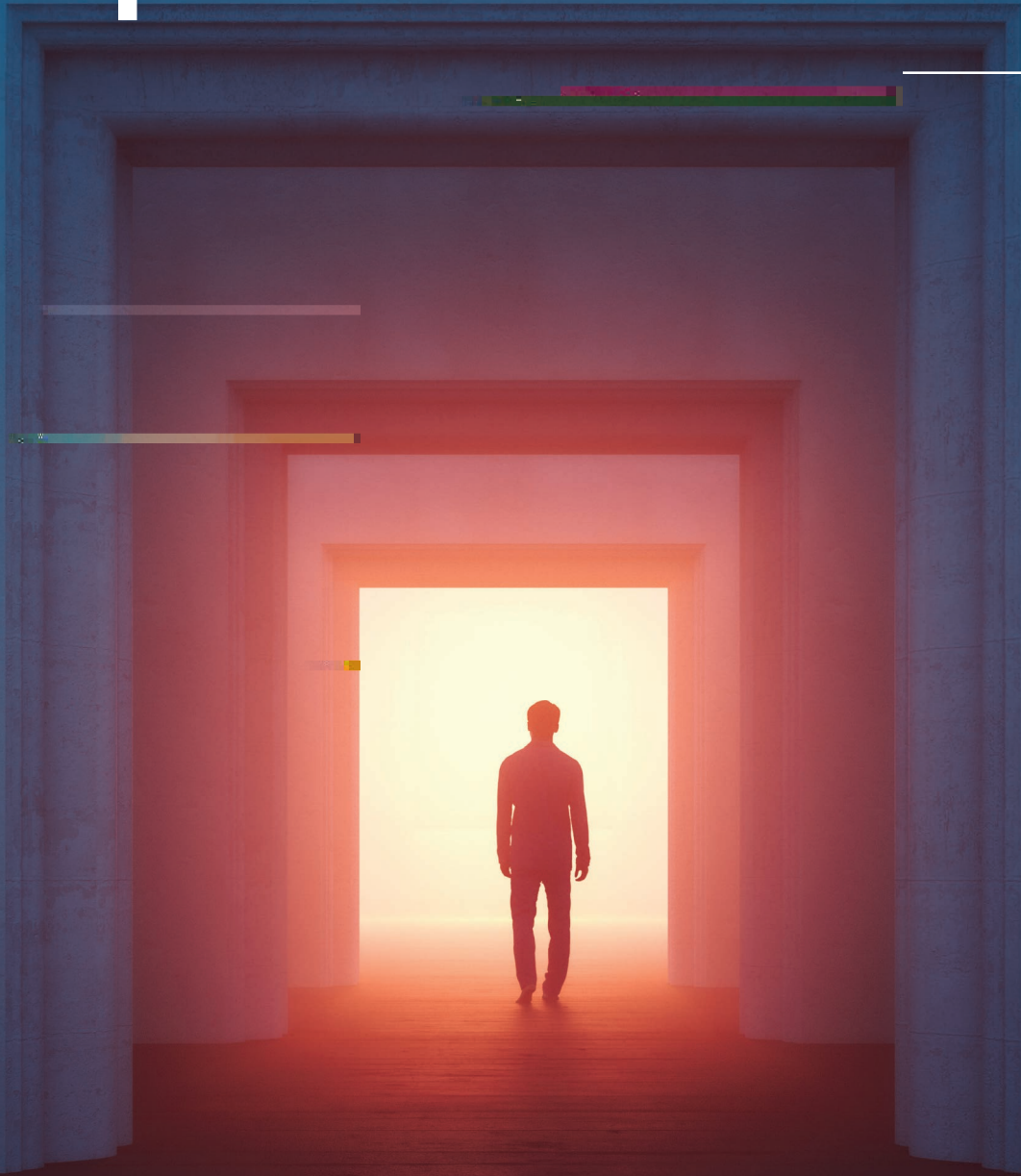


triple hel



transitions

from Ghana to the UK, training health workers through war and instability, returning from mission, motherhood, retirement, the history of medical mission, child witch accusations, resilient discipleship

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

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 Steven Fouch

Editorial Board

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

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. 82 autumn 2022

contents

News Review	4
Closing the Tavistock GDS - <i>Julie Maxwell</i>	
WMA and freedom of conscience - <i>Mark Pickering</i>	
Archie Battersbee's legacy - <i>Trevor Stammers</i>	
Costing our lives - <i>Steve Fouch</i>	
Transitions 1: moving between healthcare systems	6
<i>Mercy Domi-Kwame</i>	
Transitions 2: training health workers through war & instability	8
<i>Alice Caisley</i>	
Transitions 3: Bangladesh to East Sussex	10
<i>Ruth Butlin</i>	
Transitions 4: lessons from early motherhood	12
<i>Alice Gerth</i>	
Transitions 5: double harvest	14
<i>Simon Ramsbotham</i>	
Lessons from the archive 2: the birth of modern medical mission	16
<i>Mark Pickering</i>	
Child witch accusations	19
<i>Susie Howe and Paul Stockley</i>	
Resilient discipleship	20
<i>John Greenall</i>	
Reviews	22
Final thought: rest deficit	23
<i>Matt Baines</i>	

The times they are a-changin' ¹

When God takes us through such seasons of transition, they can become doorways leading to transformation and renewal

The week of 6-12 September 2022 will long be held up as one of the most noteworthy ones in the recent history of the United Kingdom. We started the week with one Prime Minister and the Queen; we finished it with a new Prime Minister and a new King. The sad death of Her Majesty Queen Elizabeth II on 8 September marked the end not just of a seventy-year era that has seen unprecedented change in British society but also the end of a life dedicated to the service of her nation and her God. As the Archbishop of Canterbury said at her funeral, *'Her Late Majesty's example was not set through her position or her ambition, but through whom she followed'*.² Her example of serving Christ in her work exemplifies the Christ-centred, servant-hearted leadership and professionalism CMF seeks to encourage and share.³

Whatever your political beliefs and views about the British Monarchy, few could disagree that the death of Queen Elizabeth II marked a significant point of transition for the UK. Such transitions are always stressful, but we seem to face them on multiple fronts right now. Overseas there are wars in Ukraine, Yemen, Armenia, and the Horn of Africa, among others; at home, it is runaway inflation and failing public institutions, including our health and social care services; there are environmental disasters on multiple fronts; and still lurking in the background is the COVID-19 pandemic. As Paul urges us in 1 Timothy 2:1-3, we need to pray for King Charles III and the new Prime Minister, Liz Truss, as they assume their offices at a time of multiple crises nationally and internationally.

Times of change and uncertainty, then. But also of opportunity. When God takes us through such seasons of transition, they can become doorways leading to transformation and renewal. Even if we cannot see it at the time, even if we would not choose the path we are on or the situation we are in, God works out his purposes. Although we often only see those purposes as we look back.

In this edition, we consider several such transitions. Transitions between countries and healthcare systems; transitioning into the role of a health worker amid war and instability; returning home after years overseas; becoming a parent, or transitioning to retirement; all these changes are moments when God can open our eyes and stretch our boundaries.

Some transitions, however, are more global and less personal. One such is the rapid pace of technological innovation in every area of life, not least in medicine. Talking to an old friend recently, I was fascinated at how much their practice (and their own health) is

being affected by genomic sequencing and what this is already achieving in preventative and personalised medicine.⁴ We are transitioning into an era of personalised medicine and the emergence of new treatments and diagnostics that offer both great hope and profound ethical challenges.

In the spring 2023 edition of *Triple Helix*, we will look at these new technologies, their impact on health and healthcare, and how we live and practise our faith. Do get in touch if you would be interested in contributing anything to the next edition.⁵

Which is apt because this is the last edition of *Triple Helix* that you will see in this format. We are moving with the technology and how people read these days to widen the reach and depth of content in *Triple Helix*. From the next edition, we will have a new layout and design and a digital-first approach to publishing. What does this mean? In keeping with many medical and nursing journals, the paper edition will still be printed, but not all the articles will appear in it. Some articles will appear in print only as shorter versions. Many more and longer articles will be published first on the CMF website.

You will notice we have already started doing that in this edition. We will say more in the coming weeks and months, so keep your eyes on CMF E-News and the website over the autumn and winter.

As we look ahead, whatever the transitions we are going through, let us all keep our eyes focused on Jesus Christ, the author and perfecter of our faith.

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. For the joy set before him he endured the cross, scorning its shame, and sat down at the right hand of the throne of God. Consider him who endured such opposition from sinners, so that you will not grow weary and lose heart. (Hebrews 12:1-3)

The Editorial Team

references (accessed 19/9/22)

1. Dylan B. *The Times They Are A-Changin'*. Copyright © 1963, 1964 by Warner Bros. Inc. renewed 1991, 1992 by Special Rider Music. bit.ly/3LeGmFN
2. Queen's funeral: Here is the Archbishop of Canterbury's sermon in full. *Evening Standard*. 19 September 2022. bit.ly/3Bpl76J
3. CMF beliefs, values, and identity. cmf.li/3ROZhQZ
4. Redman M, Sansbury F. Whole Genome Sequencing: challenges and opportunities. *CMF Blogs*. 22 June 2022. cmf.li/3OBcHy5
5. Email: communications@cmf.org.uk or ring +44 [0]20 7234 9660

Closing the Tavistock GIDS

a chance to improve gender identity services for children

Review by **Julie Maxwell**
a community paediatrician

At the end of July, it was announced that the Gender Identity Development Service (GIDS) at the Tavistock would be closing.¹ This was confirmed in August by Dr Hilary Cass in a post on the website of the Cass Review (the NHS England independent review into gender identity services for children and young people).²

In her interim report in February, Dr Cass stated that *'a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.'*³

As far back as 2004, clinicians and parents

WMA temporarily misplaces its conscience

but is reminded of it by responses to consultation

Review by **Mark Pickering**
CMF Chief Executive

The World Medical Association (WMA) is close to the end of a lengthy revision process of its International Code of Medical Ethics (ICoME). Originating in 1949 as a companion to its Declaration of Geneva, the ICoME has undergone various revisions.¹

Concern arose in 2021 when the draft revision included the phrase: *'Conscientious objection must only be considered if...undelayed continuity of care is ensured through effective and timely referral to another qualified physician.'* Such 'effective referral' requirements have caused considerable problems in jurisdictions such as Canada, where some physicians who object to involvement in euthanasia and refuse to refer to a willing colleague have been forced out of practice.²

CMF responded to the 2021 consultation,³ as did numerous other ICMDA⁴ member movements. A slightly improved draft went to a dedicated conference in Indonesia in July. There, experts and members of the WMA working group debated for and against various

options.⁵ Thankfully, a better draft has emerged. This was further honed at another WMA meeting in Washington, USA, in August 2022.⁶ Excellent coordinated action by allies, including ICMDA member movements in the USA and Canada, as well as the Anscombe Bioethics Centre⁷ – was instrumental in ensuring that this improved draft emerged.

The final step in the process will be a ratification meeting in Berlin in early October 2022. The current draft of the section reads:

'This Code represents the physician's ethical duties. However, on some issues there are profound moral dilemmas concerning which physicians and patients may hold deeply considered but conflicting conscientious beliefs...Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient's health is not endangered.'

The physician must immediately and respectfully inform the patient of this objection and of the patient's right to consult another qualified

physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.'

This represents a much more balanced approach. We should be encouraged to see how wide consultation by the WMA, and sustained engagement by partner organisations, has produced an improvement. It also reminds us that *'the price of liberty is eternal vigilance'*.⁸

1. Public consultation on a draft revised version of the International Code of Medical Ethics – WMA. April 2021. bit.ly/3dAInVR
2. Spiegel L et al. Canada: Court Affirms Physician Requirements To Provide Effective Referrals For MAID – mondaq.com. 15 May 2018. bit.ly/3BwH8As
3. Submission to World Medical Association Public Consultation on a draft revised version of the International Code of Medical Ethics. CMF. 4 June 2021. cmf.li/3xltqcF
4. International Christian Medical and Dental Associations. icmda.net
5. WMA Meeting – ICoME 2022. bit.ly/3LxpqkP
6. Cook M. World Medical Association protects conscientious objection by rejecting mandatory referral – [BioEdge](https://bioedge.org). 15 August 2022. bit.ly/3qTpa6f
7. Open Letter to the World Medical Association on Conscientious Objection. Anscombe Bioethics. bit.ly/3qSQxxl
8. thepriceofliberty.org/2019/10/15/eternal-vigilance



Archie Battersbee's legacy *can we learn the lessons from this tragic case?*

Review by **Trevor Stammers**
CMF Public Policy Associate

A heart-rending series of legal disputes surrounding twelve-year-old Archie Battersbee was fought not only in the courts but also amidst a blaze of media coverage. Archie was discovered unconscious at home by his mother following a presumed online challenge involving self-asphyxiation, resulting in a cardiac arrest. His heart was restarted but not before extensive ischaemic brain damage had occurred.

Within three days of Archie's admission, his parents were approached to obtain consent to harvest his organs. Archie's family were understandably distraught, which may have played a significant role in the breakdown of trust with the medical team. (High Court ruling, Paragraph 100) ¹

CT scans in April showed 'severe hypoxic encephalopathy', (Para 56) brain swelling and 'significant injury to multiple areas of the brain'. (Para 60) Two consultants gave second opinions that respectively concluded 'The extent of brain injury is incompatible with any meaningful recovery' (Para 61) and '[Archie]

is unfortunately unlikely to survive' (Para 63).

On 14 April, at a meeting with Archie's family, his consultant 'recommended brain stem testing to confirm...that he had died'. (Para 66) The family, however, did not accept this and requested more time for Archie to recover. A series of court hearings ensued, with a final judgment on 15 July. Mr Justice Hayden declared 'on the most compelling of evidence' that the Court 'could not authorize or declare lawful the continuation of...treatment' which 'serves only to protract his death, whilst being unable to prolong his life'. (Para 46)² After a series of further legal rulings, Archie's ventilation was removed on 6 August, after which his heart stopped beating.

At least two ongoing issues raised by Archie's story make it likely that similar cases will recur. The first is the general lack of public understanding about brain stem death. It is of the utmost importance, especially in children, to determine the accuracy of its diagnosis. Once diagnosed, brain stem death means recovery is impossible, and the person is legally dead.^{3,4}

Enabling families to come to terms with this death will prove more helpful in resolving grief long term. It is a difficult concept for the medically trained to grasp. How much harder for the lay public when they see their loved one appearing so alive and 'breathing'? This is an area where churches should play a role.

The second issue relates to the timing of requests for organ donation from patients with severe brain injury. There can be few things more certain to undermine trust than such an early request when the family did not even accept Archie was dying.

If it leads to an increased sensitivity to the timing of donation requests and more public education about brain stem death, Archie's death will leave a legacy of enduring value.

references (accessed 15/9/2022)

1. *Barts Health NHS Trust v Dance, Battersbee and Battersbee* [2022] EWHC 1435 (Fam)
2. *Barts Health NHS Trust v Dance, Battersbee and Battersbee* [2022] EWFC 80
3. Stammers T. Brain death, resurrection, and Archie Battersbee. *CMF Blogs*. 9 September 2022. cmf.li/3B2dQJU
4. Brain Death: Overview. *NHS*. [bit.ly/3U83twQ](https://nhs.uk/3U83twQ)

Costing our lives *the health impacts of the cost-of-living crisis should concern us*

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

Anyone in clinical practice knows that wealth impacts health and vice versa. Despite having a healthcare system free at the point of need, the poor still have worse health than the wealthy.^{1,2}

We are amid a cost-of-living crisis due in part to the supply chain chaos in the wake of the Covid pandemic and the war in Ukraine. It is already having a significant impact on the sick. Patients on haemodialysis who already faced an extra £600-£1,500 a year in utility bills will see them skyrocket.³ We hear of patients going back to hospital for treatment, forgoing independence just to afford to live.

Pensioner poverty is at its worst in over a decade.⁴ With poverty comes a poorer diet, poorer housing, and less heating. The risks of non-communicable diseases and early mortality rise rapidly in such circumstances.

And the health service is struggling – with a backlog of patients post-Covid, and a rise in chronic and acute physical and mental health problems, the NHS has run all summer with the sort of pressures only seen in the worst

of winters. What this winter will bring is even harder to tell.

The UK government is taking steps to try and address this,⁵ but it is open to debate how effective these measures will be.⁶ But this is a problem way beyond any single government intervention. It is global and systemic, historical, and natural. It is a storm, not all of our own making, but one for which we have not adequately prepared so that we could weather it well.

There are no easy answers, no simple reassurances that all will be well. But neither are we helpless or hopeless. Scripture repeatedly reminds us that the storms will sweep upon us, but God will not abandon us.⁷ That when we see the vulnerable suffering or in need, we have a duty to stand with them.⁸ And that when it is our turn to be in need, others will stand with us.⁹ It is a challenge to the church to pull together and support one another and the broader community in Christ's name, and lead the rest of society by example.

We should engage with this politically,

but not by shouting on the social media sidelines. Write to MPs and councillors, get on the committees of professional bodies, or become a shop steward. We need godly voices and hands in all these places. Volunteer at foodbanks, get on your church council and get them engaged.

But above all, such crises should drive us once again to prayer. For our nation, our patients, our colleagues, and one another.¹⁰

references (accessed 15/9/2022)

1. Goddard A. The cost of living crisis is another reminder that our health is shaped by our environment. *BMJ* 2022;377:01343. doi.org/10.1136/bmj.01343
2. Behind the Headlines: the unequal impact of the cost of living crisis. *National Voices*. April 2022. bit.ly/3DfSurB
3. Cost of living: the impact on kidney patients. *Kidney Care UK*. bit.ly/3doBmJO
4. Life is becoming unaffordable for pensioners on low and modest incomes, warns Age UK. *Age UK* 26 May 2022. bit.ly/3QPXD02
5. Energy bills support factsheet: 8 September 2022. *Gov.UK*. 8 September 2022. bit.ly/3DsFApe
6. Age UK responds to new Prime Minister's energy price guarantee. *Age UK*. 8 September 2022. bit.ly/3S5gGVo
7. *Eg Psalm 11:3-4*
8. *Eg Isaiah 1:17, James 2:14-17*
9. *Ecclesiastes 4:11-12*
10. Join us for a Week of Prayer from 31 October to 6 November – see cmf.li/Week-of-Prayer

Mercy Domi-Kwame

reflects on her experiences of transition between the Ghanaian and UK healthcare systems

TRANSITIONS 1

MOVING BETWEEN HEALTHCARE SYSTEMS



e points

- The process of passing PLAB exams, finding clinical placements, finding a job, and obtaining GMC registration can be daunting for international medical graduates.
- The cultural differences, including the attitudes of entitlement among many British patients and UK trained junior doctors, can be hard for health professionals coming from other, less well-resourced, and accessible healthcare systems to accept.
- Despite these obstacles, God is faithful and an enabler and equipper to those who call on him.

Life is a journey, and an interesting one at that. It never stays the same and is often marked by transitions, some seamless, some challenging, but all taking us one step further along life's course.

I graduated from the University of Ghana medical school in 1997, when specialty training in Ghana was not well established. This, coupled with poor remuneration, led many doctors to emigrate. I left for London immediately after graduating to sit for the United States Medical Licensing Examination. There, I met my husband, who was resident in the UK, got married, and started a family.

Practising medicine in Ghana

I returned to Ghana after a couple of years of being a full-time mum to do my house jobs, rotating in paediatrics and general surgery.

The healthcare sector in Ghana at the time ran as a 'cash and carry' system, meaning patients had to pay for everything upfront. There was also a general lack of resources, which meant that even if you had all the money in the world, you could not always get the appropriate investigations or treatments. Clinical decisions were influenced by the patient's ability to afford both investigations and treatments and their availability. A patient with limited finances presenting with signs and symptoms of pneumonia would have to opt for blind treatment with the most affordable antibiotics instead of getting a blood test and a chest X-ray.

Doctors were held in high esteem in a paternalistic culture. Doctors gave patients very basic information about their care, and the patients did not

question their decisions. There was not much accountability for the care delivered because of a high patient-doctor ratio (which did not allow time for communication), the lack of resources, and the lack of a professional governance framework. Consequently, one could easily become complacent, unprofessional, and perhaps even unethical.

Whilst this healthcare climate was challenging, it provided a platform to integrate my Christian values with my working practice. I found my Christian walk provided a moral compass ensuring professionalism, good communication, and the delivery of good care despite the circumstances.

Practising medicine in the UK: the hurdle of passing exams

I returned to the UK in 2000 after my house jobs and completed my family. In 2004 I embarked on my next major transition – preparing for a medical career in the NHS. At this point, I had three children under five and had been working as a health care assistant (HCA) to help meet the bills. I was encouraged by a friend to sit for the PLAB (Professional and Linguistic Assessments Board) exam, but I did not think I would be successful. I was working as an HCA, looking after my kids, and had been out of medicine for four years. With the high failure rate, even amongst people who had no such commitments, I felt I had no chance of passing the exam.

PLAB was like Goliath to me. I understood how the children of Israel must have felt when they faced the Philistines. This challenge, however, would allow me to experience the truth of Proverbs 27:9 'Oil and perfume make the heart glad, and the

sweetness of a friend comes from his earnest counsel' (ESV). The encouragement, support, and counsel of good friends would see me pass the PLAB on my first try. This challenge also had me seeking after God. This helped to bolster my faith. I believed that God's hand was on my medical career and that he would see me get back on track.

Practising medicine in the UK: the hurdle of getting a clinical attachment

The next hurdle on this journey was securing a clinical attachment. These were mostly private arrangements between international medical graduates (IMGs) and a consultant willing to take them on. This was another big challenge for me with my commitments.

God, in his faithfulness, brought my way a local GP and a doctor I met via the Royal College of Physicians. With their support, a few weeks later I received an offer of a clinical attachment via a scheme run by Kings College Hospital (KCH) and Queen Elizabeth Hospital (QEH), Woolwich.

Practising medicine in the UK: the hurdle of getting registration

Becoming certified as a doctor in the UK requires registration with the General Medical Council (GMC). You could only do this when you had a job, irrespective of your PLAB or nationality status. Unfortunately, most Trusts would only employ people who are already registered with the GMC, creating a chicken and egg situation. Without registration, you could not get a job, but without a job offer, you could not get registered. Hospitals would only consider you if there was no other candidate with GMC registration. Most IMGs had to churn out hundreds of applications.

The only thing I could do was pray and trust God. By his grace, I bumped into a consultant towards the end of my clinical attachment at QEH, who offered me a week's locum on the Trust bank, enabling me to get my GMC registration.

Practising medicine in the UK: the real deal!

Transitioning to being a locum SHO was quite daunting. Isaiah 41:10 (*'Fear not, for I am with you; be not dismayed, for I am your God; I will strengthen you, I will help you, I will uphold you with my righteous right hand'* – ESV) was a key source of encouragement during this time. My first day as a locum SHO in early 2005 was covering wards on a weekend on-call. I had not been given any induction, so I had to navigate the day by asking for help and guidance from the nursing staff and other doctors, which was difficult as fewer staff were on at the weekend. I felt like a fish out of water. By the end of the day, I had barely touched any of the jobs, and handing over in the evening was an awful experience.

Despite trying to take comfort from Isaiah 41:10, I left the shift feeling helpless and hopeless, as I thought I had done a really poor job. Discouraged by this, I went back to working as an HCA. I felt I wasn't

cut out to be a doctor in the UK. I could identify with Simon Peter's comment, *'I'm going fishing'*¹

To my amazement, the locum agency called a few weeks later to say that the hospital had contacted them and asked specifically for me. If I had found favour with my colleagues, it was because of God.

This time around, it was a weekday shift. I met with the team and had an induction and a clear job description. The following weeks and months would mark my transition into the NHS system.

One of the key challenges was getting used to the fact that every diagnostic test and treatment was readily available and did not require discussions with families about affordability.

Treatments, such as renal replacement therapy, were quite new to me, as well as the whole concept of clinical governance, audits, and formal training using an e-portfolio.

The culture was completely different. Junior doctors, especially IMGs, were not respected. Some of the patients talked down to us, demanded regular updates on their treatment, and expected a high level of care and accountability despite their rudeness. Some patients refused treatment for seemingly trivial reasons, such as asking for discharge against medical advice while awaiting an angiogram to avoid missing a football match.

Despite the entitled attitude of some patients, doctors were expected to always be professional, and most were. This clash of attitudes was a massive culture shock!

Most IMGs were from minority ethnic groups and faced a lot of discrimination. This may have been because we trained abroad, but it could also be due to racism. Irrespective, there was a clear distinction between IMGs and UK graduates, who were highly confident, knew their rights, and could sometimes be extremely arrogant. I remember being berated by a fellow SHO because I had prescribed salbutamol wrongly. They clearly thought of locum IMGs as 'rubbish doctors' and treated us as such. It was humiliating and demoralising.

But my Christian faith instilled in me a godly nature, enabling me to maintain a high level of professionalism and good communication at all times. This made it easier for me to integrate. As Christians, our conduct allows us to flourish in every circumstance. Developing a Christ-like nature supersedes human weakness.

Settling into the NHS system required the humility to learn from everyone, including the nursing staff, mental fortitude to endure the hostility (mainly from patients), and the resilience to soldier on in a sometimes-hostile environment. With the support of the various mentors I had acquired on the journey, the encouragement of family and friends, and the help of Almighty God, I completed my training. I got a consultant job exactly where my journey began – the QEH in Woolwich.

is a Consultant in Acute Medicine at Queen Elizabeth Hospital, Woolwich and a Medical Examiner and Postgraduate Supervisor

My Christian faith instilled in me a godly nature, enabling me to maintain a high level of professionalism and good communication at all times



I could do that
edited by Andrew Fergusson and Steve Fouch
£3

Serving Two Masters
Paul Coulter
£7.50

Code Red
Andrew Drain
£3

Available online at
cmf for u oo store

reference

1. John 21:3

autumn 2022 | triple helix

Alice Caisley tells the story of a training initiative in South Sudan, initiated by ICMDA, that has overcome significant obstacles to bring healthcare and the good news of Jesus to some of the world's poorest people

TRANSITIONS 2

TRAINING HEALTH WORKERS THROUGH WAR & INSTABILITY



points

- Just as a new training institute for Christian health workers was about to be set up in 2013, civil war broke out in South Sudan, one of the newest and poorest nations on Earth.
- God amazingly provided an alternative training site in Uganda until a return to South Sudan in 2018.
- Graduates of the NIHS now work across the country, bringing greater access to healthcare and a significant Christian witness to communities throughout the nation.

A couple of months after we visited the potential site for the ICMDA¹ National Institute of Health Sciences in Jonglei, South Sudan (NIHS) – a Christian training institute for South Sudanese health workers – civil war broke out across the country in December 2013. This seemed disastrous for an already fragile nation with some of the worst health indicators in the world. Seventy-five per cent of people in South Sudan did not live near a trained health worker, and there were only 200 doctors for the whole country of 11 million people. We began to wonder if the NIHS would get off the ground at all.

With the country more in need of healthcare professionals than ever, the Institute's directors, Drs Anil and Shalini Cherian (a consultant paediatrician and a consultant obstetrician and gynaecologist from India), looked for alternative places to launch the training. They eventually came to an agreement with Mengo Hospital, Kampala, Uganda, and the following summer, students took the long bus journey from Juba to Kampala, and the NIHS began.

Tuor Ghai Mabiei was one of those first students and remembers the turmoil of the time.

'To begin with, I was teaching in a primary school.

The application and selection process for the NIHS is what I would name as 'God's call'. I was the last person to submit my application because I got the information one day before the deadline. I had to walk on foot for four hours to Bor Town, where people were applying, and I was lucky to get the last form.'

When the conflict erupted, he moved to another state and lost the contact details to find out the results of his application. Providentially, his brother met a friend in Juba who said Ghai had been successful and needed to get to Juba as soon as possible.

'I went to Juba, where all the successful candidates were waiting. I was lucky to join them before their departure (to Kampala), and I became the last student in the nursing class.'

Kampala was a beautiful and secure place to study, providing ample opportunity to build skills in hospitals and clinics. Also, Anil and Shalini could share the teaching load with health professionals from around the country and even the world who could fly in to train students on various topics. However, it was complicated setting up shop in a different country. A lot of time was spent sorting out visas, accommodation, and helping the students settle in. One example of their teething problems was a timetable clash at Mengo Hospital that meant

initially the NIHS could only have classes between 4 and 8 pm.

The first intake of students also took a bit of time to adjust to the new culture in Uganda. Many had never been outside South Sudan before, and one had never owned a pair of shoes! They also had the shadow of war hanging over them, concerned about family and friends back home. Tuor Ghai Mabiei says:

'We were not at peace among ourselves because we left the country due to internal conflict based on tribes, and all the tribes were in the Institute. So it was challenging accepting ourselves for the first months.'

Over the next five years, the Institute got into a rhythm, took on more students and trained 58 men and women to become midwives, clinical officers, and nurses for South Sudan. And also to bear witness to Jesus Christ as they worked. When the first cohort graduated, Dr Anil Cherian told them:

'You are going to find [a] health system which is yet to stabilise. Let the conflict there not destabilise you.'

Even in the face of instability, graduates were extremely committed to returning to work in their home country. As Simon, another graduate of NIHS said:

'I think I'm the third person who was trained as a clinical officer in my area, and I'm very glad to do that...I feel so great to go back to my village.'

After a big celebration, the graduates returned to South Sudan, a country in desperate need of these new health workers. Despite this, many found it difficult to find work.

'It was not easy to get a job because the government hospitals would complain of no vacancies and no budget to employ new staff, so I had to work in a private clinic for four months, which was later closed. Then I had to go back and teach in my primary school until I got employed in 2018 after one year without a medical job.' – Tuor Ghai Mabiei, Nurse.

Once they found a job, graduates of the NIHS faced the same pressures that new health workers experience across the globe:

'On my first day at work, I felt the responsibility of taking care of patients. As a student, you are always working under supervision, but as staff, you take the full responsibility to manage your patients.' – Tuor Ghai Mabiei.

But they also faced the additional pressure of working in an underdeveloped and unstable environment. They experienced a lack of pay, tribal conflict erupting near health clinics, and fellow health workers being killed. Almost all reported a huge shortage of staff and resources. This lack of personnel meant that graduates often rose quickly into senior positions, managing health centres and training others.

One graduate, Rebecca, was shot during her first job and ended up with a broken hand. Today, she continues to serve her people by training Primary Health Care Centre staff and Traditional Birth Attendants with up-to-date midwifery practices.

Another graduate, Angeline, works as a clinical officer in an insecure region of South Sudan and

can see over 200 patients a day:

'I love my profession to save lives. That is why I am where I am, far away from my mum. She always told me to leave this place because of insecurity. However, I tell her that God will protect me, and I love my job.'

In 2018, there was a new peace agreement in South Sudan, and the NIHS relocated back to Bor, South Sudan. The new Institute was renamed 'The Jonglei Health Sciences Institute' (JHSI). Everyone was glad to be back in South Sudan. But new challenges soon arose: patchy internet connections, little access to training hospitals and resources, fewer outside teachers, and a greater teaching burden on Anil and Shalini. Then in 2020, the Institute was struck not only by the pandemic but also by floods, making it difficult for students to get to class.

Despite the ongoing challenges of training health workers in South Sudan, Drs Anil and Shalini remain dedicated to training these students, caring for them, and teaching them the Bible, offering weekly Bible studies and annual Bible retreats.

'The best thing I like about the JHSI is the knowledge and skills I acquired from my tutors, Drs Anil and Shalini. The JHSI has provided us with some modern practices and equipment for clinical postings eg how to do blood pressures, use an obstetrics calendar, stethoscopes, and many others, which are very difficult to get in other institutes here in South Sudan...They're not just providing us with medical knowledge but also spiritual growth. This semester, we have learnt from the Gospel of Mark.' – Tereza Jok, student midwife.

Another graduate, David Lado Chance, works in a remote region of South Sudan where fighting still breaks out intermittently. He talks about the difference his training has made:

'Just recently, a neonate was brought in with asphyxia and comatose. The parents were already hopeless, crying for their beautiful and precious baby girl. In the midst of all this, I carefully reflected back to one of the lectures given by Dr Anil Cherian (paediatrician) and was able to follow the correct steps of neonatal resuscitation. The baby breathed again, and the parents were happy.'

Drs Anil and Shalini Cherian have committed almost ten years to training midwives, nurses, and clinical officers for South Sudan. They recognise that the need for health workers is vast. Their vision has always been to expand the training of Christian healthcare professionals. They want to see graduates return to their communities to transform healthcare provision and strengthen the church. So, as we look to the future, we pray for the growth and development of more Christian training centres like this that will impact South Sudan for decades to come.

For more information, please visit the Anglican International Development website: anglicaninternationaldevelopment.org, follow them on social media, or contact simon.tustin@interanglicanaid.org.

is the Communications Manager with Anglican International Development

Photos: Anglican International Development 2022



A T

2

- South Sudan has only one doctor per 65,000 people (compared with one per 250 in the UK)
- There is only one midwife per 17,000 mothers.
- Close to one in 100 mothers die in pregnancy or childbirth
- One in ten children will die before the age of five

references (accessed 19/9/22)

1. The International Christian Medical and Dental Association – icmda.net
2. Figures taken from Anglican International Development – anglicaninternationaldevelopment.org/our-work/training-health-workers-for-south-sudan-jhsi

Ruth Butlin reflects on the lessons learned on returning to general practice in the UK after many years in global mission

TRANSITIONS 3

BANGLADESH TO EAST SUSSEX



e points

- The transition back to the UK after decades in South Asia revealed the huge changes in British society and healthcare over that period.
- Moving from a Christian to a secular work environment presented both challenges and opportunities.
- A fresh perspective on UK society opened new doorways for ministry, recognising unmet and unseen needs.

aving moved from the UK to Maharashtra, India, in 1982, I subsequently moved from there to Nepal in 1991. From Nepal, I moved to West Bengal in 2001 and from there to Bangladesh in 2003.

My last major geographical move was from rural Bangladesh to East Sussex in 2007. At this point in my life, I was also transitioning from being a medical missionary (an NGO leprosy specialist) to a general medical practitioner within the NHS.

Professionally

Although I had tried to keep up with developments in general medical practice (as well as in leprosy), I had underestimated how much British general practice had changed since finishing my GP vocational training in 1981. I had no experience in keeping medical records on a computer. I was surprised by how few home visits were undertaken. I was amazed at how many apparently healthy people were cancer survivors. I was perplexed to see how many older adults were on long-term polypharmacy prescriptions. I was unfamiliar with the Quality and Outcomes Framework (QOF), which seemed to dominate much of the thinking about patient care. Even to work efficiently in a small practice as a part-time sessional GP with the kind support of colleagues was very challenging. Seeing me, a 55-year-old woman at work as a qualified GP, patients naturally

assumed I had about 30 years of experience in this type of work. The discrepancy between their expectations and my reality (no British general practice work since a couple of locum fortnights in 1981) made me uncomfortable.

Culturally

After living amongst impoverished people in resource-poor communities for so long, I was appalled at the extravagance, materialism, and waste I observed in East Sussex. This was incomprehensible to me and probably made me appear mean when I avoided expenditures that seemed trivial to others.

Although I had visited the UK many times since 1982 and maintained a constant stream of two-way correspondence with a range of UK residents throughout my time abroad, I was not as well-informed as I thought regarding changes in UK culture. The England of the twenty-first century, into which I hoped to become integrated, was not much like the England of the 1980s, which I had physically left behind (but kept in my head). Over that period, family break-up and reconstitution through divorces and remarriage (or just changes of partner) seemed to have become the normal lifestyle. Safeguarding had become a significant part of social life, whether in professional or voluntary work, with the result that (with some difficulty, because I had been out of the country) I soon had acquired a collection of CRB/DBS¹

certificates. One problem I did not expect to face with this move was learning a new language. However, I soon found that my unconsciously 'foreign' pronunciation marked me out as somehow different. It was the only outward sign of the invisible change inside me.

Until that time, I had scarcely realised the extent to which my perspective on world issues might differ from that of people who had always lived in the UK. Some of my new neighbours seemed not to appreciate that they were part of the privileged minority in the world. But I had to learn to recognise there were also unmet needs in my rural community. These included the loneliness of elderly people who could not easily go out, the despair of those whose loved ones developed dementia, and other semi-hidden problems like alcohol dependence in middle-aged, middle-class professionals. Looking around to see who were the marginalised in British society (equivalent to the leprosy-affected people in Bangladesh), I saw that those with serious enduring mental illness who needed to be detained under the mental health act were a largely unseen group of sick people. So, I became a voluntary associate hospital manager for Sussex Partnership NHS Trust, working to protect patient rights and show them compassion.²

Personally and domestically

Having lived in staff quarters on a mission hospital compound for 25 years, moving to a private house presented some challenges. Had I needed to buy or rent a place and live alone, I might not have coped, being unused to managing household affairs and maintenance myself. I was blessed in that I moved in with my father (who needed a companion since my mother had died the previous year). He gave me an informal introductory course in household management!

Initially, one of my problems was being unable to prove my identity since I had no documents (such as utility bills) bearing my home address. I had a valid driving licence, but – not having driven a car in the UK since 1982 – I would not have been safe on the roads alone and in charge of even an automatic vehicle. A neighbour who was a trained driving instructor generously gave me some lessons, and my father bravely sat with me as he had done when I first learned to drive in 1977. It was good for me to take a job, albeit part-time, as the work environment helped me to get to know people and indeed gave me a social role other than that of 'returned missionary'. This was more important than the financial benefit of working since my taste was for an inexpensive lifestyle. Finding some secular voluntary work (in Girlguiding) gradually introduced me to others outside the narrow circle of people I already knew in the area.

Spiritual aspects

Although I had been living in a predominantly non-Christian society while abroad, because most of my close colleagues and neighbours in the staff quarters were believers, and the organisation for which I worked was an overtly Christian NGO, I had existed

in a Christian bubble where daily staff prayer times and open discussion of the spiritual aspects of the work were routine. Suddenly I found myself as part of a minority of the UK population who acknowledged Christ. I was now unsure how to express my faith publicly.

I attended the local parish church but soon discovered that most of the congregation did not live in the parish. Belonging to the village church congregation helped me to understand the local lifestyle better and led to individual friendships as well as opportunities for service. Being a member of an Anglican church again (as in my youth) reintroduced me to the treasures of the liturgy, and it was such a pleasure to worship (and hear sermons) in my own language week after week! My soul benefitted from this nurture as I adjusted to a new phase of my Christian pilgrimage

A biblical model to heed

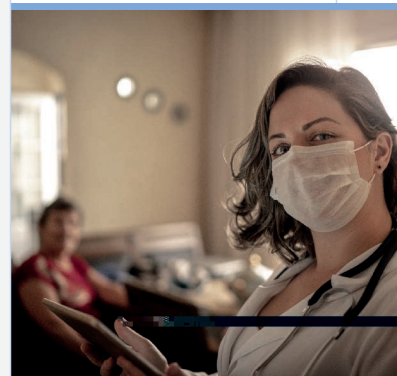
Shortly after I arrived in western India, circumstances arose that threw doubt on the feasibility of my staying long-term. I felt reluctant to put down roots, which might soon be torn up. About this time, our superintendent had invited someone from Pune Theological college to give Bible teaching to our staff. He spoke on Jeremiah 29, and it seemed to me a personal message. God told his people (who had not chosen to relocate to Babylon), *'build houses and settle down; plant gardens...marry and have sons and daughters...seek the peace and prosperity of the (place) to which I have carried you...'* (Jeremiah 29:5-7) Translated into the language of my situation, it was *'build a home, settle down, learn the language, make friends, seek the welfare of the place where I have put you...'* even though you do not know for how long you will be there.

This lesson served me well in 1984, and I applied it again in 2007. The passage continues, *'I know the plans I have for you, declares the Lord'*, (v11) which is most reassuring when you have no clear plans of your own and hesitate to formulate your hopes.

Conclusion

'Coming home' to one's own country after many years abroad is more complicated than it might appear. One has to be constantly alert for situations where one makes the wrong assumptions and could unwittingly offend someone. One has to expect to be misunderstood at times when the global perspective on issues which comes naturally to you clashes with the more parochial outlook of the local people. Tolerant Christian friends or relatives who are prepared to give candid feedback are invaluable. Deliberately targeted efforts to become meaningfully involved in community activities help a lot, and the local church is a key place to start. Recognising another mission field in the place where one now is, arouses a renewed sense of vocation, while using one's past experiences to help to open the eyes of local people to the wider world is another ministry to accept.

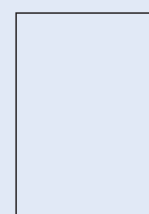
*is an ex-missionary and retired GP;
she is also part of the Triple Helix editorial committee*



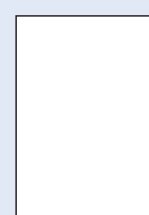
'Coming home' to one's own country after many years abroad is more complicated than it might appear



The Call to Social Justice
Peter Saunders
£3



Faith and Action
Peter Saunders
£3



Off the Beaten Track
£3.50

references (accessed 19/9/22)

1. Criminal Records Bureau, now known as the Disclosure and Barring Service – a system for checking new employees and volunteers for criminal records, especially in roles working with vulnerable groups – see gov.uk/government/organisations/disclosure-and-barring-service/about
2. Butlin R. When a Christian voice can be heard. *Triple Helix*, Summer 2018, cmf.jj/2ku9isB

Alice Gerth reflects on how the experience of becoming a mother to twins has re-framed her sense of identity and understanding of her relationship with God

TRANSITIONS 4

LESSONS

FROM EARLY MOTHERHOOD

5 points

- Becoming a mother breaks up familiar sources of identity and affirmation, showing the shallowness of all worldly sources of identity.
- Learning that the basis of our identity is in Christ, not in our careers or even our status as parents or spouses, is liberating.
- The demands of raising children can remind us of the way that God loves us unconditionally, even when we do not reciprocate.

We are continually moulded by our experiences and our relationships. Most of the time, this is a slow and steady weathering. But then there are the landslides that reshape everything. Landslides can be triggered by both sorrowful and joyful events: serious illness, bereavement, new jobs, or having children. They can leave us feeling lost until the new landscape settles and establishes itself. For me, becoming a mother was a colossal landslide. At times it has felt like all of my old identities have been washed away. When I meet new mothers at baby groups, I am Albert and Theo's mother. Conversations are about sleep and developmental milestones, not work and holidays. I feel disconnected from work colleagues. When I return, I will be a different doctor from the one that left for maternity leave. The boys will always be at the back of my mind, and my priorities will have changed.

At times it has felt like all of my old identities have been washed away

How do we, as Christians navigate our shape-shifting identities? Especially working in professions where our jobs can define us. I would like to explore with you three things I have learnt from this latest transition: the emptiness of the world's offers to help you reconnect with yourself, a deeper understanding of my foundational identity as a child of God, and a wonder for God's unconditional love.

Firstly, the emptiness of the world's offers to help you find yourself. In those first few weeks, you put yourself aside to care for your baby, whether that be feeding with cracked, painful nipples, cuddling

them back to sleep when you can barely stay awake, or changing a particularly unpleasant nappy when you yourself are unwell. As you suppress your needs, you can lose yourself. Beyond the newborn phase, you remain lower down the priority list – packing for a holiday, your suitcase is packed last after the children's (and in my case, the dog's!), regularly resulting in you forgetting something.

The world's answer is either to embrace it or fight it. The 'embrace it' option involves becoming 'super mum'. Follow these accounts on Instagram to provide your child with excellent sleep and nutritious weaning, or attend these baby classes, which will help you connect with your baby and make new friendships with other mothers. The problem is that these set unrealistic expectations. Instagram and TikTok aren't true representations of motherhood. They are the glossy, edited version of cuddles and cuteness. The baby classes don't lead to the friendships you'd hoped for or become another stressful outing right in the middle of your child's preferred nap time. As a result, you can be left feeling like you are letting your child down.

The 'fight it' solution is to find a fitness class to get your pre-baby body back, get help, and not let your baby stop you from doing the things you love. This leaves you feeling like you are letting yourself down.

In and of themselves, baby classes and getting fit, etc. are not bad things. However, it is a fallacy to suggest that they will answer the questions of 'who am I?' and 'who have I become?'.

This brings me to my second point. As a Christian, the foundational identity I have is as a person made in the image of God. God does not see me any differently now that I have Albert and Theo. I am still his dearly loved daughter. Jesus still died for my sins. My worth is not dependent on being able to get Albert to sleep, or when Theo can sit independently, the boys being non-fussy eaters, how many new friends I have, or when I can run a 5k again. This firm foundation helps me adjust to the new version of myself.

The Bible is full of mothers, but there aren't many stories exploring the challenges of motherhood. You see fleeting glances – the prostitute who would rather give up her baby than see it shared (1 Kings 3:16-28); Hannah who, on having her prayer answered for a son, offers Samuel back to the Lord (1 Samuel 1:28); and women pleading with prophets and Jesus to heal their children (for example, 2 Kings 4:18-37 and Matthew 19:13-15). In these stories, you see God's love for the women involved. God sees the individual and answers their prayers. In the same way, he sees each and every mother and the challenges and joys that they face. He rejoices with those rejoicing and weeps with those weeping. God is present and hears my prayers, whether it be at 3 am or 3 pm. Thankfully, the Spirit intercedes when I'm too tired or frustrated to find the right words. With God's strength, I can accept my fragility.

Finally, I have a new sense of awe at God's unconditional love for us. The boys were born six weeks early. Thankfully they didn't need to spend any time in NICU (Neonatal Intensive Care Unit) and so came home at five days old. However, this early arrival meant that we had a prolonged newborn phase. They didn't learn to smile until twelve weeks, had tiny stomachs, were slow feeders, and wanted to be held all the time. Towards the end of this season, I was desperate for some sort of acknowledgement from them that they appreciated all that I was doing for them. Now, when they smile at me, my heart melts. Those first few weeks are a metaphor for God's experience of loving us. He showers us with good gifts, and for much of our lives, we don't acknowledge him. He even sent his Son to die for us whilst we were still sinners, which now I have my own sons, is even more overwhelming. Then when we look up and smile at him to say thank you, there is a celebration in heaven. I struggled to love my boys unconditionally for twelve weeks – God loved me for years before I smiled at him.

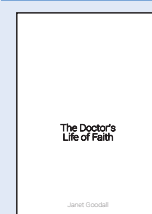
God's love for us is costly, not just because Christ died for us, but because it is so one-sided. Having my own children is slowly developing my understanding of what it means for God to choose to be 'our Father' rather than simply our King or Deity. It carries a level of personal cost at the pain of rejection, as well as a need for endless patience as we do another silly thing requiring forgiveness.

In summary, my understanding of who I am as a child of God continues to evolve as new facets of my calling are exposed. The foundation I have in Christ gives me reassurance that I can weather life's storms. As I transition into motherhood and my understanding of this facet of my identity evolves, so does my understanding of what it means for God to be Father.

is an anaesthetics registrar and a member of the Triple Helix editorial committee

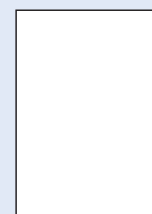


I have a new sense of awe at God's unconditional love for us



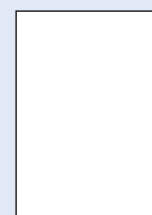
Doctor's Life of Faith

Janet Goodall
£5



Human Journey

Peter Saunders
£7



If Only

Jennie Pollock
£6

Simon Ramsbotham

suggests that retirement may offer new opportunities for Christian doctors' service to God

TRANSITIONS 5

DOUBLE HARVEST



e points

- Many doctors are reconsidering their retirement options in the light of COVID-19 and the subsequent long-term pressures on the NHS.
- Phasing retirement or returning after a period away from practice can offer ministry and giving opportunities.
- There are challenges to serving the Lord this way, but for some, it may be a great way to expand their Christian ministry through the twilight years of their professional lives.

or the last two years, doctors in the UK have had to adapt to new pressures of work and to new ways of working because of the pandemic. The Covid

pandemic seems to be moving into a new, less acute phase. Many doctors have delayed retirement or, having retired earlier, have returned to work to help with the crisis. Now many are rethinking their next steps.

However, it seems that there has been a growing tendency in the UK for doctors to retire earlier than in previous years. Now that the immediate need created by the pandemic is receding, perhaps now is the time to re-examine the retirement question for Christian doctors and what it means for the NHS and the kingdom of God.

So why are so many doctors in the UK retiring at 60 or even in their fifties and, in many cases, deregistering? Do we suddenly lose our skills at 60? Or do we suddenly become dangerous as soon as we get our lump sum and pension?

How is it that at the one moment in the history of the NHS when there is an increasing shortage of

doctors, especially GPs, so many of us want to hang up our stethoscopes as soon as we hit 60 or earlier when we still have so much more to give?

Many Christian doctors at retirement begin a new medical career in the developing world. Others focus on pastoral care in their local church or become pastors and vicars. Some become hospital chaplains. This can be an excellent way to use our transferable skills. Others focus on evangelism through hospitality or looking after aged and infirm parents. They have not retired. They have changed their place of work in God's plan for their lives.

However, for some of us, there is another way. Why, after taking our lump sum and drawing our pension, retire from the NHS at all? Of course, we do not have to go on working full time. There are endless opportunities to continue as locums or salaried partners. For GPs, this could mean continuing in our practice. If this means standing in the way of younger doctors, it might be preferable to do sessions in another practice, which is what I did after retiring at 64 from the practice where

I had been working since the age of 30.

At the end of September last year, I finally retired fully and permanently from medical practice at 72.



Mark Pickering looks at the roots of the modern medical mission movement and how they fed into the founding of CMF

LESSONS
FROM THE
ARCHIVE
EPISODE 2

THE BIRTH OF MODERN MEDICAL MISSION

TO CHINA, EDINBURGH, AND THE 'ENDS OF THE EARTH'

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 second of a series of articles featuring some of the main highlights.



Key points

- Medical mission has ancient, deep roots but did not intentionally marry a strategic concern for health and wellbeing with the proclamation of the gospel until the 1820s.
- Empire, trade, and war created the pathways for medical missions to go into Asia and Africa in the mid-to-late nineteenth century.
- While engaged and committed overseas, many of the most impactful and long-lived medical missions also looked to take care of the health and spiritual needs of Britain's own urban poor.

In my last article,¹ I outlined the birth of the Christian Medical Association in 1854, which led to the Medical Prayer Union in 1874. These associations of Christian doctors contained many who were great supporters of medical missionary work. But how and when did medical mission begin? This article will sketch out some of the main features of this incredible movement.

The first beginnings

Catholic Jesuit missions experimented with healthcare projects in the sixteenth and seventeenth centuries, particularly in Japan and the Philippines.² During this period, European Protestants were understandably preoccupied with establishing the Reformation in Catholic countries. However, by the early eighteenth century, a few were beginning to reach out further, such as the Danish-led missions to South India from Halle in Germany. Caspar Schlegelmilch, the first physician sent out by this mission in 1730, sadly died of dysentery after less than three weeks!³ Mission was a risky business in those early days.

Better known to many evangelicals is William Carey, who founded the Baptist Missionary Society (BMS) in 1792 and became a pioneer missionary in West Bengal, India. Less well known was his mission partner, Dr John Thomas, who was actually the BMS's first missionary (Carey was appointed second). Thomas had been converted as a naval surgeon with the British East India Company (EIC). He had done independent missionary work in

Calcutta before returning to England, meeting Carey, and convincing him to go with him to India instead of his original planned destination of Tahiti!⁴

Other early pioneers included John Scudder, an American doctor who went to work in South India in 1819. He was the first of several Scudders who continued his work, including his granddaughter Ida, who founded the famous Christian Medical College at Vellore, which still exists today.⁵

Medicine as a multiplier of mission

Many of the early intersections between medicine and mission were sporadic. This began to change in the 1820s as some realised the immense strategic value of medical practice to the spread of the gospel message itself. Karl Gützlaff was a German missionary who worked in Thailand and China. Although not formally trained in medicine, he had some basic medical knowledge, which he used to great effect. He realised that compassionate, physical healing often communicated far more than words, opening the way for many to listen to the Christian message. Gützlaff promoted the concept of medical mission and inspired great medical missionaries such as David Livingstone and Hudson Taylor, who founded the China Inland Mission.⁶ He was also very influential on Peter Parker in his early years in China.⁷

Many other changes were happening in the world at that time. With the expansion of trade and empires, many Western nations were coming into much greater contact with those of other nations and cultures. Western scientific medicine was

making great strides and, in many cases, had a real opportunity to reduce suffering.

Revolution in China

In God's providence, several key people and factors coincided in southern China in the 1830s, resulting in a significant gear-change for medical missions. At this time, Western trade with China was limited to just two locations centred around the Pearl River delta - the city of Canton/Guangzhou, and the Portuguese island colony of Macao at its mouth. Several Western nations had trading outposts there, including the EIC, amongst whose employees was a young Christian surgeon named Thomas Colledge.

Colledge had trained at St Thomas' Hospital in London before taking up this role. The EIC's generous salary enabled him to devote time, resource, and energy to relieving disease in the local population. He quickly realised that surgical skills were particularly limited in China, and his own proficiency in ophthalmology meant he could make a dramatic impact by performing surgery for cataracts and other eye conditions. He opened a small eye hospital in 1827 in Macao before moving upriver to Canton in 1828, where he set up a similar hospital.

The next significant factor was the arrival of Peter Parker, a young American who was apparently the first anywhere to obtain dual training in theology and medicine with the deliberate aim of being a 'medical missionary'. He arrived in Canton in 1834, where he soon teamed up with Gützlaff, Colledge, and others.

Over the next few years, they developed their ideas further until, in 1838, they formed the Medical Missionary Society in China (MMSC) – the world's first medical missionary organisation. Remarkably far-sighted, they aimed to attract many others to follow their example, producing printed appeals in the UK and USA particularly, and calling mission agencies to send other 'pious physicians' to do the same.⁸ God's timing, again, was remarkable. The setting up of the MMSC owed much to Thomas Colledge, and its final establishment in 1838 occurred just weeks before he left Canton forever. He did, however, remain its honorary President until his death in 1879.⁹

Problems are opportunities in disguise

The international trade that had brought the gospel to China also brought darker forces. Western nations wanted many of the exotic goods that China could supply. Yet China wanted little of European goods, creating a problematic trade deficit. However, there was one lucrative product the West could export to China – sadly, that was opium, grown in India and sold in China. Chinese authorities resisted this, sometimes by force, in what became known as the Opium Wars.

The First Opium War was in 1839-1842, ending with the Treaty of Nanking, which ceded Hong Kong Island to the British Government.¹⁰ The fighting made Parker's medical work impossible, forcing him to leave in 1840. But far from ending his influence, this flung it worldwide. In some ways, it was like the

Apostle Paul's imprisonment in Acts, which caused him to write many of the letters we know and love from the New Testament today. Parker returned temporarily to the USA but also spent time in the UK and France, spreading the cause of medical missions and the work of the MMSC. He met many notable Christians in London and Edinburgh in the summer of 1841. This catalysed the birth of two medical mission organisations with very similar origins but very different outcomes.

The Syrian Medical Aid Association

Parker's visit to London helped stimulate the launch of the Syrian Medical Aid Association (SMAA) in 1841. Two of the chief organisers were Thomas Hodgkin (discoverer of Hodgkin's Lymphoma – a Quaker who was a pathologist at Guy's and then St Thomas' Hospitals and who became a good friend of Parker) and Culling Eardley Smith (who went on to help found the Evangelical Alliance in 1846).

The SMAA got off to a quick start, recruiting a missionary doctor to go to Lebanon and later another to go to Damascus. Sadly, it did not last and had completely evaporated by early 1847, leaving Hodgkin saddled with personal debts. Despite lofty ambitions and wealthy backers, the SMAA went too far, too fast, overcommitting itself to complex situations that it had not understood properly. When complications came, and early enthusiasm waned, there was little solid base on which to stand.¹¹

The Edinburgh Medical Missionary Society

It was a different story when Parker visited Edinburgh, also in 1841. Local Christian doctors formed a committee, which soon became known as the Edinburgh Medical Missionary Society (EMMS). Instead of making the mistake of the SMAA and committing themselves early to send out their own missionaries, the EMMS promoted the concept of medical mission, especially amongst students, and raised awareness and funds for the work of the MMSC in China, and the SMAA in Syria.¹² They also found time to encourage Dr Golding Bird in 1853, spurring on his early efforts to found the Christian Medical Association (see the previous article in this series).¹³

This slow and steady approach must have been frustrating to some, but it clearly paid off in the long run, as 180 years later, EMMS is still going strong!¹⁴ During that time, hundreds of medical missionaries have given service totalling thousands of years in dozens of countries – their inspirational stories would take a lifetime to tell!

Just one well-known story is that of Dr Kaloost Vartan, an Armenian doctor who trained in Edinburgh under the EMMS and was inspired by this to go to Nazareth in 1861, founding the Nazareth Hospital. This incredible institution is

1787

James
Carey & John
Thomas, India

1819

John
Scudder,
India

1820

Karl Gützlaff,
Thailand &
China

1827

Thomas
Colledge,
China

1834

Peter
Parker,
China

1838

Medical
Mission
Society
in China

1841

Edinburgh
Medical
Missionary
Society

Syrian
Medical Aid
Association

1853

William Burns
Thompson and
the Cowgate
Dispensary



William Carey

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 at admin@cmf.org.uk

Available in the online edition of *Triple Helix*, David Cranston on whether medical mission is still needed today
cmf.li/3SgKQ8t

references (accessed 12/9/22)

1. Pickering M. *Golding Bird and the Christian Medical Association. Triple Helix*. Spring 2022. cmf.li/3AK9834
2. Grundmann C. *Sent to Heal!* Lanham. University Press of America, 2005: 22-29
3. Grundmann 31-35
4. Carey SP. *William Carey*. London: Hodder & Stoughton, 1923: 96-105
5. Ida S. Scudder. *Wikipedia*. bit.ly/3Rd13es
6. Grundmann 51-56
7. Grundmann 63-64
8. Medical Missionary Society in China. *Internet Archive*. bit.ly/3cF309n
9. A fascinating biography of Thomas Colledge has recently been written by his great-great-grandson. See Colledge R. *Medicine and Mission*. Malvern. Aspect, 2020.
10. First Opium War. *Wikipedia*. bit.ly/3TzVmJ9
11. Kass A. The Syrian Medical Aid Association. *Medical History*. 1987, 31: 143-159. bit.ly/3B8am9L
12. Lowe J. *Medical Missions – Their Place and Power*. Edinburgh: John Menzies, 3rd ed, 1890: 201-205
13. Pickering 2022
14. EMMS International. emms.org
15. The Nazareth Trust. nazarethtrust.org/about/our-history
16. These will be further outlined in a future article in this series.
17. The Mildmay Mission Hospital will feature in a future article in this series.
18. The Christian roots of modern nursing will feature in a future article in this series.
19. A good example is *Interserve*, formerly the Zenana Bible and Medical Mission – interserve.org/our-story
20. Matthew 13:1-23

still a beacon of light and hope to the local region today, supported by the Nazareth Trust, now independent of EMMS International.¹⁵

William Burns Thomson

Back in the slums of Edinburgh, a local Christian doctor started a dispensary in 1853, providing free medical care for the poor people of the area. This gradually became more closely associated with EMMS and, by 1861, was their official 'training institution', relocated to the Cowgate area of Edinburgh. Medical students could live in the EMMS Hostel under the watchful eye of the Superintendent, Dr William Burns Thomson. In this supportive, mission-minded environment, they were trained in 'home medical mission', both providing free medical care to the population and sharing the gospel with them. Through this strategic arrangement, many students went on to serve as medical missionaries all over the world; both sent directly by EMMS and by other mission agencies.

Dr Burns Thomson was a force of nature for the cause of medical missions. Originally planning to be a non-medical missionary, he was on a pastoral visit in the tough slums of Edinburgh when a woman mistook him for a doctor. Her demeanour instantly changed. She listened intently and gladly received his prescription of gospel truth along with the castor oil he had suggested for her ailments! Sensing a strategic opportunity, he applied for medical training. Although he never worked overseas as a medical missionary, Thomson had incredible influence, training students in the Cowgate, publishing and circulating inspiring stories from his contacts around the world in the *Medical Missionary Journal* and championing the cause of 'home medical mission'. The mission dispensary he ran in Edinburgh gave rise to many others based on its model – in Aberdeen, Glasgow, Birmingham, Liverpool, and London, to name a few. The London Medical Mission was foundational to the birth of the Medical Prayer Union and the Medical Missionary Association in the 1870s.¹⁶

Dr Burns Thomson later retired to London, where he lived on the compound of the Mildmay Mission Hospital, working as a chaplain to support the Mildmay nurses, many of whom also went out to mission hospitals all over the world.¹⁷

To the 'Ends of the Earth'

The middle decades of the nineteenth century saw the medical mission movement begin in earnest, slowly gain traction, and then finally begin to grow exponentially. More and more people grasped medical mission's immense strategic importance for relieving suffering and multiplying gospel influence holistically, much as Jesus himself went about 'proclaiming the good news of the kingdom and healing every disease and sickness'. (Matthew 4:23)

As we look back from our current vantage point, however, the movement is not without its controversies. The key players in the early decades were virtually all white men from Europe or the USA.

'This is less surprising when we realise that it was not until 1849 that the first woman was permitted to qualify as a physician in the USA, and 1865 in the UK. Also, the vast waves of missionary nurses who have contributed so much to the movement mostly came a little later, as mission hospitals became more established and the modern nursing profession was codified.¹⁸ Hundreds of female missionary doctors also served as medical training opened up and as the need became clear to reach the many women secluded in the harems and zenanas (female domestic quarters) of South Asia and the Far East. This prompted entire missions and training centres as part of the Zenana medical missionary movement.¹⁹

We also see how so much of the early medical mission movement was mixed up with colonialism and the expansion of the military and trade networks of Western empires. Many indigenous physicians and other local assistants were crucial to the projects led by Western pioneers whose names are better known. Most Western missionary physicians had a genuine, deep desire to serve indigenous populations who were equally made in God's image. But despite this, it was sometimes hard to avoid (or even recognise) implicit feelings of cultural superiority that can jar painfully in today's globalised, multicultural world. These underlying assumptions are quite rightly being reappraised by contemporary thinkers, but in doing so, we must take great care not to swing too far the other way. Genuine humility, careful listening and equal partnership are always vital in any cross-cultural situation. The CMF Global team are wrestling with the challenging contemporary implications through our 'Western Saviours?' working group.

What can we learn from the early medical mission movement?

This brief survey of a complex and fascinating movement can teach us numerous lessons for today:

- It was a product of its age – rapid changes in medicine, trade, and empire brought great opportunities but also many complications. We should always be willing to reappraise Christian history through a biblical lens.
- God's amazing providence is evident throughout – chance meetings, difficult people, even wars – the Lord uses them all to accomplish his purposes!
- The importance of training students early is shown to great effect by the example of the EMMS.
- The contrasting stories of the SMAA and EMMS remind us that steadily building something that lasts is better than growing fast and then fading away – see the parable of the sower!²⁰
- Medical mission was once 'new' and 'strange' and took decades to become well established. We should never be afraid to try something new that has not been thought of before – it might just change the world!

is CMF Chief Executive

Susie Howe and Paul Stockley look into an area of physical and spiritual abuse that all Christian healthcare professionals need to be aware of

CHILD WITCH ACCUSATIONS

This is a summary version of a longer article that explores in depth the forms and root causes of CWA and ways in which it can be identified and tackled. We recommend you read the full article online on the CMF website at cmf.li/CWA – please note, some of the stories and practices described in the full article are very disturbing.

itches crop up in every culture, but definitions vary. In some contexts, words translated into English as ‘witch’ refer to a person who is believed to use occult powers in secret, typically at night, to harm others.¹ In cultures where an overriding ‘fear versus power’ dynamic² is pervasive, such as those found on the African continent and Latin America, a dominant worldview can prevail in which an invisible, unseen world of malevolent spirits is believed to intimately interconnect with the seen, physical world, causing harm. In such cultures, the belief that witches, or ancestral spirits, can curse and cause sickness, death, loss of crops, or unemployment (for example) is common.³

In such cultures, when something goes wrong, the response is not, ‘What has caused this?’ but rather, ‘Who has caused this?’ Suspicion tends to fall on the most vulnerable members of the community – that is, those least able to defend themselves, such as orphans and widows – the very ones that the Bible exhorts us to nurture and protect.⁴

Child witch accusations (CWA) happen in the UK and many other parts of the world. Accusations of being a witch can be made against anyone, young or old, but in recent years have become more common against young people. Children and young adults are accused by the community of causing a calamity – from failed crops to disease or death. The children in question may be subjected to violent exorcism; this can include burning, beating, drowning, starvation, or other forms of abuse.

The scale of the problem is unclear. CWA is a hidden issue, shrouded by fear and secrecy. There has been very little systematic reporting on the numbers of children who have been accused of being witches. Neither has the issue been on the radar of most agencies working in regions where CWA are prevalent, leading to a lack of related research.

Children who are ‘different’ in some way are particularly vulnerable to accusations of practising witchcraft. As part of the research for a Save the Children report,⁵ religious leaders and community members compiled a list of ‘signs’ that a child was a witch. These included: children who are thin and pot-bellied; those with scabies, unclean clothes, and dirty bodies; those with epilepsy, deafness, or other disability; aggression, disobedience, sadness; children perceived to be too wise, too clever, too courageous, too nice, quiet, rude, inattentive, full of initiative, fearful; those who sleep badly, wet the bed, defecate in their clothes, and sleepwalk. Many of these so-called ‘signs’ are part of normal child development, or are

common among those living in poverty, suffering neglect or trauma, or experiencing health conditions and disabilities. Hence children of all ages and stages could be at risk of CWA.⁶

CWA is not limited to non-Christians. Indeed, it is prevalent in some streams of churches, particularly those in Central, East and West Africa, with pastors taking on the role that a diviner or witch-doctor would have taken in earlier times. Such church leaders can make a lucrative business out of divining and exorcising so-called ‘witches’. Many of these pastors and their congregations wed animist and spiritist beliefs to the gospel, misinterpreting and misapplying Scriptures such as Exodus 22:18 to justify the abuse. Many other African church leaders recognise this for the deception it is and seek to challenge CWA, but it is a hard struggle.

As health professionals we can all come across children subject to CWA, whether we are working globally or in the UK, so it’s crucial that we know how to respond. It is a very real safeguarding issue. The good news is that there are active strategies to tackle the problem of CWA, and networks to support those encountering it.

Further help and resources

Stop Child Witch Accusations (SCWA) Coalition is an international Christian network working with churches to end CWA. You can find out more on the SCWA website stop-cwa.org **thirtyone:eight** is an independent Christian charity which helps individuals, organisations, charities, and faith and community groups to protect vulnerable people from abuse. They have a helpline 0303 003 11 11 and further information at thirtyoneeight.org

is the Founder of The Bethany Children’s Trust, and a founding member of the SCWA Coalition.

is an independent consultant working with Amor Europe, and a founding member of the SCWA Coalition.

references (accessed 19/9/22)

1. Cimpric A. Children Accused of Witchcraft: an anthropological study of contemporary practices in Africa, UNICEF, 2010, 8
2. Note: there are at least four common dynamics present in cultures worldwide (fear versus power, shame versus honour, guilt versus innocence, and taint versus purity), with different dynamics more predominant in different cultures and subcultures.
3. Georges J. *The 3D Gospel: Ministry in Guilt, Shame, and Fear Cultures*. London: Time Press, 2017. Note: Georges only distinguishes three of the four common cultural dynamics.
4. Exodus 22:18; Deuteronomy 24:17; Psalm 68:5; Psalm 82:3-4; Isaiah 1:17; James 1:27
5. Molina J. *The Invention of Child Witches in the Democratic Republic of Congo*. Save the Children, 2005: 12
6. Cimpric 2010: 16

John Greenall looks at what our members and research are telling us about being resilient disciples of Jesus working in healthcare

RESILIENT DISCIPLESHIP IN HEALTHCARE

Key points

- We set out to follow up on existing research to find out what makes resilient disciples of Jesus Christ in the modern healthcare professions.
- We found that many of the characteristics of such disciples, as found in other research, were the very qualities CMF's training tracks and volunteer programmes sought to foster.
- We looked at some small samples of members to see if this held true in the lives of those who had been through our tracks and programmes and present a summary of the evidence here.

It happened at every changeover in August and February. Would any of my new colleagues be Christians? How long would it take to find out if any of the staff on my ward shared my faith? Maybe, like me, you look around our increasingly secular landscape and feel oddly alone. Perhaps you relate to Daniel and his friends as they arrived as exiles in Babylon,¹ temporary residents in a land not their own and hostile to Christian beliefs.² This 'feeling' is supported by the facts. Only five per cent of the UK population now attend church.³ Seminal research by the Barna group in the United States, the 'You Lost Me' report, tells us that nearly two-thirds of all young adults who were once regular churchgoers have dropped out.⁴ This is sobering stuff.

And yet...The Bible shows us people like Daniel, Joseph, and Esther who model the importance of spiritual preparation. They also demonstrate a clear principle: that God uses early experiences to shape the hearts and minds of his servants. So how do we thrive in our 'Babylon'? How do we grow as disciples of Jesus and lead others to do the same? And how is CMF placed to develop such resilient faith?

Resilient disciples

In 2019, Barna released '*Faith for Exiles*'⁵ to help us better understand how to develop disciples in 'digital Babylon'. They identified a small group, around ten per cent of the 100,000 18-29-year-olds they sampled who grew up as Christians, whom they term 'resilient disciples'. They are exiles who remain faithful to their true home, a countercultural group of young Christian people whose faith is robust and who display four key characteristics (see Box 1). Barna's research showed that resilient disciples engage in five essential practices (Box 2).

Box 1: Resilient disciples

- Attend church at least once a month and engage with their church more than just attending worship services
- Trust firmly in the authority of the Bible
- Are committed to Jesus personally and affirm he was crucified and raised from the dead to conquer sin and death
- Express desire to transform the broader society as an outcome of their faith

Box 2: Five Practices that characterise resilient disciples

- Practice 1: Experience intimacy with Jesus
- Practice 2: Develop the muscles of cultural discernment
- Practice 3: Forge meaningful, intergenerational relationships
- Practice 4: Train for vocational discipleship
- Practice 5: Engage in countercultural mission

We realised that CMF's training track programmes (Box 3) foster several of these practices. These are peer-learning communities of 6-24 members keen to learn and grow in organisational, thought, specialty, cross-cultural, and social justice leadership, and evangelism and apologetics.⁶

Box 3: CMF Tracks & Committees (total numbers involved, 2015-2022)

- Evangelism and Apologetics Track (28)
- Speakers Track (23)
- Global Track (68)
- Health + Justice Track (22)
- National Student Committee (70)
- Junior Doctors Committee (27)
- Nurses and Midwives Advisory Committee (13)
- Deep:ER (41)

CMF Tracks focus on developing a close walk with Jesus, cultural discernment, critical thinking, theological literacy, and more. We prioritise intergenerational learning relationships with mentors, developing vocational leaders⁷ passionate about disciple-making. As learning communities, we encourage one another to live counter-culturally with a missional outlook.

To become 'resilient disciples' in our digital and fragmented world we need, more than ever, to be in small, peer-learning communities like Jesus led.⁸

Resilient discipleship in CMF

Over the past year, we have researched and published a study seeking to replicate these findings in a vocational healthcare setting in the UK.⁹ We surveyed 200 students, junior doctors, and nurses, and seven alumni of CMF Tracks. Our retrospective study contained quantitative (questionnaire-based) and qualitative (semi-structured interviews) elements. Within the group of those classified as 'resilient disciples' we looked at whether any patterns emerged in their characteristics of faith and practice.

Some key findings include:

- Ninety-two per cent of respondents fit the profile of a 'resilient disciple'. CMF seems to disproportionately attract such young people in the earlier years of study and training.
- Whilst based on a very small sample size, our data would tend to agree with the Barna research that resilient disciples and non-resilient disciples differ in characteristics. For example resilient disciples were more likely to:
 - have a mentor (70 per cent vs 33 per cent)

- belong to a Christian group outside of church (77 per cent vs 57 per cent)
- serve in church or other Christian settings (91 per cent vs 71 per cent); and
- consume Christian content (a median of 30 vs 15 minutes a day)

Meaningful relationships, vocational discipleship, and countercultural mission were central as in Barna's original research. Some key conclusions and implications:

- CMF is one of many organisations training small numbers in peer-learning communities, spearheaded by our training Tracks.
- CMF and like-minded organisations are well placed to deliver this vocational, countercultural training and to resource and equip the wider church.
- CMF needs to focus on what only we can do, ie discipleship focused around the interface of faith and professions. Both our and Barna's research imply that focusing this way is more effective.
- Mentoring is key; intergenerational relationships focused on being countercultural in a specific area of life and practice. CMF is developing mentoring programmes, training, and guidelines to help develop these relationships.¹⁰
- One of CMF's primary aims is to promote Christian values in society.¹¹ Our research suggests exercising Christian beliefs, practices, and values in the workplace might be considered a form of 'mission'.
- Our research did not focus much on how CMF reaches and draws in those more on the periphery. We must consider how we effectively engage with less engaged members, creating a clear pathway from 'lower level' to 'higher level' engagement.
- Thousands of Christian doctors, nurses, and midwives are not CMF members. Given the benefits attested to in this research, they might be missing out. CMF has a role in sharing knowledge and being a welcoming community for Christian healthcare workers.

Conclusion

Feeling like exiles should not surprise us; it can be isolating and challenging. Yet we have seen exiles thrive in Babylon before, and we can see it again. It would appear CMF has a role in supporting and encouraging churches to teach and mentor into vocational spheres like healthcare, offering discipleship communities where we nurture resilient faith.

Let's pray that God would raise up many 'resilient disciples' who lead and catalyse others to be whole-life disciples, leaders of the present and the future, united and equipped to live and speak for Jesus in medicine and nursing.

For more details about training with CMF visit cmf.org.uk/volunteer or email volunteer@cmf.org.uk.

To read the full research please see: cmf.li/ResilientDisciple

*is CMF Associate CEO
and a paediatrician in Bedfordshire*



**BOOK
STORE**

Discipleship: Serving Without Sinking

John Hindley
£8

Foundations

CMF
£20



Surviving the Foundation Years

Peter Saunders
£3

Available online at
cmf.org.uk/bookstore

references (accessed 19/9/22)

1. Daniel 1
2. 1 Peter 1:1; 2:10-12
3. Brierley P. *Estimates of Church Attendance in Britain, 1980-2015*. bit.ly/2XilZF7
4. See the research summarised in Kinnaman D. *You Lost Me: Why Young Christians Are Leaving Church... and Rethinking Faith*. Ada: Baker Books, 2016
5. Kinnaman D, Matlock M. *Faith For Exiles: 5 Ways for a New Generation to Follow Jesus in Digital Babylon*. Ada: Baker Books, 2019
6. For more details see Greenall J. Leadership: 'out-there' & 'in-here' leadership. *Nucleus*. 2017;47(2): 22-24. cmf.li/3cJnbhw
7. Greenall J. Leadership: vocational discipleship. *Nucleus* 2017;47(3):20-22. cmf.li/3KDV7IZi
8. eg Mark 3:14
9. Rayel I, Greenall J. Factors Contributing to Resilient Discipleship in Healthcare. *CMF*. September 2002. cmf.li/ResilientDisciple
10. For more information see CMF's Pastoral Care, Wellbeing and Mentoring service at cmf.li/3cF35ou
11. cmf.org.uk/about



Finding Grace in the Face of Dementia

John Dunlop MD

- Crossway, 2017, £10, 208pp, ISBN: 9781433552090
- Reviewed by **Ruth Eardley**, a GP in Market Harborough and a member of the *Triple Helix* editorial committee

ementia, dignity, and honouring God. How these three unlikely bedfellows are not mutually exclusive but, in God's economy, entirely harmonious, is this book's main theme. As an experienced geriatrician, John Dunlop knows his subject and illustrates his points with clinical histories. He is also grounded in medical ethics and both his parents had dementia.

Although written for a lay readership, medics will recognise the scenarios and 'the good, the bad, and the ugly' in terms of symptomatology. The author lays biblical foundations for understanding the tragedy of suffering, considers diagnoses, treatment, and what dementia feels like for both patient and caregiver. His exploration of inherent, made-in-the-image-of-God dignity is a challenge to societal ideas of 'worth' and chapter eight (How Can We Honour God through Dementia?) is the highlight of the book; so good I read it twice.

There is a useful index and I particularly liked the short prayers at the end of each chapter. They are straightforward, honest, 'pray-able' prayers that beautifully condense our bewilderment and pain. There is an American bias, as you would expect, but the stories are universal. The approach is direct, kind, realistic, and reassuring. Above all the author is confident in God's sustaining grace and the ability to discern his image, even when dementia ravages those we love.

Highly recommended.

Denis Burkitt

A Cancer, the Virus, and the Prevention of Man-Made Diseases

John H. Cummings

- Springer, 2022, £35, 437pp, ISBN: 9783030885625
- Reviewed by **David Cranston**, an Associate Professor of Surgery at the University of Oxford, and an Honorary Consultant Urological Surgeon at the Oxford University Hospitals Foundation Trust.

enis Burkitt is a name known universally not only for the lymphoma that bears his name but also for his work on dietary fibre and Western diseases. A committed Christian, he was a lay reader in the Church of England and President of the Christian Medical Fellowship in 1967. On the one hand, this is the most comprehensive biography of Burkitt published to date, while on the other, it reads like a detective novel tracing the search for the cause of Burkitt's lymphoma.

Written with the full support of his family, the book takes excerpts from his personal diaries and family archives as it follows his journey from his evangelical, Irish Protestant roots, to the Colonial medical service in Uganda. It also speaks poignantly of the cost to his wife, Olive, and relates her repeated bouts of depression.

During his two decades in Uganda, the book traces the way some of Burkitt's strict views (no alcohol, cinema, theatre, or dancing) were modified under the influence of his wife. He was able to qualify as a surgeon, despite the loss of one eye at the age of eleven, and often said that God gave him the ability to see with one eye what many had failed to see with two.

Never one for spending money unnecessarily, he would usually travel economy when flying, and did not enjoy the social functions that he had to attend in Uganda as a Colonial Surgeon and even less the bigger events as his fame spread. But he was a man who always gave credit to others for the work they did.

At ease with royalty or students, humble and gracious in his demeanour the book paints a picture of an internationally respected, deeply Christian man who only on rare occasions let pride get the better of him, and who always felt that the fellowship of Christian believers meant more to him than the Fellowship of the Royal Society.

Walking with communities

Ian Campbell, Alison Rader
Campbell, Robin Rader

- Salvation Books, 2022, £25, 325pp, ISBN: 9781911149859
- Reviewed by **Fi McLachlan**, Head of CMF Global

'...Not outlining a theory, but is a powerful testimony to the presence of God everywhere and in every situation. How care can lead to lasting hope and change. It describes mission at its best'

These introductory remarks to this beautifully presented, and engaging 'non textbook', do sum up the stories it tells from around the world.

Ian, Alison, and Robin recount a listening and appreciative approach to integrated mission. As healthcare workers, seeing the relevance and need to engage communities in addressing their own issues, their aim is to engage and provoke anyone on the journey of integrated mission.

The book outlines an approach called SALT – exploring **stories**, an **appreciative** (rather than deficit) mindset, **learning by listening** and **transferring** vision. We see examples of where this approach has enabled communities to grow and be transformed.

The authors exemplify principles such as the need to be genuinely caring to achieve sustained change, the importance of creating safe spaces for openness and shared confidentiality, or that the organisation is more than the structure, amongst others.

The book has a somewhat complex structure, mapping a wonderful walk on the South West Coastal Path in the UK onto memories of seeing God's healing grace at work in lives and communities around the world. The book also lists helpful reflective questions at the end of each section to enhance our recognition of where God is at work in some of the situations in which we are engaged.

If you wish to delve into stories of God at work across his world, with fitting examples and beautifully illustrated with photographs, and if you are willing to be provoked into thinking about the broader aspects of healthcare and how we walk alongside those we serve, then this book is a good buy!

Matt Baines reminds us of an often forgotten commandment among Christians and health professionals

REST

'Come to me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls. For my yoke is easy and my burden is light.' (Matthew 11:28-30)

No matter how well I think I understand and appreciate the need to rest, recuperate, and recharge, time and again I struggle to maintain this essential discipline. I often naively believe that I'm too busy to rest. I live in the fear of wasting time. When I haven't adequately switched off and recharged for a while, it becomes much harder to do so. The rest I need is hard to cultivate.

We live in a 24/7 'always on' society. Smartphone notifications pester us at all times. We can all find it easy to develop a 'rest deficit'.

God wrote the importance of sabbath rest into the ten commandments,¹ signifying how vital it is to take regular but purposeful time out from our labours. Jesus emphasised this further in both his teachings and his actions, inviting us to come and learn from him.

Firstly, to come to him means to intentionally carve out time for the Lord in our lives. This can be in worship, meditation, stillness, prayer, Bible reading, or going on a prayer walk. We are gently invited, not commanded or coerced, to come to him; it needs to be our decision.

Secondly, to learn from Jesus is to watch how he acted and model what he did. There are many accounts in the Gospels of Jesus resting before, during, and after significant decisions, healings,

and miracles. The Gospel writers describe him getting away: *'...Jesus often withdrew to lonely places and prayed'*. (Luke 5:16) Before choosing the twelve disciples, *'...Jesus went out to a mountainside to pray, and spent the night praying to God'*. (Luke 6:12) Jesus chose solitude and rest over being with people to better serve people.

It's a life-giving and highly liberating thought that God did not design us to work all the time. He created us with a need for rest. When we, as we are created to, learn to tap into his rest, our productivity and overall wellbeing improves greatly.

Rest is not an optional extra. It's an essential prerequisite to living an effective, Christ-centred life. Regularly stepping back and stopping requires great faith and discipline; there will always be more work to do.

As healthcare professionals, this kind of intentional, Christ-centred rest can challenge the idea that our worth is to be found in our busyness and being indispensable.

The biblical model of rest is found in a person – Jesus. Rest is intentionally coming to Jesus as our source of life and purpose. It's learning from him, as the great teacher, following his model of habitual, intentional, regular rest, so that our areas of service are more effective, and our wellbeing is preserved.

is a GP Partner in Coventry

reference

1. Exodus 20:8

21-23
cmf.li

Songs

for the struggle

national conference 2023 cmf li at on23