

for today's Christian doctor

# triple helix



## justice

speaking truth to power, responding to human need, justice in the workplace, lessons from the archive, miscarriage: why me?, suicide: living with the aftermath

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** admin@cmf.org.uk

**Web** cmf.org.uk

**President** John Wyatt MD FRCPCH  
**Chair** Euan McRorie FRCP  
**Interim Treasurer** Howard Lyons  
**Chief Executive** Mark Pickering MRCP

#### 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** David Smithard

**Managing Editor** Steve Fouch

#### Editorial Board

Ruth Butlin, Sarah Germain, Ruth Eardley, Mark Pickering,  
Alice Smith, David Smithard, Patricia Wilkinson,  
Kenneth Wong, Sheldon Zhang

**Design** www.S2.Design

**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.

No. 81 spring 2022

# contents

<b>News Reviews</b>	4
Assisted suicide - <i>Mark Pickering</i>	
Concerning news from Scotland - <i>Jennie Pollock</i>	
Nationalities and Borders Bill - <i>Margaret Hooper &amp; Steve Fouch</i>	
Covid vaccine mandates - <i>Steve Fouch</i>	
<b>Speaking truth to power</b>	6
<i>Becky Macfarlane &amp; Neil Merrylees</i>	
<b>Responding to human need</b>	8
<i>Edithmadonna Iheama &amp; David Smithard</i>	
<b>Getting involved</b>	10
<i>Edmund Michaelson, James Adams, &amp; Elle Webb</i>	
<b>Lessons from the archive: 1</b>	12
Golding Bird and the Christian Medical Association <i>Mark Pickering</i>	
<b>Juniors' forum: justice in the workplace</b>	15
<i>Olamide Dada</i>	
<b>Why me?</b>	16
<i>Alice Gerth</i>	
<b>Suicide...living with the aftermath in general practice</b>	18
<i>Rebecca Torry</i>	
<b>Reviews</b>	20
<b>Christians in healthcare leadership network</b>	22
<i>John Greenall</i>	
<b>Final thought</b>	23
<i>Matt Baines</i>	

## Faith during wartime



You too will be asking the same two questions, 'what can I do, and how should I pray?'

**S**hock and disbelief were my first two reactions when I awoke on 24 February to the news that Russia had invaded Ukraine. Horror as I saw residential buildings across the country bombed. Outrage as civilians were trapped by shelling in cities to the south and east of the country. Compassion as I saw the millions massing in L'viv awaiting passage to safety. And thanksgiving as I saw the welcome being extended by the people in surrounding nations.

I have no idea what the situation will be when you read this. It changes by the hour, and writing on such a fast-moving situation seems futile. But if you felt some of the same reactions as me, you too will be asking the same two questions, 'what can I do, and how should I pray?'

### Prayer

My prayers were angry, fearful, uncertain. Then I heard Mark Meynell in Bucharest talking with Tim Farron on the 'A Mucky Business' podcast<sup>1</sup> about the stories he heard from the Ukrainian church since the war began. He shared how turning to the book of Habakkuk had helped him to pray. Habakkuk 1:2-5 expressed almost everything I felt, and 2:2-14 expressed everything about God's anger at injustice – much of it sounding eerily contemporary! At an ICMDA leaders' gathering a few days later, as we prayed and planned our responses to the situation, we prayed from Psalm 46, reminding us that the Lord:

*...makes wars cease to the ends of the earth. He breaks the bow and shatters the spear; he burns the shields with fire. (Psalm 46:9)*

Only God can stop the SU-24 assault aircraft, the T-80 tank, or the AK-47 assault rifle. Only he can thwart evil and injustice and end suffering. Scripture is an excellent guide to prayer in the face of such circumstances – the Psalms and prophets, in particular, express those thoughts and feelings we struggle to articulate, especially when faced with something as awful as the war in Ukraine. It is also a comfort to know that whatever evils we face today, the world has seen them before, God has dealt with them before, and he will deal with them again.

The International Christian Medical and Dental Association (ICMDA) has run several regular Ukraine prayer meetings on Saturdays to share news, encourage informed prayer across the globe, and mobilise practical support. Contact them to find out more.<sup>2</sup>

### Action

The welcome being extended by the people of Eastern Europe to the more than two million Ukrainians who

have so far fled the war has been humbling. Ordinary people welcoming refugees into their homes, WhatsApp groups set up to share the availability of accommodation, schedule lifts, and coordinate supplies – all set up and run by ordinary people, especially through local churches. Churches here in the UK have been coordinating collections and shipping supplies out, especially to Poland, which contends with nearly two million refugees on its own.

Another vulnerable group caught up in this conflict is the thousands of international students studying in Ukraine. ICMDA are in contact with many medical students who have had to abandon studies and flee to Europe. Their welcome has been more uncertain. Many are from the Middle East, South Asia and Africa, and some have been met with hostility and racism at the borders. These students need particular help and support, as their passports and visas do not give them automatic refugee status. They can face further racism and suspicion on trying to enter the EU and other neighbouring countries, making it even harder for them than fleeing Ukrainians. ICMDA is working hard to help those they know about through Ukrainian partner organisations and the Ukrainian Christian Medical Association.

Sourcing supplies locally and using local skills and suppliers is both more cost-effective and faster than getting provisions together and sending them from the UK. One of the best ways to support refugees and those in the war zone is to give money to organisations with those local connections and contacts.

The UK Disasters and Emergencies Committee (DEC) coordinates a national appeal, with £25 million matched funding from the British Government via *UK aid*, to get supplies and resources to those in most need.<sup>3</sup> In its first five days, it raised £75 million on top of that Government funding, showing the substantial public concern for those displaced by this war.<sup>4</sup>

But the needs within Ukraine are even more significant. Food and medical supplies are particularly needed. Thankfully, all the borders from neighbouring nations to the west of Ukraine remain open, so getting supplies in is still relatively easy. CMF Poland and CMA Ukraine have been working together to buy, collect, transport, and distribute medical supplies, supported by funds raised by ICMDA from their appeal fund.

CMF will be sharing news and resources from partners in the UK and overseas in the coming weeks and months, so check your inboxes! Please continue to pray. You can give to the ICMDA Ukraine Appeal at [icmda.net/ukraineappeal](http://icmda.net/ukraineappeal)

*Steve Fouch* is CMF Head of Communications and managing editor of Triple Helix

### references (accessed 8/3/22)

1. Ukraine and Russia: how do we respond? *A Mucky Business*. 1 March 2022. [bit.ly/3Myx7ax](http://bit.ly/3Myx7ax)
2. [icmda.net/about/contact](http://icmda.net/about/contact)
3. DEC. Ukraine Humanitarian Appeal. [bit.ly/3Kp7bwj](http://bit.ly/3Kp7bwj)
4. Associated Press. Ukraine aid appeal tops £100m in UK. *The Guardian*. 7 March 2022. [bit.ly/3IT4wuA](http://bit.ly/3IT4wuA)

## Assisted suicide: *the onslaught continues*

Review by **Mark Pickering**  
CMF Chief Executive

In recent months there has been continual pressure to legalise assisted suicide all around the British Isles. In Westminster, Baroness Meacher's bill had its second reading in October, with an excellent seven-hour debate; it is unlikely to progress beyond Committee stage. However, an amendment by Lord Forsyth to the Government's Health & Care Bill would, if passed, mandate the Government to bring forth its own 'assisted dying' bill within a year. This is a highly irregular misuse of parliamentary protocol and reflects campaigners' frustrations at their lack of concrete success despite continual lobbying. Meanwhile, Baroness Finlay's tireless campaigning on palliative care received a fantastic boost in February, when the Government adopted her amendment to the Health and Care Bill. This would result in universal commissioning of palliative care

within the English NHS and should help to reduce difficult deaths.<sup>1</sup> Dignity in Dying (DiD) continue to press their mantra of 'terminally ill, mentally competent adults with six months to live'. However, *all* the other campaign groups in the British Isles (at least six) want to go further. DiD's narrow campaign is simply a pragmatic attempt to get a foot in the door; others would then push it wider.<sup>2</sup> In Scotland, Liam McArthur's public consultation received over 10,000 responses; we await analysis of these and further indications of his draft bill. In Jersey, the Citizens' Jury led to the States Assembly approving the principle of 'assisted dying' legislation in November.<sup>3</sup> We expect to see draft legislation later this year, after elections in Jersey. In Dublin, although the Dying with Dignity Bill was rejected last year, a special

committee will soon examine 'assisted dying' proposals in more detail.<sup>4</sup> CMF continues to work through our partner organisations to promote good palliative care and to highlight the dangers of 'assisted dying' legislation. Please consider signing up to Our Duty of Care to receive regular updates on how you can help. [ourdutyofcare.org.uk](http://ourdutyofcare.org.uk)

### references (accessed 8/3/2022)

1. Govt backs right to end-of-life care for all. *The Christian Institute*. 2 March 2022. [bit.ly/3sSaB4L](https://bit.ly/3sSaB4L)
2. Our Campaign - What We Want. *My Death, My Decision*. [bit.ly/3sSfb2Y](https://bit.ly/3sSfb2Y)
3. Jersey approves principle of legalising assisted dying. *BBC News Online*. [bbc.in/3pQ1T5f](https://bbc.in/3pQ1T5f)
4. Joint Committee on Justice recommends Special Oireachtas Committee examines topic of assisted dying following scrutiny of Dying with Dignity Bill 2020. *Houses of the Oireachtas*. 21 Jul 2021. [bit.ly/3sSlgfv](https://bit.ly/3sSlgfv)

## Concerning news from Scotland: *the 'Conversion Therapy' ban*

Review by **Jennie Pollock**  
CMF Head of Public Policy

Last year the Scottish parliament ran a consultation<sup>1</sup> seeking views on how they should respond to a petition 'Calling on the Scottish Parliament to urge the Scottish Government to ban the provision or promotion of LGBT+ conversion therapy in Scotland'.<sup>2</sup> Later in the year, Westminster also launched a consultation on the topic. CMF responded to both consultations.<sup>3</sup> We and many of our partner organisations pointed out that both consultations lacked any definition of the term 'conversion therapy', but made the assumption that anything coming under this banner is inherently harmful. For example, the Westminster consultation began by saying: 'The Government will ban conversion therapy. There is no justification for these coercive and abhorrent practices'.<sup>4</sup> The consultations also offered little reassurance for counsellors, medical practitioners, or church leaders that their normal work of supporting people to explore questions of sexuality and gender would be protected.

The glimmer of light in this is that CMF and other Christian organisations weren't the only ones highlighting these problems.

Most notable was the response by the Equalities and Human Rights Commission (EHRC), the first of several high-profile organisations to leave LGBTQ+ charity Stonewall's 'Diversity Champions' scheme last year.<sup>5,6,7</sup> The EHRC raised many of the same concerns as we did, and noted: 'The legislation must be carefully drafted in order not to catch legitimate and appropriate counselling, therapy or support which enables a person to explore their sexual orientation or gender dysphoria, and to avoid criminalising mainstream religious practice such as preaching, teaching and praying about sexual ethics.'<sup>8</sup> While the Government Equalities Office in England has appeared to listen carefully to our concerns, in Scotland, the situation looks much more serious. Holyrood will shortly debate a report produced by the Equalities Committee presenting its findings following the consultation.<sup>9</sup> That report calls for a 'fully comprehensive' ban, covering 'sexual orientation and gender identity, including trans identities, for both adults and children in all settings without exception and include "consensual" conversion practices.' It commends the legislation in Victoria, Australia<sup>10</sup> – the most far-reaching in the

world to date – as 'one of the best practice examples'. This is of deep concern. We are working with partner organisations to ask MSPs to ensure that any bill targets only genuinely harmful practices and provides for parents, pastors, and healthcare professionals to operate in line with orthodox Christian teaching on these issues.

### references (accessed 4/3/2022)

1. Views on the 'End Conversion Therapy' petition. *The Scottish Parliament*. 13 August 2021. [bit.ly/3IKZlwx](https://bit.ly/3IKZlwx)
2. PE1817: End Conversion Therapy. *The Scottish Parliament*. 13 August 2020. [bit.ly/35nhjD](https://bit.ly/35nhjD)
3. [cmf.org.uk/advocacy/submissions](http://cmf.org.uk/advocacy/submissions)
4. Banning Conversion Therapy Government Consultation. 29 October 2021. p. 12. [bit.ly/3ScY6Ki](https://bit.ly/3ScY6Ki)
5. McManus J. Human rights body leaves Stonewall diversity scheme. *BBC News*. 23 May 2021. [bbc.in/3hEDxXu](https://bbc.in/3hEDxXu)
6. Tobin S. Ofcom is latest to leave Stonewall's Diversity Champions workplace scheme. *The Times*. 26 August 2021. [bit.ly/3sGeSlr](https://bit.ly/3sGeSlr)
7. Andersson J. BBC quits Stonewall's Diversity Champions scheme over impartiality concerns. *iNews*. 10 November 2021. [bit.ly/3sEWzDj](https://bit.ly/3sEWzDj)
8. Banning conversion therapy: Response submitted to UK Government consultation. *Equality and Human Rights Commission*. January 2022. [bit.ly/34gf7Ra](https://bit.ly/34gf7Ra)
9. Report on Petition PE1817: End Conversion Therapy. *The Scottish Parliament*. 25 January 2022. [bit.ly/3slsdjG](https://bit.ly/3slsdjG)
10. Change or Suppression (Conversion) Practices Prohibition Bill 2020. *Victorian Legislation*. 16 February 2021. [bit.ly/35OqqXI](https://bit.ly/35OqqXI)



## Nationalities and Borders Bill: *charging vulnerable asylum seekers for basic healthcare*

Review by **Margaret Hooper**, of the CMF Global Advocacy Group  
& **Steve Fouch** CMF Head of Communications

**T**he Nationality and Borders Bill<sup>1</sup> currently passing through both Houses of Parliament is promoted as a means of stopping small boats from crossing the channel and of breaking up the gangs of people smugglers. The Bill also contains clauses to create prison-like conditions for asylum seekers, holding them away from welcoming communities and with poor healthcare access. There will also be cuts to Legal Aid, making it difficult to present an accurate case. The opportunity for family reunions will also be reduced, leaving some partners and children unable to join them.<sup>2</sup>

Since 2015, the NHS in England (but not in the other British nations) has charged asylum seekers with no leave to remain for all but treatment in A&E, for listed infectious diseases, conditions related to torture, domestic and sexual violence, and female genital mutilation.<sup>3</sup> For all other treatments, they are charged as overseas visitors at 150 per cent of cost. These are vulnerable

people who have escaped from war zones and persecution through dangerous and arduous conditions and who have no recourse to public funds nor the right to work.

CMF has long argued that these measures are unjust, carry public health risks, and violate a Christian ethos of welcome and care for the stranger. Many of the concerns that have spurred this legislation are spurious.<sup>4</sup> This new bill brings in further measures that will make an already desperate situation immeasurably worse for many.

At the time of writing, over two million refugees have fled the war in Ukraine, mostly to EU and other adjacent nations.<sup>5</sup> This number could well reach six or seven million in the coming months. We hope many of those will be welcomed into the UK. Yet, in recent years, we have not extended much of a welcome to those fleeing war, persecution, and poverty from the Middle East, Africa, and Asia.

CMF's Global Advocacy Group has

written a briefing, blogs,<sup>6</sup> a podcast, and a letter to the Home Secretary, challenging the Bill and current policy. We have also produced a resource to help you write to your MP about the Nationality and Borders Bill,<sup>7</sup> and have signed a joint faith leaders' letter to the Government.<sup>8</sup> There is still time to encourage our leaders to welcome the stranger and the refugee by ensuring their access to NHS treatment.

### references (accessed 8/3/2022)

1. Nationality and Borders Bill. *House of Commons*. 2021-2022. [bit.ly/3MkQC6t](https://bit.ly/3MkQC6t)
2. Hooper M. I was a foreigner, and you did not welcome me in: the challenge of the Nationality and Borders Bill. *CMF Blogs*. 7 February 2022. [cmf.li/337JWqj](https://cmf.li/337JWqj)
3. McFarlane B. Brief on healthcare charging in the UK for people with insecure immigration status. *CMF Briefing Papers*. May 2021. [cmf.li/3soXO4V](https://cmf.li/3soXO4V)
4. Asylum in the UK. *UNHCR*. [bit.ly/3MBxjWz](https://bit.ly/3MBxjWz)
5. Operational Data Portal: Ukraine Refugee Situation. *UNHCR*. 8 March 2022. [bit.ly/3CsBLcN](https://bit.ly/3CsBLcN)
6. Refugee health. *CMF Blogs*. October 2017 & February 2022. [cmf.li/3HHBOCJ](https://cmf.li/3HHBOCJ)
7. Suggested points for letter to MP. *CMF Briefing Papers*. May 2021. [cmf.li/3Hg8pli](https://cmf.li/3Hg8pli)
8. Faith leaders letter on the Nationality and Borders Bill. Joint Public Issues Team. 28 February 2022. [bit.ly/3tMnqWw](https://bit.ly/3tMnqWw)

## Covid vaccine mandates: *why the Government's change of policy is a wise move*

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

**F**ew issues have created such division among health professionals as Covid vaccine mandates. While most NHS staff freely accepted vaccination and are strong advocates for it with their patients and colleagues, a small minority (about five to six per cent)<sup>1</sup> have thus far refused vaccination. Even when the Government introduced regulations making it mandatory for workers in NHS England from April 2022,<sup>2</sup> nearly 80,000 continued to refuse. The UK Government had already made it mandatory for social care staff in England from November of 2021. Then, as many as ten per cent of the social care workforce remained vaccine-hesitant, even at the cost of their jobs.

The reasons for hesitancy are complex. Undoubtedly misinformation through social media, conspiracy theories, and some questionable eschatological teaching from a minority of churches contributed. However, some had genuine ethical reasons, concerned about the role of cell lines that may have originated from an aborted fetus

in the 1970s in vaccine production and testing. Rather than collude with what they saw as evil, a minority of Christian health and social care workers saw vaccine refusal as the only option.

There is no doubt that Covid vaccines were vital in getting the UK, and much of the rich world, out of the worst of the COVID-19 pandemic. So, while we continue to take a different position on Covid vaccines to some Christians, CMF fully supports their right to freedom of conscience.<sup>3</sup> Indeed, if we had not taken such a stance, we would have been hypocritical in our advocacy for the right to freedom of conscience in other areas.

But the other significant issue was that when the health and social care workforce was already overstretched, we could effectively have sacked over 100,000 workers across both sectors. The impact would have been devastating.

CMF was not alone in this concern. The RCGP, RCN, and other professional bodies expressed similar concerns to Government,

who this February wisely paused the measure subject to a (very) brief consultation. It has now reversed its social care vaccine mandates policy and is no longer pursuing them for NHS or social care staff.

We still need to convince those deceived by vaccine misinformation of the safety and efficacy of Covid vaccines. We will continue to advocate for the development of vaccines not tested on controversial cell lines. But this episode and its historical antecedents show that mandates tend to harden the position of a small minority of vaccine-hesitant individuals rather than persuade them; dialogue, advocacy, and persuasion are more effective.<sup>4</sup>

### references (accessed 7/2/2022)

1. Lacobucci G. Covid-19: government abandons mandatory vaccination of NHS staff. *BMJ*. 2022;376:o269. [bit.ly/3MCHUAE](https://bit.ly/3MCHUAE)
2. Vaccination as a condition of deployment (VCOD) for healthcare workers: Phase 1 - Planning and preparation. *NHS England*. 6 December 2021. [bit.ly/3Ci3YvM](https://bit.ly/3Ci3YvM)
3. Greenall J. Vaccine Mandates: A defining justice issue for our professions? *CMF Blogs*. 12 January 2022. [cmf.li/3Fn2tfJ](https://cmf.li/3Fn2tfJ)
4. Crutchlow L. Vaccines. *CMF file*. 73. November 2021. [cmf.li/3e2pCsa](https://cmf.li/3e2pCsa)

**Becky Macfarlane** and **Neil Merrylees** explain how CMF has engaged with global health advocacy issues



# SPEAKING TRUTH TO POWER

## THE CMF GLOBAL ADVOCACY GROUP

### key points

- Formed in 2020, the CMF Global Advocacy Group has been finding out from members about key global health issues.
- The group has focused on COVID-19 - treatment and vaccine access for developing nations and the impact of UK asylum policy on the health of asylum seekers in the UK.
- The authors share the specific ways they have been lobbying the government and some of the resources they have produced for CMF members and others.

*'What can I do as an individual to help right some of the wrongs I see going on in the world?'*

*'How can I influence what the government is doing when it is totally against my beliefs?'*

*'How do we work against the causes of poverty and challenge injustice?'*

**W**e have all felt like this at times. There is no easy answer, but there is a theological and biblical basis for advocacy. There is a long tradition of speaking out for justice among Christians, as we explored in the last edition of *Triple Helix*.<sup>1</sup>

If we accept that advocacy for justice on behalf of the poor and oppressed has an important role in our faith, then what is the most effective way to go about it?

Over the last couple of years, CMF's Global Advocacy Group (GAG) has been grappling with this in relation to advocacy for global health. In this article, we highlight our work.

The group was formed in February 2020 as a short-term working group to consider how to support CMF members working in resource-poor settings worldwide to engage in advocacy for those they serve. We also looked at whether CMF has a direct role in global advocacy. After an initial meeting at the CMF office in London, we moved to online meetings during the pandemic. We consulted members working internationally about

their priorities for the group to consider and how we could pray for them. We also sought advice from the Tearfund Advocacy team.

The group has been directly involved in facilitating CMF global advocacy on three issues:

- UK Government support for the global response to COVID-19
- Global inequity in Covid vaccine access
- NHS charges for immigrants with insecure immigration status, including refused asylum seekers.

The group wrote the CMF booklet *The Advocacy Journey*<sup>2</sup> as a resource to enable Christian healthcare professionals, particularly those working in resource-poor settings, to think further about our responsibilities and opportunities for advocacy and how to work practically with others to effect positive changes in global healthcare.

The work of this group has been, and continues to be, stimulating and challenging for those involved. Group members are aware that they have much to learn and are keen to receive feedback and ideas.

*Neil Merrylees is a GP by training and Clinical Teacher in the Department of General Practice at Dundee University with a particular interest in Global Health.*

*Becky Macfarlane works as a speciality doctor in sexual and reproductive health in Glasgow with a background in general practice and a particular interest in the care of refugees. She is currently Chair of the CMF Global Advocacy Group.*

Contact the Global Advocacy Group by emailing: [globalcoordinator@cmf.org.uk](mailto:globalcoordinator@cmf.org.uk)

## COVID: UK government support for the global response

### April 2020 CMF letter to the UK government Department for International Development (DFID)<sup>3</sup>

GAG expressed the following:

1. Community Health and Primary Care workers in resource-poor settings face a lack of personal protective equipment during the COVID-19 pandemic and such basic hygiene necessities as running water.
2. The importance of ensuring that all groups of the population receive appropriate care, especially the most vulnerable and marginalised.
3. The provision of respiratory support equipment to many of the poorest countries where this equipment is totally lacking or in very short supply could extend the current efforts to produce ventilatory equipment once the projected UK requirements are met to produce a surplus that can be sent to areas of need.
4. The provision of test kits: once the UK need for Covid test kits has been met, the increased production levels could be continued to generate a surplus to be deployed to developing countries.

### May 2020 – DFID response:

The UK Government is putting £50 million into partnership with Unilever and NGOs<sup>4</sup> to fund handwashing and surface hygiene programmes to reach a billion people worldwide and provide over 20 million hygiene products in the developing world.

*'Unlike in the UK, the weaknesses in health systems and limited access to health care in many developing countries mean that mechanical ventilators would benefit only a very small subset of patients.'*

### August 2020 – GAG reply:

We expressed concerns about the merger of the FCO and DFID to form the FCDO;<sup>5</sup> that this might downgrade the focus on global health-related issues.

Regarding the initiative with Unilever, we believed that *'investment in smaller local companies using local knowledge and innovation would increase sustainability and help the local economy.'*

Provision still needs to be increased for patients who develop respiratory difficulties. This could include oxygen concentrators and CPAP equipment which requires a lower level of training than full mechanical ventilation.

## COVID Vaccine Global Inequity

### August 2021: GAG letter to Prime Minister and Foreign Secretary

#### Background:

Worldwide, by August 2021, there had been more than 4.67 million deaths directly attributed to COVID-19 or its complications. The devastating economic impact has disproportionately affected the poor and vulnerable, thereby widening global inequalities. Nowhere has this been seen more starkly than in the distribution and administration of Covid vaccines across the world. As of August 2021 only 0.5 per cent

of vaccines administered globally had been given in low- or middle-income countries such as in Africa and the Middle East.

If this inequity remains, then:

- If rich countries continue to monopolise the first doses of vaccines instead of distributing them globally, there could be 'twice as many deaths' from COVID-19.
- Vaccine hoarding could cost the global economy up to \$9.2 trillion. Rich countries will bear half those costs because of supply chain disruptions and demand shocks.
- Each new infection is an opportunity for mutation. Some mutations are proving more transmissible than other strains. This increases the risk of the disease evolving to an extent where current vaccines, diagnostics, and treatments no longer work.

#### Recommendations:

1. Ensure the stockpiling of vaccines does not occur by immediately releasing any surplus supplies held by the UK.
2. Demonstrate active logistical support for countries struggling with managing the roll out of vaccine programmes.

As of writing, no response has been received from the Prime Minister or Foreign Secretary.

#### Correspondence with Gordon Brown

The letter was also copied to Gordon Brown given his well-publicised efforts for vaccine equity. Mr Brown responded with a supportive email and some valuable information.

NHS England charges for immigrants with insecure immigration status, including refused asylum seekers.

The group considered the impact of these charges on deterring vulnerable immigrants from accessing healthcare, including maternity care. This issue was also a seminar topic at the CMF RASH course.<sup>6</sup>

CMF Global signed a letter to the Home Secretary early in the COVID-19 pandemic regarding prioritising public health over 'hostile environment' immigration policies, including healthcare charging.<sup>7</sup>

GAG also produced a briefing<sup>8</sup> and suggested points for writing to MPs for CMF members to encourage individual advocacy on NHS charging.<sup>9</sup>

## NHS England charges for immigrants with insecure immigration status, including refused asylum seekers

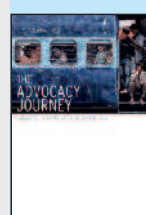
The group considered the impact of these charges on deterring vulnerable immigrants from accessing healthcare, including maternity care. This issue was also a seminar topic at the CMF Refugee and Asylum Seeker Health course.<sup>6</sup>

CMF Global signed a letter to the Home Secretary early in the COVID-19 pandemic regarding prioritising public health over 'hostile environment' immigration policies, including healthcare charging.<sup>7</sup>

GAG also produced a briefing<sup>8</sup> and suggested points for writing to MPs for CMF members to encourage individual advocacy on NHS charging.<sup>9</sup>



## There is a long tradition of speaking out for justice among Christians



CMF's Global Advocacy Group has produced a resource on advocacy in global health called *The Advocacy Journey*,

which is available from the Bookstore [cmf.org.uk/bookstore](http://cmf.org.uk/bookstore)

#### references (accessed 24/2/22)

1. Macfarlane B. Why Christian healthcare workers should advocate for the disadvantaged. *Triple Helix*. Autumn 2021. [cmf.li/3B0kHGw](http://cmf.li/3B0kHGw)
2. Available from the CMF Bookstore at [cmf.li/3xcFRvU](http://cmf.li/3xcFRvU)
3. DFID merged with the Foreign and Commonwealth Office in September 2020 to form the Foreign, Commonwealth & Development Office – [gov.uk/government/organisations/foreign-commonwealth-development-office](http://gov.uk/government/organisations/foreign-commonwealth-development-office)
4. Non Governmental Organisations
5. See point 3
6. For details of CMF's Refugee and Asylum Seeker Health course, which is held in different locations throughout the UK and online, see [cmf.li/RASH](http://cmf.li/RASH)
7. Protecting everyone against Covid-19: Our joint letter to the Home Secretary. *Joint Council for the Welfare of Immigrants*. [jcwio.org.uk.bit.ly/3vjiQsp](http://jcwio.org.uk.bit.ly/3vjiQsp)
8. Macfarlane B. Brief on healthcare charging in the UK for people with insecure immigration status. *CMF*. May 2021. [cmf.li/3soX04V](http://cmf.li/3soX04V)
9. Suggested points for letter to MP about charging vulnerable groups for healthcare. *CMF*. May 2021. [cmf.li/3Hg8pli](http://cmf.li/3Hg8pli)

**Edithmadonna Iheama**

and **David Smithard**

consider how we respond to the needs of refugees in ways that tell of the good news of Jesus



# RESPONDING TO HUMAN NEED

## key points

- The author recounts how her own experience of being an asylum seeker spurred her to help others facing similar problems.
- Accepting the stranger, the foreigner and the outsider are responsibilities for God's people.
- Prevention and crisis intervention in health are vital for asylum seekers' wellbeing and need a multi-pronged approach.

An asylum seeker is someone who claims to be a refugee but whose claim hasn't been evaluated. ... Someone is an asylum seeker for so long as their application is pending. So not every asylum seeker will be recognised as a refugee, but every refugee is initially an asylum seeker.<sup>1</sup>

### *What comes to mind when you hear about refugees and asylum seekers?*

People migrate to the UK for many different reasons. Many come by the accepted legal systems; others seek alternative and often dangerous paths through no fault of their own. Such people are designated refugees or asylum seekers (box above). The news media, often supported by local and national politicians, reports their arrival on UK soil as if there is an organised invasion, suggesting that we are about to be swamped by illegal migrants who are only coming for financial gain. Such negative reporting paints a picture of scroungers and criminals who have no right to expect to stay. Yet they are often vulnerable and need our compassion.

The present legal pathways leave people in limbo for prolonged periods, often years, prevented from seeking work, in constant fear of detention, family separation, and deportation. People are allocated temporary housing, which cannot be secured from the inside, and they may be moved at a moment's

notice. The National Asylum Support Service (NASS) administrates financial and accommodation support to eligible asylum seekers who would otherwise be destitute. They may apply for accommodation and financial assistance, accommodation only or financial assistance only. However, if leave to remain is granted, this accommodation and funding is removed, resulting in homelessness.

Although the portrayal of asylum seekers is frequently negative, there are golden nuggets of hope. I have seen legal teams working *pro-bono* and headteachers ensuring that children would not go to bed hungry by continuing to provide free breakfast, lunch, and a grab bag for tea when the local council stopped providing free meals.

Has the Christian church forgotten how the Israelites were refugees in a foreign land or that Mary and Joseph fled to Egypt to escape from Herod with the newborn Jesus? Jesus was a child refugee. Have you pondered what would have happened to the course of humanity if Egypt refused Mary, baby Jesus, and Joseph asylum and deported them back to their home country? Would you have supported granting sanctuary to Jesus's family if they sought refuge in the UK? Could you imagine how different things could have been if Herod had killed baby Jesus along with the other two-year-olds?<sup>2</sup>

Why do we cry foul when those in need are



offered shelter? Mary and Joseph were offered a place for her to give birth, and I suppose it was probably not convenient for the people who took them in; the place was packed, but they made a space. Could you imagine what could have happened had Mary given birth to Jesus on the roadside, on a cold winter night, in the middle of nowhere? We can safely assume that she got help from someone when she went into labour. They offered her a manger, a blanket to wrap up and protect baby Jesus from the winter cold and looked after their donkey.<sup>3</sup>

**What is our response when we see the need in front of us? Do we see a person that requires help, or do we see a scrounger? Do we respond with platitudes, or do we intervene?**

*What good is it, my brothers, if someone says he has faith but does not have works? Can that faith save him? If a brother or sister is poorly clothed and lacking in daily food, and one of you says to them, "Go in peace, be warmed and filled," without giving them the things needed for the body, what good is that? So also faith by itself, if it does not have works, is dead. (James 2:14-17)*

Or in the book of Matthew:

*For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me.' Then the righteous will answer him, saying, 'Lord, when did we see you hungry and feed you, or thirsty and give you drink? And when did we see you a stranger and welcome you, or naked and clothe you? And when did we see you sick or in prison and visit you?' (Matthew 25 35-40)*

Edith Ihema (doctor, entrepreneur, and priest) was herself a refugee and has experienced the vagaries of the asylum system. She reports *'While I was going through the challenges of hostile environment as an asylum seeker, the only thing that kept me going was knowing that I am loved by God and the love and compassion shown to me by others. When one is at the lowest ebb in life, hope is often very hard to find, but in my case, my faith helped me to endure in hope (Hebrew 11:1). I was able to feel peace, which could not be explained by immediate circumstances (Philippians 4:7; John 14:27). The gospel is a message of hope. Being able to respond to human needs through practical service, providing physical support to people in their times of need, is a way of making our gospel relevant to them. Particularly offering refugees and asylum seekers food, shelter, and signposting to other organisations is a way of sharing the good news and bringing hope to people in despair.*

Dr Ihema noticed a gap in awareness of wellbeing, health needs, and adequate statutory community health support for many minority communities in her locality, including Refugees and asylum seekers. In response, she has set up a social enterprise business known as CHATS (Community Health Awareness Training Service),<sup>4</sup> to address the lack of expert and culturally competent services for ethnic minority and migrant

communities. They make use of the skills, knowledge, and insight of her lived experience, from the experiences of other asylum seekers, and from those of ethnic minority backgrounds.

The CHATS service aims for crisis prevention, supporting vulnerable people in their wellbeing journeys, empowering them to take control of their own health, and preventing people from presenting in crisis.

**What do we need to do as health professionals? How often do you feel powerless? Refugees and asylum seekers still face barriers and discriminations within the statutory health services. How can you respond to the health needs of asylum seekers and refugees through loving service?**

Doctors and nurses are role models. Over the years, we have been figureheads. Many of us have campaigned and are working to transform society's unjust structures, challenge violence of every kind, and pursue peace and reconciliation. We must work towards bringing sanctuary for refugees in our communities, speaking up against the unjust structures in society, wars, persecutions, and violence of any kind that force people to flee and abandon their families and livelihood to seek refuge.

Dr Ihema feels that working to bring transformation to the unjust structures of society is a real opportunity to share the good news of the gospel afresh to an increasingly secularised world.

As Blaise Pascal noted:

*What else does this craving, and this helplessness, proclaim but that there was once in man a true happiness, of which all that now remains is the empty print and trace? This he tries in vain to fill with everything around him...though none can help, since this infinite abyss can be filled only with an infinite and immutable object; in other words by God himself.'*<sup>5</sup>

And, also quoting St Augustine, *'You have made us for yourself, O Lord, and our hearts are restless until they rest in you'*.<sup>6</sup> I sense a yearning to fill that God-sized hole and the restlessness these theologians talked about in people who do not profess any faith, looking for ways to fulfil their spiritual needs by campaigning for social justice. We Christians should stand at the forefront, championing these causes.

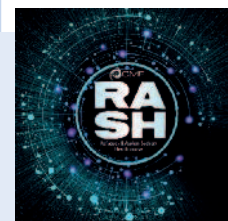
In conclusion, Dr Ihema believes that as we work to bring such transformation, it will be an opportunity to tell the whole story of the fall, the redemption achieved by the death and resurrection of Jesus Christ, and the full glory and the manifestation of the Kingdom of God that is to come.

**Edithmadonna Ihema** is the founder and the Chief Executive Officer of CHATS

**David Smithard** is a Consultant in Geriatric Medicine at Lewisham and Greenwich NHS Trust, a Visiting Professor at the University of Greenwich, and is the Triple Helix Editor.



Has the Christian church forgotten how the Israelites were refugees in a foreign land or that Mary and Joseph fled to Egypt to escape from Herod with the newborn Jesus?



The 'Refugee and Asylum Seeker Health Course' aims to equip Christian healthcare practitioners and others to:

- Improve knowledge of the health care needs of refugees and asylum seekers in the UK
- Hear examples of good practice
- Foster a dialogue between those working with refugees and asylum seekers for mutual encouragement and support
- Inspire creative ways to engage with health systems for better provision, support and care

For more information email [globalcoordinator@cmf.org.uk](mailto:globalcoordinator@cmf.org.uk)

references (accessed 24/8/21)

1. Refugees, Asylum Seekers & Migrants: A Crucial Difference, *Habitat for Humanity*. [bit.ly/3swMvvi](http://bit.ly/3swMvvi)
2. Matthew 2:13-18
3. Luke 2:1-16
4. [vanclaron.co.uk/home/about-us](http://vanclaron.co.uk/home/about-us)
5. Pascal B. *Pensées*. 1670, accessible at Project Gutenberg. [bit.ly/3HEsAR8](http://bit.ly/3HEsAR8)
6. Augustine. *Confessions*. c.400AD & 1998. Oxford:Oxford University Press

We look at three examples of CMF members engaging with the needs of the world



## ENGAGING WITH JUSTICE AS A CHRISTIAN HEALTHCARE PROFESSIONAL

### key points

- CMF has been equipping members to make a difference for Jesus in their workplaces and the wider world for many years.
- Scripture calls on believers to meet the needs of the poor, the marginalised, the sick and imprisoned.
- Christian health professionals have a unique privilege in addressing all these needs in our work and by lending our skills to other organisations and ministries reaching out to those on society's margins.

CMF has always had at its heart a passion for releasing members into Christ-focused ministry for the Kingdom. This is why we have invested in training and discipleship programmes of different kinds for many years.

Current programmes include **DeepER**, equipping students and the newly qualified to find, develop, and express their gifting and calling while growing in character. The **Health + Justice** and **Global Tracks** are long-term courses to develop biblical understandings of justice and mission and practical ways of engaging in these areas.

#### EDMUND MICHAELSON & 500K

Edmund is an Accident and Emergency (A&E) Doctor and an alumnus of DeepER and writes here about setting up his charity, **500k**.

I'm passionate about human flourishing. I want all people to reach their full, God-given potential. I think there are two keys to this: physical health and spiritual health. My work as a doctor addresses the first of these and helps me address the second. My work with the charity 500k, which I set up six years ago, addresses both spiritual and physical wellbeing.

'500K exists to empower indigenous people in their work of sharing the love of God and establishing faith communities in South Asia. We use the parable of the Good Samaritan<sup>3</sup> as our template, demonstrating the scriptural instructions of Micah

Alumni of these and other CMF programmes are already making a difference in the world. They may not be famous, but where they work, these servants of Christ are using their clinical skills and what they have learned through being engaged with CMF over the years to make a real difference.

*The Kingdom of heaven is like a mustard seed, which a man took and planted in his field. Though it is the smallest of all seeds, yet when it grows, it is the largest of garden plants and becomes a tree, so that the birds come and perch in its branches. (Matthew 13:31-32)*

6:8 and John 3:17 in practice. We do this by employing and working alongside local people to develop transformation hubs. We seek to bring families and individuals together to forge stronger communities that look inward in mutual care and support and outward, sharing the love of God with the wider community. They do this by providing care and support for acute and long-term physical and mental health needs. We provide mediation in family and village conflicts, advice and impartial support.

'Two of our distinctives are: maximising our impact by stewardship of our resources (we can make a bigger impact employing and empowering locals than sending expatriates) and making a difference globally while still working as health professionals in the UK.'

### JAMES ADAMS & NUMBER 11

James is an alumnus of the Health + Justice Track and writes here about setting up the charity **Number 11** in Burslem, Stoke-on-Trent.

One of the commonest themes in the Bible is serving the poor and vulnerable. Scripture dedicates more time to these themes than giving, leadership, heaven and hell, and even prayer! Clearly, this is a topic that is on God’s heart. As we would never see prayer as an optional part of being a Christian, so why would we say justice is just for those who “have that calling”?

‘As health professionals, we should be supporting our patients physically, socially, psychologically, and spiritually – learning to look at the broader picture and root causes. This is something the GMC<sup>1</sup> and NMC<sup>2</sup> require of us all, yet often falls through the gaps in a busy workplace. As Christian healthcare workers, shouldn’t we advocate to ensure the care we provide to our patients meets these needs?’

‘As a medical student, I set up a charity called Number 11. Our focus is on creating a family and

a home where we address many of the social determinants dictating the health of our clients. We work to support clients with homelessness, addiction, battles with mental health, benefits and employment, low skill levels, bereavement, and more. Ultimately, we focus on the underlying causes of our client’s situation, whether it’s abuse, relationship breakdown, isolation, or poor self-esteem – all to support individuals to move from crisis to independence.

‘Eating together, laughing together, playing stupid games and informal workshops, whether they be based on music, art, creative writing, or sewing, all have just as much, if not more of an impact as the counselling sessions or employment workshops we run. Why? Because it’s not just programmes and services which change people’s lives. It’s relationships.

‘The thing we hear most from clients isn’t that they are grateful for support in beating addiction, gaining accommodation, or finding employment. We hear most that they are grateful for being given a family – this is the foundation which helps them overcome many other barriers.’



### ELLIE WEBB & INTEGRITAS HEALTHCARE

Ellie is a clinical fellow with **Integritas Healthcare**.

In 2012, Rachael and Mark Pickering (both GPs with expertise in health care in prisons and among marginalised populations), with the support of colleagues founded Integritas Healthcare, a Christian faith-inspired CIC/NGO with a HEART for offender health care. The HEART of the service includes Healthcare, Expertise, Advocacy, Research and Training. It seeks to provide high-quality, low-cost healthcare to vulnerable patient groups, most especially those detained within the criminal justice system (prisons, police stations, forensic psychiatric units, and other secure environments).

‘Alongside healthcare provision, Integritas has gained various opportunities for commercial work, including previous relationships with Leeds University to provide Offender Health Care training and special study modules. It also offers medical report services and expert witness work for detainees, both in the UK and other high-income

countries (HICs). In 2015, Integritas began to deliver the same services either directly or indirectly within Low and Middle-Income Countries (LMICs) on a pro bono or humanitarian basis, supported by the monies raised by their commercial activity.

‘Integritas has established links in the Philippines, forming a separate charitable arm, Integridad, in 2021 to oversee the work. Prior to recent travel restrictions, Integritas provided face-to-face clinical services to Filipino and tourist offenders in local prisons. Currently, this service is provided by weekly telemedicine clinics. Our local Filipino team attend the police stations and jails, providing food, medicines, and facilitating video consultations between detainees and our UK-based doctors.

‘As prison populations across the world continue to increase at an alarming rate and health inequalities grow ever wider, there is an urgent and increasing need for the services of Integritas to continue and grow in support of these vulnerable and marginalised people.’



Setting up your own charity or community interest company is not the only way to address the needs you encounter. For most of us, the best way to respond is to join in with work already going on through existing organisations. But these three stories show how people saw a need in their local area, another part of the world, or their area of clinical expertise, realised that a new response was

needed that no one else was providing, and created a new organisation to respond practically, showing the love of Christ in action as well as in word.

You can find out more about becoming a DeepER fellow at [cmf.org.uk/deeper](http://cmf.org.uk/deeper)

You can find out more about all our different training tracks at [cmf.org.uk/volunteer/training-tracks](http://cmf.org.uk/volunteer/training-tracks)

Mark Pickering, in the first of a new *Triple Helix* series, looks at the CMA, the first precursor of the Christian Medical Fellowship, and at its founder, Dr Golding Bird

Golding Bird (1814-1854), physician and natural philosopher. Oil painting by Alexander Craig, 1840. Enhanced by S2 Wellcome Collection.

# GOLDING BIRD

## AND THE CHRISTIAN MEDICAL ASSOCIATION

### key points

- The requests for help by medical students in 1853 spurred Dr Golding Bird to set up the Christian Medical Association to bring Christian medical students in London together for fellowship, Bible study, and prayer in 1854.
- While initially successful, the CMA struggled to keep meeting and folded in 1871.
- The legacy of Golding Bird and the CMA inspired some of the students who had benefitted from the association to form the Medical Prayer Union in 1874.

*CMF was founded in 1949, and 2024 will be its 75th anniversary. However, its roots go back much further, and there is plenty to learn from the people and organisations that came before it. This is the first of a series of articles featuring some of the main highlights.*

In the mid-19th century, Charles Dickens was at the height of his career, and Queen Victoria was not far into her long reign. London was changing rapidly with the arrival of the railways, and the squalor and disease that Dickens so vividly brought to light was all around.

At the southern end of London Bridge, not far from today's CMF office, was the original site of St Thomas' Hospital. Dating back at least to the 1100s, this ancient place of healing emerged from the monastic church that is now Southwark Cathedral.

It served weary travellers who were approaching London from the south and Europe, or were on pilgrimage to Canterbury, when London Bridge was the only fixed crossing of the River Thames.

It is a place steeped in history: the first printed English Bible was produced here in 1537; Florence Nightingale began her nursing school here in 1860, shortly before the expansion of London Bridge railway station forced the relocation of St Thomas' Hospital to its present site by Westminster Bridge.

Over a century earlier, Thomas Guy, a governor of St Thomas' Hospital, endowed a new hospital next to St Thomas', for chronically sick, incurable, and mentally ill patients. Guy's Hospital was founded in 1721 and remains there today, retaining many of its historic links with St Thomas's, such as joint student teaching, and now being a single NHS Trust.<sup>1</sup>

The early 19th century saw rapid developments in western medicine, and the trading and military expansion of the British Empire; together these produced fertile ground for the birth of modern medical mission, which also had numerous links to Guy's Hospital.<sup>2</sup>

### A lonely voice in the BMJ

In the 1840s, there were 16 separate medical schools in London alone, and only eleven others in the rest of the UK. In addition to the older medical Royal Colleges, the British Medical Association had recently begun in 1832 and was gaining momentum through its *British Medical Journal* (BMJ), launched in 1840.<sup>3</sup>

The socially aware, active, evangelical Christianity that characterised the Victorian period was advancing, and many doctors were committed Christians. But as yet there was no national movement to unite or equip Christian medical students or doctors to live or speak for Jesus Christ.

In those turbulent times, an anonymous student wrote to the *BMJ* in October 1853.<sup>4</sup> Titled *'What can the Association do for Medical Pupils?'*, he made a passionate plea for students to be somehow incorporated into the BMA. He spoke of isolation and temptation, surrounded by colleagues who *'laugh at his religious scruples'* and by others who are *'ever ready to corrupt him'*. Medical students in those days were *'usually described as immoral and depraved... and certainly with some reason'*. Craving the support and mentorship of senior colleagues, he voiced the vulnerability of many contemporary students: *'with the many temptations which surround him... can we wonder if he fall?'*

### Golding Bird reaches out

This anguished cry aroused the compassion of a young Christian physician at Guy's Hospital, Dr Golding Bird. He responded promptly in the *BMJ* letters section, urging the BMA to do something about the *'moral and ethical training of our students during the years of their most serious temptations'*.<sup>5</sup>

However, he was also *'convinced that no great improvement will ever take place in the ethics of our profession'*, until serious attention was given to *'the religious training of our pupils'*. He referenced the positive influence of the Young Men's Christian Association on many in different trades, and advocated something similar amongst medical students, adding that it had the potential to transform the whole medical profession.

He went on: *'Already does the nucleus of something of this kind exist in several of our hospitals. In more than one of them, several of the students meet together on one evening of the week for study of the Holy Scriptures and mutual edification.'* The Bible class at Guy's Hospital had been established in 1849 by Dr Samuel Habershon, a gastroenterologist and medical school lecturer at Guy's.<sup>6</sup> Just a week prior to writing, Dr Bird had been shown some proposed rules for the wider *'medical Christian association'* that the Guy's students hoped to organise. These included:

- *That a medical Christian association be formed, composed of members of the profession and students.*
- *...to promote spiritual religion amongst its members; and to diffuse the same among all others who come within the sphere of their influence.*
- *That the means employed...be the study of the Holy Scriptures, devotional meetings, addresses, and any other means...*

There was a flurry of response in the *BMJ*. Some angrily accused Dr Bird of encouraging *'saponaceous piety'* and *'organised hypocrisy'*,<sup>7</sup> whilst others could *'conceive of no proposal more promising...than...diffusing among the rising members of our influential profession, the precious truths of Christianity'*.<sup>8</sup>

One of the Guy's students responded himself, reminding opponents that *'the abuse of a remedy is no argument against its legitimate and necessary application'*. He thanked the many distinguished clinicians who had responded in support of Christian students, and reflected that, as he approached the end of his own studies, he had been *'encouraged to believe that to all my possible skill and knowledge...may be added the additional excellence of humble Christian piety – a guide through life, a safeguard from the evils of life, and a support in...the hour of his death'*.<sup>9</sup>

### The transformation of Golding Bird

Golding Bird was a brilliant young physician, whose life shows the Lord's incredible timing in transforming him at just the right time. He had a prodigious mind and an incredible grasp of collateral sciences such as botany and electrochemistry; even whilst a medical student himself he was appointed to lecture other students. His precocious talent drew the notice of senior physicians such as Thomas Addison (of Addison's Disease). He became an authority on renal disease and was the first to describe oxaluria, also known as Bird's Disease.<sup>10</sup> Accumulating multiple accolades, at just 28 years old his private practice was bringing in around £1,000 annually (currently worth around £80,000!).<sup>11</sup>

He was an active Christian and was known to devote a significant part of his busy schedule to care for poor sick people for free. Despite this, there was a deep flaw in his way of life. His biographer notes that, *'he had never cared for money, but...his snare and idol was ambition – reputation.... He had a good deal of vanity, which led him constantly to seek his own exaltation.'* His own minister reflected, *'There was a little vanity in this...as if...God could not do without him'*.<sup>12</sup>

This tendency led him to overwork: his labours *'engaged him till evening; and many hours of the night – often, too often, the entire night – has passed in unbroken study'*. Overwork led to illness, and he succumbed to rheumatic fever with resulting rheumatic heart disease. His symptoms *'all pointed*

1841

Edinburgh Medical Missionary Society

1849

Guy's Hospital Christian Union

1854

Christian Medical Association 1854-1871

1874

Medical Prayer Union

1878

Medical Missionary Association

1942

Inter-Hospital Nurses Christian Fellowship

1949

Christian Medical Fellowship



The resting place of Golding Bird in Tunbridge Wells.

## We can never know the lasting value of what is begun in faith

### references (accessed 12/2/22)

1. My wife and I both trained at Guy's and St Thomas', so this history has a personal poignancy to me.
2. A future article in this series will focus on the birth of modern medical mission.
3. Both names evolved in their early years to what they are today. The *BMJ* was named the *Association Medical Journal* in 1853/4.
4. What can the Association do for medical pupils? *Association Medical Journal*. 1853; s3-1:1002. [bit.ly/3rOXKzK](https://doi.org/10.1136/bmj.s3-1:1002)
5. Medical Students. *Association Medical Journal* 1853;s3-1:1042 [bit.ly/3GQmZpl](https://doi.org/10.1136/bmj.s3-1:1042)
6. Some references state 1846/7, but current evidence seems to favour 1849, as Dr Habershon became tutor at Guy's medical school in 1849.
7. Medical Students. *Association Medical Journal* 1853;s3-1:1090. [bit.ly/34INnEX](https://doi.org/10.1136/bmj.s3-1:1090)
8. Medical Students. *Association Medical Journal* 1853;s3-1:1153. [bit.ly/3Jydqxx](https://doi.org/10.1136/bmj.s3-1:1153)
9. Medical Students. *Association Medical Journal* 1853;s3-1:1138. [bit.ly/3gQACew](https://doi.org/10.1136/bmj.s3-1:1138)
10. Golding Bird. *Wikipedia* - [bit.ly/3JrP3KW](https://en.wikipedia.org/wiki/Golding_Bird)
11. Balfour J. *Biographical Sketch of Golding Bird*. Edinburgh, Thomas Constable, 1855: 16
12. *Ibid*: 19,21
13. *Ibid*: 18
14. *Ibid*: 18,19,42
15. A future article in this series will focus on the birth of modern medical mission.
16. Leading Articles. *Association Medical Journal* 1854;s3-2:959 [bit.ly/3uYud8](https://doi.org/10.1136/bmj.s3-2:959)
17. Grainger RD. *An Address Delivered to the Christian Medical Association*. London, 1854
18. Johnson D. *The Christian Medical Fellowship - its Background and History*. London. CMF, 1987:8
19. *Br Med J* 1869;2:611 [bit.ly/3JxRMJv](https://doi.org/10.1136/bmj.2.611)
20. A future article in this series will focus on the MPU.

out the necessity for caution, but his enthusiasm led him to neglect these warnings'.<sup>13</sup>

From 1848 he had periodic relapses that finally forced him to cut back on professional commitments, eventually transforming his outlook. *'Failing health appears to have been the means blessed by God in weaning him from worldly honours'*, and this *'ended in his mind undergoing a very decided and happy change'*. By summer 1853, a friend described him thus: *'Simplicity and godly sincerity...and an earnest zeal for the spiritual welfare of all with whom he associated'*.<sup>14</sup>

### The formation of the CMA

Humbled through physical frailty, Dr Bird was now about to perform the service that God had prepared: to *'do what only he could do'*. At last, he was spiritually ready to respond to the anonymous medical student in the *BMJ*, and to support the fledgling Christian Union at Guy's; to support spiritually the place where he had laboured so hard professionally.

He acted rapidly. In November 1853, writing to the *BMJ* as outlined above, he gathered Christian colleagues from across London. They considered how they could replicate and unite these groups across the 16 London medical schools, and perhaps further afield.

His reply in the *BMJ* produced further unexpected encouragement. The committee of the Edinburgh Medical Missionary Society (formed in 1841)<sup>15</sup> wrote, urging him to implement his plans. Their letter reached him on 17 December, just a few hours before the second meeting that he had called to consider how such an association might be formed.

With this momentum, the committee of the Christian Medical Association was formed by January 1854. It was not a month too soon for Golding Bird, for his health was failing fast. He resigned his post at Guy's and retired to Tunbridge Wells, where he died on 27 October 1854, at just 39-years-old.

### The work of the CMA

During his final months of life, he supported the CMA committee with prayer and advice. The first public meeting of the CMA was planned for 10 November 1854. Indeed, the meeting was announced in the *BMJ* on the very day of Dr Bird's death!<sup>16</sup> The event was a great success, bringing together around 50 doctors, and over 250 medical students. The speaker's text was published; outlining the vision and formation of the CMA, he mourned the recent loss of Golding Bird, concluding: *'we may hope, the Divine blessing resting on our exertions, that this Association may become the instrument of winning many souls to Christ'*.<sup>17</sup>

Regular London-wide meetings continued at least until 1869, but the difficulties of maintaining these central activities eventually supervened, and the CMA ceased to exist in 1871.<sup>18</sup> But the fire had been

lit, the need demonstrated, and many individual students and doctors transformed. A brief report of an 1869 CMA meeting in the *BMJ* noted that the committee soon hoped to begin a medical mission in London (providing free medical care to the poor), as had been done in *'Edinburgh, Liverpool, and other places'*.<sup>19</sup> The London Medical Mission was duly established in 1871, which proved vital in relaunching the movement that the CMA had begun, through the formation of the Medical Prayer Union (MPU) in 1874.<sup>20</sup> Several who benefitted from the CMA as students became leaders of the MPU.

### What can we learn from the CMA?

The story of Golding Bird and the CMA has numerous lessons for us today:

- Students were key throughout. Guy's Hospital CU was begun to support students, and the student's letter in the *BMJ* galvanised Golding Bird into action. Students also led actively – the idea for a wider association came from the Guy's students, they defended the project in the *BMJ* and the students of the CMA later became the leaders of the MPU.
- Great knowledge and skill, even in the life of a Christian, can easily become idols unless they are dedicated to God's Kingdom and his purposes. The Lord may use sickness and suffering to humble us and turn us back to him, but his timing is also incredible. The eternal value of Golding Bird's work in forming the CMA was accomplished swiftly in what proved to be the final few active months of his life.
- We can never know the lasting value of what is begun in faith. Golding Bird died before the CMA had fully launched, and even those who led and supported it can have had little idea of the lasting legacy they had birthed, and what would spring forth from its ashes.

**Mark Pickering** is CMF Chief Executive

This series will continue to sketch out the history of the modern Christian medical and nursing movements in the UK, as we approach CMF's 75th Anniversary in 2024. If any readers have an interest in this area, or relevant material to contribute, please contact Mark on [admin@cmf.org.uk](mailto:admin@cmf.org.uk)

**Olamide Dada** encourages us to follow the example of Jesus as we pursue justice in our workplaces

# JUSTICE IN THE WORKPLACE



**T**he word 'justice' has been very much on the tips of our tongues recently. With global and national events exposing injustices, it seems everyone feels the need to make the world a fairer place somehow. Contemporary justice concerns include climate change, the refugee crisis, racial justice, and modern slavery, to name but a few.

As Christians, we ought to see our pursuit of justice as a demonstration of God's character.<sup>1</sup> God reveals his heart for justice throughout Scripture. *'For the Lord is righteous, he loves justice, the upright will see his face.'* (Psalm 11:7)

What our society believes to be 'the good' is constantly shifting. If we are to measure what is good by our own standards, we will fall short of the mark that God has set. While God is always good, what we mark as 'good' is not always of God. As humans, we are likely to redefine what is 'good' to our own advantage at the expense of others. In contrast, Scripture reminds us that *'He has shown you, O mortal, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God'*. (Micah 6:8)

Jesus is our great example. His way of life was righteousness. He encouraged his followers to do the same.<sup>2</sup> He was attentive to the needs of the marginalised and the outcasts of society.<sup>3</sup> Jesus' vision for justice for the vulnerable arose from his teaching about the Kingdom of God, driving his intent and directing his actions.<sup>4</sup> Jesus demonstrated love for God, self, neighbour,<sup>5</sup> truth,<sup>6</sup> righteousness,<sup>7</sup> and justice.<sup>8</sup> He continually righted wrongs, despite never being at fault himself.<sup>9</sup> He championed freedom from oppression – discrimination, social exclusion, inequity, poverty, sin, and injustice. Through the life of Jesus, we see that to love is to be just and to be just is to love.<sup>10</sup>

Pursuing justice in the workplace requires intentionality. While occasional efforts may change some things, truly fixing the systems in which we work and offering equal access to tools and opportunities for all colleagues and patients requires more consistent action. In the busyness of our working lives, this can be particularly challenging.

Think back to when you or someone you know was mistreated just because of who they happened to be. How would you have wanted someone to support or fight for you when you were mistreated? It is easy to feel far removed from these issues when you have not been directly affected. However, it is not until you have personally experienced such instances of unfairness that you might feel the need to do anything about it.

We have an individual responsibility to bring about justice through our persistent love for others.

## Learn to do good

Seeking justice starts with a personal commitment to continual learning. Our actions must be rooted in compassion and knowledge. Just as Jesus was attentive to the needs of the marginalised, we need to identify their needs and do what we can to meet them.<sup>11</sup>

## Seek justice

We must actively look for opportunities to promote fairness and equality in workplaces for everyone. Workplace bullying and discrimination remain an issue within the healthcare workforce. As Martin Luther King Jr famously said, *'injustice anywhere is a threat to justice everywhere'*.<sup>12</sup>

## Help the oppressed

To help, we must first get alongside the people we wish to support. Jesus sat with the prostitutes, tax collectors, orphans, widows, and lepers, embracing them and breaking cultural boundaries.

## Defend the cause

We must actively choose to use our voice to speak with and for those on the margins. *'Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy'*. (Proverbs 31:8-9)

## Fight for the rights of others

It won't always be easy, convenient, or comfortable. We must first truly believe that others are worth fighting for, viewing them just how God views them.

In summary, we need to remember that there is no one size fits all rule when it comes to fighting for justice. Learning to do good, helping the oppressed, defending their cause, and fighting for their rights will come in various shapes and sizes. This can mean designing strategies to alter processes, policies, practices, and perceptions. It may mean joining like-minded individuals campaigning for change or personally interacting with and valuing the opinions of marginalised groups. Every context requires a different approach.

I encourage you to reflect on how you can demonstrate justice in the coming weeks and months. You do not need to lead a revolution. Look around at your various professional and social settings to see how you can 'do justice'. What problems are people facing? How can you be a solution? And through doing so, you will be living a life that further resembles that of Christ.

*Olamide Dada is a Foundation Year 1 doctor*

## references (accessed 12/2/22)

- |  |  |
|--|--|
| 1. New Bible Dictionary, 2nd Ed. 1962, Leicester: IVP, pp644-646 | 7. Matthew 5:6   |
| 2. John 20:21  | 8. Matthew 12:18   |
| 3. Matthew 5:3-12  | 9. Isaiah 53:1-9   |
| 4. Eg Matthew 25:31-46; Luke 4:14-20                             | 10. Micah 6:8  |
| 5. Mark 12:29-31   | 11. Psalm 41:1   |
| 6. John 14:6   | 12. King M. <i>Letter from the Birmingham Jail</i> . 1963, 1994: San Francisco: Harper One |

**Alice Gerth** explores the pain of miscarriage and why society and the church struggle to acknowledge its all-too-common pain



# WHY ME?

## THE SILENT QUESTION HIDDEN IN OUR CHURCH PEWS

### key points

- Miscarriage is incredibly common, ending 25% of all pregnancies, but also seldom discussed.
- Modern cultural expectations on women add to the grief because it can seem to be a failure and a loss of control and autonomy.
- Scripture gives us many insights into how God sees this pain and is a starting point to helping us approach those affected with greater compassion and sensitivity.

The waiting room for the emergency gynae clinic is a strange place. The air is thick with nerves. No-one makes eye contact, conversations with partners are had in hushed tones. The walls covered with posters offering support and counselling services that only serve to reinforce the sense of inevitability. There's one poster in particular that stands out – it simply reads '1 in 4 pregnancies end in why me?' As I read and re-read the poster the question is not 'Why me?' but just 'Why?' Why does a God that 'knits us together in our mother's womb' allow the thread to get caught and the beautiful knitting to unravel into the mess of blood and tissue now leaving the body? Social media threads campaigning to protect the value of the unborn child painfully emphasised what was lost, part of me wanted to respond, 'I know, but must you rub it in?'

If one in four pregnancies end in 'why me?', then miscarriage affects many more than one in four. That is a lot of people asking 'why?'

Along with the 'why' came a sense of powerlessness. For many professional women children are something they'd like to have, but feel they need to wait for the right time. For us it was finishing my

'I knew, as I clutched my firstborn child, that I was losing my second'

Meghan Markle<sup>8</sup>

professional exams, for others it is the promotion that provides financial security or time in job to allow them maternity leave. As such, choosing to start a family is a planned and prepared-for process – many will stop drinking alcohol and caffeine, up their exercise, start antenatal vitamins. Consequently, conception feels like a personal success and miscarriage as a failure. We have become so used to being in control of our day-to-day lives, from paracetamol for headaches to vaccines for COVID-19, that trying to conceive can be the first time many women come face-to-face with powerlessness. When I miscarried, I was processing not just grief but also shame and guilt. The sense that I had let my husband down was huge. It didn't matter how often he told me it was not my fault, I had no one else and nothing else to blame. And yet, a pregnancy is begotten of God not made by me and my lifestyle. A failed pregnancy is a consequence of the fall, not my personal failure.<sup>1</sup>



*His disciples asked him, 'Rabbi, who sinned, this man or his parents, that he was born blind?' 'Neither this man nor his parents sinned,' said Jesus. (John 9:2-3a)*

Miscarriage, infertility, and subfertility are highly emotive issues that are rarely spoken about in Christian circles, even at women's conferences. As Christian healthcare workers, we might have helped people through this 'why me' professionally. But it is highly likely that many young couples we know from our churches and personal life will be also asking this 'why'. This may be the first time they need to grapple with the reality that they are not in control of their lives. Walking alongside young couples means speaking to the big questions dominating their day-to-day lives, which includes miscarriage and subfertility as well as the transition to parenthood. For us and our female colleagues, as well as other working women, the transition from multitasking, driven, successful career woman to being sleep deprived and struggling to get dressed in the morning can be traumatic. As many more women strive to balance work and motherhood the historic picture of women as homemakers may seem outdated and irrelevant and isn't always the model of biblical womanhood today. Managing the challenges of being a working mother is an area in which most of today's Christian women walk.

How can we, as Christian health professionals, support families struggling with miscarriage and subfertility? Firstly, we need to be a part of the national conversation. As women in positions of power speak of their personal experiences, we need to use the opportunity to speak of it to our friends and to our families. Speaking about my miscarriage with friends and colleagues has created amazing opportunities to pray for them and discuss God's comfort. It has also revealed pastorally insensitive comments from 'at least you know you can conceive' to 'at least it was an early miscarriage.' Even with these comments there is an opportunity to explore the value of life from conception. We see our culture's incongruence between recognising the pain of miscarriage and advocating for abortion for any reason. Meghan Markle was *losing her second child* – not just some cells or a foetus. Miscarriage is a time when many instinctively sense the value of the life they are carrying.

Secondly, talk about it from the front. Church leaders need to break the taboo of talking about fertility and miscarriage. Not just in their women's groups but also with the whole congregation. This can be within a sermon: there are many passages that explore God's love for the child in the womb and many women in the Bible struggling with barrenness, some of which will have been miscarriage related. Or having an evening for those who have experienced miscarriage or infertility to come together,

## 'At the beginning of the year, I had a miscarriage which left me heartbroken.'

Carrie Johnson<sup>9</sup>

lament and pray. Or it can simply be including it in the prayers as we pray for other members of our congregation who are unwell or dying.

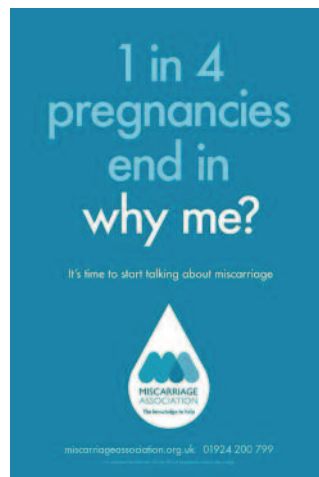
Thirdly it is looking at the whole culture within our churches. Have we created a culture whereby we over-emphasise our own power to succeed? Do we see the world and sin as something we can overcome rather than something Christ has overcome? Do we elevate the family to such an extent that those struggling to have children feel that they are incomplete? Have we preached a God that is overly masculine and so in the midst of miscarriage and infertility 'He' feels unrelatable to our current experience?

This final point I felt particularly keenly.

I converted to Protestantism as a teenager but was brought up Roman Catholic. At points in my journey, I have envied the Catholic's belief in the power of prayer to the Saints. Mary, Mother of Jesus, felt much more relatable than God the Father or Christ the Son (who never tried to have children). I sought the more maternal passages about God. In Isaiah God describes himself like a woman in childbirth crying out<sup>2</sup> and as a mother comforting her child.<sup>3</sup> In Hosea 13:8 God is *'like a bear robbed of her cubs, [who] will attack them and rip them open'*. This raw pain and grief at the loss of children is particularly powerful. Both the Father and Jesus talk of spreading their wings to provide refuge.<sup>4</sup> Whilst there are excellent models of godly women in the Bible that can inspire and encourage, it is important that God as Father and Son is preached in such a way that he speaks to feminine challenges and struggles.

Miscarriage, subfertility, and infertility are consequences of the fall. It is there in Genesis 3:16 *'I will make your pains in childbearing very severe...'* referring to more than the pain of labour itself. Epidurals have not conquered the fall! It is the whole process from wishing to conceive, to conception, to birth, to raising children. In answer to this brokenness Christ lives, dies, and rises again. He is born of a woman, who experiences the full pain of childbearing: from a socially difficult pregnancy, to less-than-ideal third trimester travel, through to the grief of seeing her son crucified. We can help those asking 'why?' to accept that their personal 'why' may never be answered and yet still, like Mary, say, *'my soul glorifies the Lord, and my spirit rejoices in God my Saviour'*. (Luke 1:46-47)

*Alice Gerth is an anaesthetics registrar*




one  
in  
four



PREGNANCIES  
WILL END IN  
A MISCARRIAGE<sup>5</sup>

one  
in  
100




PREGNANCIES  
ARE ECTOPIC<sup>6</sup>

one  
in  
seven



COUPLES  
STRUGGLE WITH  
FERTILITY<sup>7</sup>

one  
in  
ten



WOMEN  
WILL BE FORMALLY  
DIAGNOSED WITH  
POST-NATAL  
DEPRESSION AND MANY  
MORE THE 'BABY BLUES'<sup>8</sup>

references (accessed 28/2/22)

1. John 9:3
2. Isaiah 42:14
3. Isaiah 66:13
4. Psalm 17:8, 57:1, 91:4; Matthew 23:37
5. [miscarriageassociation.org.uk/information/worried-about-pregnancy-loss](https://miscarriageassociation.org.uk/information/worried-about-pregnancy-loss)
6. [nhs.uk/conditions/infertility](https://nhs.uk/conditions/infertility)
7. [pandasfoundation.org.uk/what-is-pnd/post-natal-depression](https://pandasfoundation.org.uk/what-is-pnd/post-natal-depression)
8. Meghan, Duchess of Sussex: The Losses We Share. *New York Times*. 2020. [nyti.ms/3K8mpW5](https://nyti.ms/3K8mpW5)
9. Carrie Johnson and Boris Johnson expecting second child. *BBC News Online*. 31 July 2021. [bbc.in/3HKXell](https://bbc.in/3HKXell)

**Rebecca Torry** looks at the impact of a colleague's suicide, and the issues around the support for those left behind



# SUICIDE...

## LIVING WITH THE AFTERMATH IN A GENERAL PRACTICE

### key points

- The author recounts the traumatic experience of learning that a much-loved colleague had died at her own hand.
- While not frequent, suicides of health professionals are not uncommon either, but little room is given to help colleagues cope with the trauma, guilt, and grief of such deaths.
- Affected teams need support, advice, and someone to talk and pray with in the work setting.

Little has been written about the impact on a practice when a colleague dies by suicide. It is not a common event. About 16 doctors die by suicide every year. Nevertheless, the rate is high compared to the general population, notably amongst women, general practitioners, and trainees.<sup>1,2</sup> Reliable numbers for other staff are even harder to obtain. However, the repercussions are more significant than the numbers suggest. Doctors are often widely known to those they trained with, those they have worked with in various settings, and to patients.

Practices function as relatively independent units and lack the external management structure and access to occupational health available in other parts of the health service. Colleagues may work together for many years and know each other well. There are resonances with losing a family member or a member of a church community. Those who have leadership responsibility often know the person who has died as a friend as well as a colleague. They must manage their own feelings and those of everyone else while trying to make sure the practice continues to run.

*Essentially it was something I had to get through. It did affect me, but I didn't really have an outlet to discuss it. People just expected me to carry on.<sup>3</sup>*

### Our experience

On Friday, 23 January 2015, Dr Louise Tebboth, my practice colleague and a CMF member, died by suicide. She was 40 and happily married. Louise had worked with us for twelve years as an associate partner, foundation trainer, and locality safeguarding lead. Many of us were at her wedding. She had suffered from depression before but had been well for several years when another episode hit. After a couple of months off, she had been preparing to return to the job she loved.<sup>4</sup>

Our experience is not unique. In 2020, Professor Gail Kinman<sup>5</sup> and I interviewed others working in general practice who had lost a colleague, not always a doctor, by suicide. We found common themes but no easy answers.<sup>6</sup>

*The death of any colleague can be devastating. When the cause is suicide, the torrent of emotions can be overwhelming.<sup>7</sup>*

I will not forget the Saturday morning phone call from Gary, Louise's husband. At least there were five of us to sit in stunned silence for half an hour before trying to plan.<sup>8</sup>

We had to think about so many things. The staff needed to know before they came in on Monday. We divided the calls. There would be strong emotional reactions. There was a gathering of all

staff early on the Monday, and again at lunchtime. We had to decide how to tell the patients. The staff suggested a pause for 24 hours before the news was made public. That gave time to prepare posters and place flowers and memorial books for messages in the reception areas. It was our reception team who had to handle much of the distress.

Still the patients kept coming. We had to work to meet their needs while trying to cope with our own feelings and those of our colleagues.

It was hard enough for us working in a largish practice. An east London GP, Dr Farzana Hussain, describes being left to run her practice single-handed while struggling with her own grief when her partner died by suicide.

*The next day my practice manager had managed to get a locum in. But there were all the prescriptions to do. I think it took me an hour to do ten prescriptions in between tears.*<sup>9</sup>

No one should find themselves struggling unsupported as she did.

## What should we tell the patients?

There are more questions than answers. There may be uncertainty about the cause of death, or the family may not wish it to be known. Our staff knew that Louise had died by suicide, but we did not share this with patients for some time. When fundraising in aid of cancer was proposed, we started to give the information when asked. Although most patients took the news calmly, some did not. Finding the words was hard.

*We had to talk through somebody talking through the trauma of them losing our colleague. We never got to say 'You know what? This is painful for me too.'*<sup>10</sup>

## The funeral and remembering

Not being allowed to close for the funeral (to which we were invited) is a common experience and is extremely difficult for those who must stay at work. Practices can close for learning events. Why are they not supported in closing for a staff member's funeral? Sometimes too much is expected of us by others and by ourselves.

*All of us felt like somebody else's right to grief was greater than our own.*<sup>11</sup>

It was helpful for us to hold a later memorial event to which we invited family, staff, and patients.<sup>12</sup> We also created a video celebrating our memories of Louise.<sup>13</sup>

*Doctors are expected to be empathic towards their patients, even when their own emotional reserve is empty. We cannot continue to ignore deep distress in doctors and give our colleagues less care than we expect them to give patients. We must care before it is too late.*<sup>14</sup>

## Responsibility and guilt

*Do not judge and you will not be judged; do not condemn and you will not be condemned. Forgive, and you will be forgiven.* (Luke 6:37 NRSV)

Feelings are inevitably strong. People blame themselves and others. False assumptions are made. Members of the team can displace anger or distress

on to other issues without recognizing what is happening. If the person who died was the subject of a complaint, a known risk factor, feelings may be even more complex.<sup>15</sup> We need compassion for each other and compassion and support from those around us, including those who regulate us.<sup>16</sup> Individuals and the practice can remain fragile for a long time.

## Learning from loss

*...neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation will be able to separate us from the love of God in Christ Jesus our Lord.* (Romans 8:38-39 NRSV)

Judas Iscariot, repenting of his betrayal, tried to return the thirty pieces of silver he was paid to the chief priests and elders. Their response was, *'what is that to us? See to it yourself.'* He flung the money on the temple floor and went out and hanged himself.<sup>17</sup> If one of the elders had spoken to him wisely and kindly, might the outcome have been different?

When Lizzie Lowe, a Manchester teenager, died by suicide in 2015 aged 14, her church 'crumpled' as they came together in grief. Only at her inquest three months later did they discover she had been unable to reconcile being a Christian and gay.<sup>18</sup> As her minister said, *'this must never happen to another teenager, anybody, ever again'*. The church went on to challenge its own *'conspiracy of silence'* around the issue of sexuality.<sup>19,20</sup>

Depression is a potentially fatal illness, and Louise was ill. Sadly, she successfully hid her delusional conviction that she was programmed to die by suicide and that her family would be better off without her.<sup>21</sup> It is our hope that even in that darkest hour, she somehow knew the love of Christ.<sup>22,23,24</sup>

## What else would help?

*Even though I walk through the darkest valley, I fear no evil; for you are with me; your rod and staff – they comfort me.* (Psalm 23:4 NRSV)

In the aftermath of a sudden death, practices need time to talk, time to work out how to respond, time to remember. We need compassion for each other and compassion and support from those around us, including those who regulate us.<sup>25</sup> Those of us who are Christians need time to pray together, to know that God is with us, and perhaps to reflect on a verse that was important to Louise. *'Be still and know that I am God'*. (Psalm 46:10)<sup>26</sup>

We needed someone to be alongside us over a fairly long period, to listen to us, to help us to explore our complicated feelings, to talk about our colleague and the fear that we had failed her. We needed someone not immediately involved in running the practice to provide pastoral and spiritual care for patients and staff, whatever their faith. A local church may support individuals but may not be able to work with a whole practice as they grieve together. Perhaps what every practice needs is a chaplain.<sup>27</sup>

*Rebecca Torry worked as a GP in South London for 36 years, retiring in December 2020.*



## references (accessed 11/2/22)

1. Kinman G, Teoh K. *What could make a difference to the mental health of UK doctors? A review of the research evidence.* Society of Occupational Medicine, 2018. [bit.ly/33ezwFL](https://doi.org/10.3327/FL)
2. Gerada C. Doctors and Suicide. *British Journal of General Practice*. Editorial. April 2018. 167-169; [doi.org/10.3399/bjgp18X695345](https://doi.org/10.3399/bjgp18X695345)
3. Kinman G, Torry R. *Responding to the death by suicide of a colleague in Primary Care: a postvention framework.* p6. Society of Occupational Medicine and the Louise Tebboth Foundation, September 2020. [bit.ly/3swtvNF](https://bit.ly/3swtvNF)
4. Louise Marson (Tebboth) Obituary *BMJ* 2015;350:h1293
5. Dr.Gail Kinman, CPsychol FBPsS FAcSS FHEA, Visiting Professor of Occupational Health Psychology, Birkbeck University of London
6. *Op Cit.* Kinman G, Torry R
7. Sir David Haslam, LTF Patron. Launch publicity *Responding to the death by suicide of a colleague in Primary Care: A postvention framework.* The Society of Occupational Medicine ([som.org.uk](https://som.org.uk)). [bit.ly/3HMDNPD](https://bit.ly/3HMDNPD)
8. We were a partnership of four GPs and a manager.
9. Boyd S. Fallen friend, the doctor. 26: November 2020. P20-24. [bit.ly/3Bdpmll](https://bit.ly/3Bdpmll)
10. *Ibid* p22
11. *Ibid* p22
12. Marson G. *Just Carry on Breathing. A year surviving suicide and widowhood.* 2016. Dark River. p50
13. Tributes from the practice. [bit.ly/3rHCMCT](https://bit.ly/3rHCMCT)
14. Baroness Finlay of Llandaff, Louise Tebboth Foundation patron, quoted in a poster presented to the RCGP conference September 2021.
15. Gerada C. Doctors and suicide. *British Journal of General Practice* 2018; 68 (669) 168-169. [doi.org/10.3399/bjgp18X695345](https://doi.org/10.3399/bjgp18X695345)
16. Dawnay G. Doctor suicide – how many more? *BMJ opinion* June 13 2019. [bit.ly/3sCTraV](https://bit.ly/3sCTraV)
17. Matthew 27 v 3-5
18. Paul Wilkinson. It took this death to end silence on inclusion, says priest of teenager who took her own life. *Church Times* 8.6.2018.
19. [stjamesandemanuel.org/beyond-inclusion](https://stjamesandemanuel.org/beyond-inclusion)
20. Living Out Resources for Biblically Inclusive Churches. [bit.ly/3BdcbvY](https://bit.ly/3BdcbvY)
21. *Loc Cit.* Mason G. p. 17-18.
22. The Louise Tebboth foundation (LTF), founded by Louise's husband Gary, makes small grants to support doctors' mental health. [louisettebboth.org.uk/about](https://louisettebboth.org.uk/about)
23. *Op Cit.* Kinman G, Torry R.
24. LTF has worked with the Society of Occupational Medicine to fund research and publish a postvention framework to help practices following the sudden death of a colleague.
25. *Op Cit.* Dawnay G
26. *Loc Cit.* Mason G. p2
27. Hughes A. Chaplain in the practice. *Triple Helix* Autumn 2007. [cmf.li/3rJNVTY](https://cmf.li/3rJNVTY)

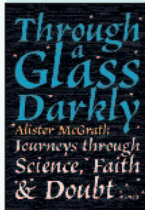


**Whatever**

*Cross-centred ethics that point to Jesus*

Giles Cattermole

- CMF, 2022, £7.50, 110pp, ISBN: 9780906747834
- Reviewed by **Matt Lillicrap**, Pastor, Hope Community Church, Cambridge

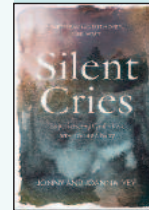


**Through a Glass Darkly**

*Journeys through science, faith & doubt*

Alister McGrath

- Hodder & Stoughton, 2020, £9.99, 225pp, ISBN: 9781529327625
- Reviewed by **Patricia Wilkinson** a GP in East Lancashire



**Silent Cries**

*Experiencing God's love after losing a baby*

Jonny and Joanna Ivey

- IVP, 2021, £7.42, 176pp, ISBN: 9781789741421
- Reviewed by **Alice Gerth**, a trainee in anaesthetics

**H**ow do we know the right or wrong thing to do? That question has vexed and perplexed humanity for centuries, keeping philosophers and ethicists, religious leaders and university professors employed.

But it's not confined to the ivory towers of philosophy and academia. It confronts healthcare workers at almost every working moment. Meanwhile, it raises its head at times in all our lives, often in uncomfortable ways.

Christian responses to ethical questions can be shallow. We want direction from God, so we search for a 'word from the Lord.' Armed with something like that, we feel we can move on, leaving discomfort behind.

Where we don't find a clear answer, we follow the status quo, whether spelt out in ethical guidelines or demonstrated by the currents and fashions of culture.

Giles Cattermole is content to let the uncomfortable question hang in the air. *Whatever* seeks to cut through overly simplistic approaches to ethics. Ethics, he argues, has as much to do with the (often) little decisions of our days as with parliamentary and societal debates about the value of human life.

This is because these decisions and the world in which they are taken have the same root. In God's world, God's design is central. Thus, '*Christian ethics starts by knowing God's character and then responding to what he's done for us in repentance and faith, living lives that glorify God.*'

This book explores that idea, examining it from one angle after another. What emerges is a vision of cross-shaped, Christ-centred ethics in which we are encouraged to allow the cross to shape our decisions.

This is not a simplistic approach, drawing up black and white principles as though the world and our decisions are without colour

**T**his is probably Alister McGrath's final book. It is a memoir of his journey to faith from an atheist scientist to a Christian theologian, how he could balance science and religion, and the people who influenced his thinking. Although I was aware of the author, I don't recollect reading any of his books. So, ironically, this was a useful introduction.

Overall, it was an interesting book, particularly the reports of the discussions with Mary Midgely. These covered how and why science and religion work together, rather than being mutually exclusive. If you haven't read his other books, this is a valuable introduction. If you have, then as McGrath puts it, 'this book explains how my theology textbooks came to be written'.

It is an interesting book for any Christian who is a scientist, and I would include health care professionals in this group. But it would also be helpful for a nonbelieving scientist asking questions about our faith.

or complexity. Giles draws on the categories of worship, wisdom, and witness. We are to define our ethics by worship as we submit and relate to God. We let wisdom guide us as we understand God's world as it truly is, yielding witness as we live in God's world as God's people.

With practical examples, many drawn from the world of healthcare, this book will prompt readers to bring the whole of Scripture to bear on ethical questions. It will undoubtedly help healthcare professionals and students but is also highly recommended to anyone thinking through how we live for Christ in a complex world.

**M**isconception and pregnancy loss are not easy topics to write on. Jonny and Joanna Ivey bravely use their own experience of pregnancy loss at 35 weeks to explore the emotions and questions asked by those experiencing this pain.

This is not an intellectual approach to the question of suffering or what happens to infants when they die. Rather, it is a worked through search for God in the darkness. As such, it provides little by the way of answers, but that is what makes it powerful. Through their experience, you see the pitfalls of Christian platitudes and theological sound bites, alongside the hope of the gospel. Jonny, in particular, explores how misapplying theology can result in burdens that aren't his to carry. For instance, the idea that suffering refines us in darker moments led him to ask, would our baby still be here if I had been more refined?

Using this approach challenges those in pastoral roles to be comfortable not having the answers. Instead, it encourages us to sit with the grieving, pointing them to God's love. It also warns against the idea that you ever 'move on' from grief. Instead, you carry it with you, but its impact can become less devastating over time.

This book will build empathy in those who have not experienced pregnancy loss but support those who have. It helps those going through the loss to know their experience is shared and their questions are valid, even if they cannot be answered. It is a raw lament saturated with the gospel. It is an emotional but essential read for the church and Christians in the caring professions.



### The Bible and Mental Health

*Towards a Biblical Theology of Mental Health.*  
Ed Christopher CH Cook and Isabelle Hamley

- SCM press, 2020, £25, 256pp, ISBN: 9780334059776
- Reviewed by **David Smithard**, Consultant in Geriatric Medicine at Lewisham and Greenwich NHS Trust, a Visiting Professor at the University of Greenwich, and is the *Triple Helix* Editor.

Exploring the intersection of mental health and Scripture, this is a multi-authored, multidisciplinary book that covers many fields, including biblical studies and psychiatry. Given the number of authors, there are several approaches taken. The contributors do not attempt to provide all the answers but to explore the relevance of the Scriptures to mental health. The book is separated into three sections: Biblical Theology, Biblical Case Studies, and Practical Focus.

Some sections of the book are easier to read than others. I found the first chapter 'Narrative, Meaning Making and Mental Health' particularly challenging.

The editors suggest that it is a book for pastors, teachers, vicars, chaplains, and for all those involved in caring for others, whether professionally or in a volunteer capacity. They also propose that it is for ordinary church members struggling with questions, and mental health professionals who want to explore how their patients' faith interacts with and can shape their wellbeing. By and large, the book succeeds in these aims, if you can get through the first few chapters. It is a book best dipped into as and when topics come to the fore and not read from cover to cover. A book to have on the shelf or desk that is there when you need it.



### Serving two masters?

*Probing the tensions between science and faith in the art of healthcare*  
Paul Coulter

- CMF, 2022, £7.50, 106pp, ISBN: 9780906747841
- Reviewed by **Werner J McIlwaine**, Retired Physician and Diabetologist and Catalyst Team Leader for Northern Ireland

Paul Coulter considers the position of faith in healthcare over six chapters, each with helpful summaries and questions for individual or group discussion. He treats the subject with care and consideration, being clear without being dogmatic.

Some have suggested that science apart from faith is the only ethical way to treat patients to respect their autonomy. This is a myth that Paul refutes, arguing that science alone cannot answer questions such as what constitutes a human person or what comprises good practice in healthcare. Biomedical science can show what is effective in treating physical illness. The social sciences can help explain what benefits a patient's emotional and social wellbeing. But neither approach can decide which emotional and physical benefits for individual patients we should prioritise. Nor can science resolve the tensions between viewing health from a population perspective (what maximises the health of the most significant number of people) and the individual (what is beneficial for this particular person). In short, medicine needs ethics, but science alone cannot provide this.

Paul ends with practical suggestions for integrating faith and practice. The book is intended for students and practitioners alike in medicine, nursing, and the allied health professions. I cannot recommend it highly enough.



### Up from the Ashes

*A Syrian Doctor's Story of Sacrifice and Hope*  
Dr 'A' and Samara Levy

- Hodder & Stoughton, 2021, £13.29, 256pp, ISBN: 9781529358421
- Reviewed by **David Smithard**, Consultant in Geriatric Medicine at Lewisham and Greenwich NHS Trust, a Visiting Professor at the University of Greenwich, and is the *Triple Helix* Editor.

Dr A is a Christian who was living in Syria when the civil war began. Dr A's family are Christian. His father was in the army, imprisoned for maintaining his integrity in the face of extreme pressure. His father was forced to leave the military, setting up a small grocery shop. The family had little money, but Dr A worked hard, facing adversity as one of the few Christians in various schools in Muslim areas. He eventually became a respected ITU and emergency care doctor. For a brief while, life was comfortable; then the 'world fell apart'.

There are several strands to Dr A's story, providing an alternative insight into the horrors of the Syrian civil war, one that the West did not report. It is a story of courage, of refusing to leave his nation like so many of his fellow countrymen and family, and choosing instead to stay and help his people until it became impossible. It is a story of his friendship with a British woman (Samara Levy) and her church and their prayer support for him and his work. And lastly, it is a story of self-discovery and his encounter with and dependence upon the real Jesus.

Dr A remains in Syria, determined to help rebuild his nation. As he says, 'But through the love, support and prayers of many faithful hearts, in Syria, in the UK, and around the world, we are certain that God will provide.'

John Greenall describes a new CMF initiative

# CHLN

## CHRISTIANS IN HEALTHCARE LEADERSHIP NETWORK

The healthcare leadership arena is an increasingly secular one. Leaders can feel isolated in their role or reluctant to step into leadership positions in the first place. Others succumb to the sacred-secular divide, where leaders and managers are involved in church and see their 'secular' work as less valuable. And many in the younger generation are looking for examples of godly leaders who remain in the NHS in various roles.

Many CMF members are in leadership roles across the NHS and other health service providers. In addition, we know there are 34,500 managers in the NHS,<sup>1</sup> many of whom are Christians, who work closely with medical and nursing colleagues and for whom there is no formal network of support. At CMF, we have recently developed a support and encouragement group called the 'Christians in Healthcare Leadership Network'.<sup>2</sup> It aims to unite and equip Christians in healthcare leadership, facilitate a supportive community, sharpen relationships, and model what it means to be salt and light in challenging circumstances. Furthermore, we seek to support one another to integrate our daily work with a distinctive faith in Jesus, seeking to influence the culture and model servant leadership to the next generation of leaders.

To achieve this, we have developed the following objectives:

1. Supporting current Christian healthcare leaders and managers through online and in-person events and monthly prayer gatherings in cohorts. These forums include role modelling and discussing issues unique to our situation, receiving support, advice and prayer.
2. Mentoring and coaching both current and future Christian healthcare leaders, including those who may not traditionally receive such support from other Christian sources and those who seek role models.
3. Producing biblical, applied resources for those in the field, including journal articles, blogs, podcasts, and briefing papers.
4. Addressing the sacred-secular divide between work and church, helping people discern their calling in healthcare and encouraging whole-life discipleship in all that we do.

'These prayer meetings are the highlight of my month. It's a joy to bring some of the unique challenges to the group, discuss them and to receive prayer in these specific areas.'

The heart of what we are doing is a monthly prayer gathering. One participant said, 'These prayer meetings are the highlight of my month. It's a joy to bring some of the unique challenges to the group, discuss them and to receive prayer in these specific areas.' This reflects the sentiment of the group, with many finding these to be uniquely supportive times of sharing and praying into the unique pressures of leadership.

Over the past 18 months, we have co-hosted a leadership conference with our friends at the Global Leadership Network.<sup>3</sup> The focus on gospel-centred and practically relevant topics has been well-received and built further momentum. A Day Conference is planned on Saturday, 17 September, titled 'Serving Not Sinking' to which all current and aspiring healthcare leaders and managers are invited. Non-clinical leaders are also warmly invited to join CMF as Associate members, and we would encourage people to share with colleagues and acquaintances who may be interested.

*Dr John Greenall is CMF's Associate CEO and a Paediatrician in Bedfordshire.*

For further details of the new network, please contact John at [john.greenall@cmf.org.uk](mailto:john.greenall@cmf.org.uk).



### references (accessed 11/2/22)

1. Key facts and figures about the NHS. *The King's Fund* - [bit.ly/3Be08cU](https://www.kingsfund.org.uk/resources/factsheets/key-facts-and-figures-about-the-nhs)
2. [cmf.li/CHLN](https://www.cmf.li/CHLN)
3. [glsuki.org/cmf](https://www.glsuki.org/cmf)

**Matt Baines** encourages us to focus on what really matters

# EYES FIXED ON HIM

*Therefore, since we are surrounded by such a great cloud of witnesses, let us throw off everything that hinders and the sin that so easily entangles. And let us run with perseverance the race marked out for us, fixing our eyes on Jesus, the pioneer and perfecter of faith.*  
(Hebrews 12:1-2)

**D**uring a difficult season four years ago, I realised that my sense of worth was becoming closely woven in with extrinsic factors, such as status, role, church responsibilities, and career. I had neglected the essential and fundamental message of God's grace.

Grace is a baffling concept to grasp in the 21st century. The prevailing culture, including social media, implies that my value is linked to external approval, which is insatiable and unsustainable. Often sowing seeds of dissatisfaction and restlessly demanding more of me. The message of the Bible is one of a truly unconditional and undeserved eternal love.

I understood afresh that grace means I am accepted, justified, and loved infinitely, regardless of what I do. If I sat at the back of church and did nothing other than enjoying God quietly (being 'insignificant' in man's eyes), this would be enough.

During this period, God spoke two fundamental truths to me in the passage above from Hebrews. Firstly, we all have our individual race 'marked out for us'. Our race is never the same as anyone else's, and we are simply called to run with what God has placed before us. We are to be forward-focused, 'blinkers on', not distracted by people around us, not comparing and not

hypothesising that others may be running 'better' than us, and not comparing ourselves in areas such as faith, status, and work.

Secondly, we are to focus on Jesus – eyes fixed on him, ignoring the noise, consumerism, culture, and celebrity of the world we are in. For too long, I had been focused on my natural accomplishments, my earthly roles, and achievements, and not focusing enough on Jesus and his unconditional grace.

As a GP, I encounter many patients who compare themselves to others; who live with regret, condemnation, or in the shadow of relatives. I see how this affects their sense of self-worth, their identity, and ultimately their health. Although there are many causes for this low self-worth, what is overwhelmingly evident is that much of it is exacerbated by social media, the prevailing culture, and societal pressures.

As Christian healthcare professionals, we have opportunities to apply biblical principles to help patients address these problems. This can involve promoting individual value – knowing that we all have a unique purpose and race to run. It can be to encourage them on the journey of taking the focus off others and championing their intrinsic value. And lastly, inspiring them to focus on something bigger than themselves, something greater, something eternal.

By truly grasping the grace message, we can understand that our value is not linked to what we do or our position. Rather, it is tied to our individual and unique worth in Christ. This is genuinely liberating, leading to great contentment and much peace.

*Matt Baines is GP Partner in Coventry*

ONE WEEK

Developing Health Course  
10-16 July 2022

DHCC

[cmf.li/DHC2022](https://cmf.li/DHC2022)

