristol University. Dr Hugh Brady was reflecting on a spate of suspected suicides at the university. One trigger, he said, was how social media creates a 'drive for perfectionism with mobile phones a key factor; taking a toll on well-being. I do worry about the sheer volume of sensory input they are receiving from their mobile devices. You are no longer allowed to have a bad day on social media, you have to be seen to be happy.' *iNews* 29 May 2018. *bit.ly/2J1RP1o*

ID check pilot underwhelms

How many Illegal immigrants are there in Britain? How many health tourists? Research show that many Britons routinely over-estimate the numbers involved, not least because of strident social media pundits. A pilot study of eleven London NHS trusts found that just 50 patients were found to be ineligible for free treatment of the 8,900 who had their ID checked. The government hopes checks will recover £500m by 2017/18. A forlorn hope it seems. Former BMA chair Dr Mark Porter had warned the pilot could 'demonise overseas patients or sow chaos and confusion within the NHS'. *Evening Standard* 29 May 2018. *bit.ly/2IXBk6x*

Talking about more than football

Apparently, Middlesbrough in England's north-east is said to have the highest suicide rate among males. Three in four suicides in the region are men. A local charity, Men Tell Health, is trying to combat this trend with coffee and conversation. Its founder Gary Pollard observed, 'Men go to the pub and talk about football but don't actually sit down and talk'. It takes a lot to get them to open up. We're talking nonsense half the time. Sometimes it can take a few sessions, but they do,' he said. *BBC News* 1 June 2018. *bbc.in/2M2H2Gj*

The friend effect

An Oxford study has found that regularly eating meals alone is the biggest single factor for unhappiness, besides existing mental illness. Why is hanging out with friends so helpful? A new study by Oxford Economics found, for instance, that people who eat alone are much less happy than people in shared meals. Why? 'We simply don't know', says Robin Dunbar a psychology professor. But, he says, it is clear that eating together is a regular social ritual, a moment of 'union and communion' in otherwise chaotic lives. *The Guardian* 23 May 2018. *bit.ly/2KMEHOR*

Nuffield study on waiting times

A Nuffield survey has found that one in ten people living in England's north-east aged over 60 have waited in excess of 18 weeks for diagnostic tests or operations. A third said this had had an effect on their mental health. Waiting, the survey found, left people 'scared', 'anxious' and 'stressed' and meant they needed to 'put their lives on hold.' A fifth reported deterioration in their health while waiting for operations or test results. *Chronicle Live* 30 May 2018. *bit.ly/2JrO2y7*

Readmission rates a worry

Better care in hospital and after discharge could significantly reduce readmissions with conditions such as pneumonia and pressure sores according to a Nuffield study. It found emergency readmissions, within 30 days of discharge, have risen by a fifth over the past seven years. Nuffield found that a small and growing proportion of emergency readmissions - around 1% - were preventable, affecting 185,000 people last year. Emergency readmissions for pressure sores almost trebled to 22,448 while patients readmitted with blood clots in a vein (venous thromboembolism) increased by a third. *BBC News* 1 June 2018. *bbc.in/2Lb4mAk*

Ruth Eardley draws lessons from when Moses encountered God on Mount Sinai.

THE SHINING FACE OF MOSES

When Moses came down from Mount Sinai with the two tablets of the covenant law in his hands, he was not aware that his face was radiant because he had spoken with the LORD.[1]

Students of forensic science will be familiar with Edmond Locard's famous principle: 'every contact leaves a trace'. Moses had been in God's presence and his face shone. It is hard to imagine luminescent skin but the Hebrew word has the idea of sending out rays.

The Latin Vulgate Bible seems to have erred at this point. It translates 'sending out' as 'horned' so that much medieval art, for example, Michelangelo's statue of Moses (in the church of San Pietro in Vincoli in Rome) features the prophet with horns sticking out of his head. Moses did not realise he was reflecting God's glory but this strange phenomenon alarmed Aaron and the Israelites. Moses had to veil his face.

2 Corinthians 3:7-18 is a marvellous parallel passage. The apostle Paul compares the fading glory of the old covenant with the 'surpassing glory'[2] of the new covenant in Christ. Moses removed the veil when he spoke with the Lord and, when the Holy Spirit reveals Jesus to us, the veil is removed from our hearts, the barriers are broken down and we can communicate directly with the almighty God.

How amazing! How wonderful that we can 'with unveiled faces, contemplate the Lord's glory.'[3] What an honour to be transformed and reflect the beauty of Christ in our lives.

We do not need physical sight to see God's glory, nor for it to be seen in us. Ephesians 1:18 talks about the 'eyes of [our] heart' being enlightened. Is the beauty of Jesus seen in you? God changed Moses. He can change you too.

***Ruth Eardley** is a GP based in Leicestershire*

references

1. Exodus 34:29
2. 2 Corinthians 3:10
3. 2 Corinthians 3:18

BOOK STORE

cmf.org.uk/bookstore

publishing and creating resources for Christian doctors and nurses for over 30 years.

cmf.org.uk/bookstore