spring 2020

for today's Christian doctor

triple helix

retirement & old age

ageing and frailty, personhood and ageing, an African journey, Christocentric ethics, self-care, psychiatry and the great commission

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contents

Errors and corrections

In the last edition (No. 76 winter 2019), we wrongly attributed the *Juniors Forum* article on finding fellowship in Shrewsbury (page 14) to *Sarah Wright*. It was in fact written by *Sajan Khullar*, with practical points by Sarah.

Also in the last edition, we wrongly recorded *Prof Rob Crouch's* role and as a specialist nurse working with a Helicopter Emergency Medicine Service in southern England. His actual professional title is *Consultant Nurse and Hon Professor of Emergency Care at the Emergency Department, Southampton General Hospital*

Where next with *Triple Helix*?

with a new Editor in post and a change in the editorial team, it would seem an opportune moment to look again at all things *Triple Helix*

No organisation can exist without considering changes to its structures and ways of working. Central to any organisation is communication with its members. CMF has had multiple ways of doing this over the years, including its various journals. *Triple Helix* was originally going to be called *Rx*, but the *Sunday Telegraph* beat us to it, using that as the title of the medical supplement of their Sunday Magazine. *Triple Helix* has now been the journal for CMF for over 20 years. Its format was last updated more than 15 years ago.[1]

The range of content in *Triple Helix* has changed over time, driven by interests and contributions of the membership, as well as editorial policy. We have published letters from readers and obituaries; there was an *International Page* edited by Vicky Lavy, who was then Head of International Ministries (now CMF Global). Several of these features are no more, although *Eutychus* and the *Juniors' Forum* have remained regulars. The number of articles submitted fluctuates, but we could always do with more!

With a new Editor in post and a change in the editorial team, it would seem an opportune moment to look again at all things *Triple Helix*. This year we have temporarily reduced the number of published editions from three to two a year and sadly goodbye to our copy editor, Oluwatosin. These were financial decisions taken in the face of a shortfall of income to reduce CMF's running costs (the overall cost of a *Triple Helix* print run being in the £10,000 ballpark).

How does *Triple Helix* come together?

While the editorial committee reviews all submitted articles, we would be pushing it a little to suggest that *Triple Helix* is a peer-reviewed journal. The editorial committee needs new members. We are looking for some dedicated people who would be willing to devote a few hours three times a year to read submissions and feedback, ie peer review them. There is a meeting in preperation for each edition, attendance at which would be preferable but not an absolute. Is this a role for you?

We do not plan themes, but with submitted work, we frequently find a theme has emerged, such as suffering in the previous edition, and ageing in this one.

Where should we be going with *Triple Helix*?

This is something we would like to ask you. Are there issues we are not discussing in our articles? If so, what topics do you think we should cover? Could you write an article as well as suggesting one?

Articles are generally a standard length. Rather than being rigid about article length, I would like to increase the number of categories, and should we have some slightly longer and some shorter articles? Should we seek to run a theme each time, which takes up part or all of the journal? Should we have a section as a round-up from other Christian journals?

Some articles, particularly those dealing with controversial topics, should generate a lot of debate. We are investigating the possibility of a rapid response area on the website. Some of these responses could then be published in a letters section of the printed journal.

If your leaning is more towards devotional and reflective pieces, maybe you could consider writing a *Final Thought* (inside the back cover). Do you find having a reflective or devotional piece in each edition is helpful? Would you like to see more of this kind of writing (or less)?

We send *Triple Helix* overseas to be distributed among members serving outside the UK and to other Christian medical associations around the world. We would love to hear from those readers and get articles from our international colleagues. Would this be of interest to you, or would you like to contribute an article to such a section in the journal?

Triple Helix could be a way of introducing people to CMF. Do you share your copy with your local vicar/minister, ward staff, or colleagues? How many people read your copy? Do you use *Triple Helix* as a way into a discussion with colleagues, as a mission tool (the NHS loves tools)?

We would love to know who we are reaching through the journal. Could some of these secondary readers become members of CMF (medical or nursing)?

We will be surveying our readers more thoroughly in the coming months to see how we might develop *Triple Helix* in the coming years, but we would love to hear your thoughts in the meantime.

Please email me on *david.smithard@cmf.org.uk* with your suggestions and comments.

David Smithard *is editor of Triple Helix*

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news reviews

Assisted suicide

Pressures continues across the British Isles

Review by **Gordon Macdonald**
CEO of the Care Not Killing Alliance

Pressure continued for the legalisation of assisted suicide and euthanasia in the UK, with a very public campaign and recently calling for a Government inquiry into the law on assisting suicide.[1] There have been two debates in Parliament calling for an inquiry into the current law and David Gauke, the outgoing Justice Secretary of the Teresa May Government tried to launch a Government inquiry. Fortunately, that was over-ruled by Downing Street and recently the current Justice Secretary, Robert Buckland, has ruled out launching such an inquiry.[2]

Various medical bodies have been polling their memberships about whether they should change their positions on assisted suicide and euthanasia. This started with the Royal College of Physicians (RCP) from January to March last year. The RCP adopted a position of neutrality after a highly controversial process requiring a 60 per cent supermajority to maintain the then *status quo* of opposition to a change in the law. That decision is still subject to the ongoing threat of legal action after the High Court ruled in October that it could be challenged under charity law.[3]

Since then, the Royal College of General Practitioners (RCGP) has polled its members on 'assisted dying'. Unlike the RCP, the RCGP consultation did not assume that doctors would be involved in the process of assisting suicide or that the patient need have a terminal illness with a prognosis of six months or less to live. The outcome of the consultation was that 47 per cent of GPs who responded opted for the College to remain opposed to assisted suicide, 40 per cent for the College to support assisted suicide, and only eleven per cent preferring the RCGP to be neutral in the issue. At the end of February, the RCGP Council announced that the College would remain opposed to the legalisation of 'assisted dying'.[4]

The BMA in February completed a poll of its members on 'physicial-assisted dying' – which it defined to include both assisted suicide and euthanasia. The result will be published before the BMA Annual Representatives Meeting in Edinburgh at the end of June, which will decide on the BMA's position.[5]

Elsewhere, in January the Parliament in the Isle of Man (Tynwald) recently rejected an attempt to move towards legalising assisted suicide,[6] and in February the Government of Jersey announced that it is setting up a Citizens Jury to consider the issue and report back to the States Assembly later in the year. In Scotland, a group of MSPs are planning to launch a consultation on legalising assisted suicide in the late summer or autumn, with a view to bringing a Bill forward after the next election in 2021.

The pressures for legalising assisted suicide remain strong, and we must remain active and resolute in maintaining our opposition to such changes.

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Transgender on trial

Court cases challenge ideology

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

In March this year judges gave permission for Keira Bell, and a woman known as 'Mrs A' to bring a case against the Gender Identity Development Service (GIDS) clinic at the Tavistock and Portman NHS Trust.

Bell is a former patient of the clinic. Born female, she had a long-term desire to transition and had 'no doubt' she wanted to become a boy. '*I wanted to go onto the medical pathway as soon as possible,' she says. 'I was very eager, and I was very reluctant about speaking to anyone who would possibly get in the way of that*'.[1] But she now regrets her decision and thinks *'it's up to these institutions, like the Tavistock, to step in and make children reconsider what they are saying because it is a life-altering path.'*[2]

She was referred to the Tavistock Centre at the age of 16 and was prescribed puberty blockers. A year later she was prescribed the male hormone testosterone. In 2017 she had a double mastectomy but now, aged 23, she regrets her decision, and feels she should have been challenged more by clinicians.

'Mrs A' is the mother of a fifteen-year-old autistic girl who is currently on the waiting list for treatment at the Tavistock centre. Mrs A has '*deep concerns' that her daughter will be placed on 'an experimental treatment path that is not adequately regulated, where there are insufficient safeguards, where her autism will not be properly accounted for and where no-one (let alone my daughter) understands the risks and therefore [the clinic] cannot ensure informed consent is obtained.*'[3]

Meanwhile, in Oxford, 'a teenage girl has applied for judicial review over official school guidance that says she should share changing rooms, lavatories and residential dormitories with trans girls.'[4] The Safe Schools Alliance, supporting the legal action, says the guidance is '*in direct opposition to all safeguarding protocols*'.[5]

The transgender agenda is being pushed very hard in some quarters, but cases such as these against the Tavistock Centre and Oxfordshire County Council are shining a bright light on some of the flawed thinking that is driving change. We applaud the courage of the women bringing these cases and hope and pray that reason will prevail.

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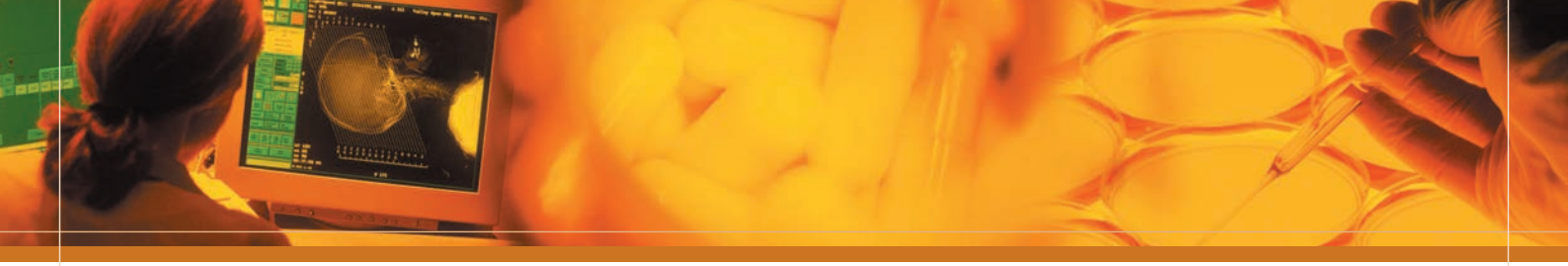

Medical litigation

A growing problem

Review by **Mark Pickering**
CMF Chief Executive

The BBC recently found that the National Health Service receives around 10,000 clinical negligence claims each year and currently expects to pay £4.3bn for these. This sum is a significant chunk of the total NHS budget, which was £129bn in 2018-19.[1]

The amounts involved are growing. In 2017 the National Audit Office stated that spending on the Clinical Negligence Scheme for Trusts had quadrupled during the previous ten years – from £0.4bn to £1.6bn, while successful damages awards had risen from 2,800 to 7,300. The cost of the claims was rising at a faster annual rate than overall NHS funding.[2]

Behind these figures are heartbreaking stories of patients who have died or been harmed whilst under the care of the NHS, in ways that should have been avoided. It is entirely right that families who have tragically lost someone through real negligence should have recourse to appropriate compensation.

But is the NHS really becoming a more dangerous and error-prone place? Doubtless, complexity increases as technology and treatment options advance, but equally, there is a growing safety and learning culture within the NHS.

Are other, darker forces also at play, such as unrealistic expectations, an unwillingness to accept imperfection, and a culture of blame? As a prison GP, I have heard many situations where a relatively minor issue is seen as an opportunity to 'put in a claim', stoked by no-win-no-fee legal assistance. In some cases, litigation can even feel like the National Lottery – a game to play where you just might win big.

Dr Christine Tomkins, Chief Executive of the Medical Defence Union, said: '*This is money that should be going to healthcare... We are now awarding compensation in sums of money higher than almost anywhere in the world. What we need is a fundamental change to the legal system.*'[3]

Sadly, families may often come looking for answers and only resort to legal action when NHS staff appear to be closing ranks. We need understanding on both sides – of the immense pressures that NHS staff and systems are under, and the difficulties that patients and families may have in understanding that despite the best efforts of NHS staff, things can still go wrong.

As Christians within the health service, we have a responsibility to be salt and light. We should be improving systems, acting with integrity, being willing to speak out where problems are being ignored or covered up, and modelling compassion and humility in the way we respond to angry or grieving people when things really have gone wrong.

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Challenging discriminatory abortion laws

Court case argues for the rights of disabled infants

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

Heidi Crowter, a young woman with Down syndrome, is taking out a landmark case against the UK Government over its current abortion law, which allows abortion up to birth for Down syndrome.[1] Arguing that both the UN Committee on the Rights of Persons with Disabilities[2] and the Disability Rights Commission[3] have criticised UK laws which allow the termination until birth of children with non-lethal disabilities, they are challenging current legislation on the grounds of discrimination against people with disabilities.

With the recent legalisation-through-the-back-door of abortion in Northern Ireland,[4] an open letter has been sent to the British Prime Minister by nearly 2,000 members of the UK Down's community asking him not to allow such a discriminatory provision to come into Northern Ireland law at the end of March.[5] A consultation on how abortion law provisions would come into effect closed in December 2019. CMF was among several organisations arguing against abortion up to birth for disabilities.[6]

Northern Ireland is the only part of the UK where children with Down syndrome are not routinely aborted.[7] In the rest of the UK, 90 per cent of Down's babies are terminated.[8] In some parts of Scandinavia, that figure is closer to 100 per cent.[9] The Down's community argues that if this rate of termination was allowed for gender, race or other characteristics, there would be an outcry. But British society seems increasingly blind and uncaring towards those living with disabilities and does not seem to want to 'waste time' hearing what they and their supporters have to say on this and many other issues.

So, it remains to be seen if these arguments will be listened to in the current parliamentary climate. While Crowter's court case and the Northern Ireland open letter make it clear that this is primarily a matter of disability rights, the pro-choice movement is strongly arguing for a radical opening up of abortion law and the removal of all current safeguards.[10] We are set up for a head-on clash around competing sets of rights and freedoms. The voices of the marginalised and vulnerable are in danger of being silenced yet again.

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David Cranston
encourages us to look at the later years of our lives as a God-given gift and opportunity

RETIREMENT & OLD AGE

AN OPPORTUNITY TO BE EMBRACED

key points

- While death is inevitable, old age is not, and thus it should be seen as a gift from God.
- A well anticipated and planned-for retirement opens up a wide range of opportunities.
- Looking at biblical examples, the author challenges us to look upon the final chapter of our walk on earth as a fresh chance to serve God.

'*It is a truth universally acknowledged*', that '*the only two certainties in life are death and taxes.*' So might a book by Jane Austen have begun had she written a novel on either subject. However, while death is inevitable regardless of age, old age is the preserve of fewer, although increasing numbers are now living to celebrate their century. When Prince Phillip retired from public duties at the age of 96, he was asked whether he found it difficult to stand down and replied that he actually found it more difficult to stand up these days. He had the unusual pleasure of inviting his 101-year-old mother-in-law to his 80th birthday party.

Retirement

Paul Tournier, a Swiss physician and counsellor, said that '*To retire successfully is no easy matter*',[1] further adding that it is something that should be '*undertaken not just undergone*'[2] and Billy Graham, in his book *Nearing Home* added '*If I had run my business with as little advanced planning as I gave to my retirement years I would have gone bankrupt*'.[3]

When I began as a consultant, my senior colleague took me on one side and said that it is never too early to think about retirement. That was nearly 30 years ago, and the time seems to have flown by.

Retirement is a time of readjustment. Loss of work can lead to loss of significance, especially for those for whom it has been an all-absorbing career, and couples who have spent many decades apart during the day living their own lives may find the sudden change difficult. My mother's comment when my father retired was that she took him in her marriage vows '*For better, for worse but not for lunch!*' and Kahlil Gibran offers wise advice when he says '*Let there be spaces in your togetherness*'.[4]

Often the years between 60 and 75 can be some of the most profitable times of one's life, as for many health remains good, and one has the experience that comes with the years. Some remain active much later; Titian was still active at 97 painting his '*Descent from the Cross*'.

While there may be less money, there will be more time. It is good to remember that what we give to God's work is not just financial, but our time, talents and energy (although I know of one senior Christian minister who felt able to give more in retirement as outgoings were much less). Each must decide before God what is right, for we cannot tell others how to spend their money.

In retirement, we need to ask if we are going to indulge ourselves all the time or use our retirement to make an impact on the lives of others, revising our priorities and searching prayerfully for fresh inspiration and other ways of service. To that end, it is helpful to reflect on whether we are primarily Christian health professionals or health professional Christians. If the latter, then in retirement only the adjective changes and may be replaced by another.

Old age

In 45 years in medicine, one of my great joys has been in learning about my older patients. William Osler, who ended his life as Regius Professor of Medicine in Oxford, once said *'It is more important to know about the patient who has the disease than the disease that has the patient.'* [5] Patients are living history, and it was through some of my elderly patients that I have understood something of the trauma of the mud and trenches of the First World War and the freezing conditions on the Arctic convoys of the Second World War.

For ourselves, old age can bring both problems and joys. For many, there is the trauma of loss. For those who are married, the loss of a spouse and possibly even the loss of children is one of the greatest traumas we will face. But whether married or single, the loss of friends will come, although Francis Chavasse, Bishop of Liverpool once reflected that while one of the trials of advanced age is the loss of old friends, one of its compensations is the love of a younger generation. [6]

In his last book, *The Radical Disciple* John Stott poignantly described his dependency on others and points out that refusal to be dependent on others is not a mark of maturity but of immaturity. God's design for our life is that we should be dependent. We come into this world totally dependent on the love, care and protection of others. We go through a phase of life when others depend on us, and most of us will go out of this world totally dependent on the love and care of others. He goes on to say, pointing to Galatians 6:2:

'I sometimes hear people including Christian people who should know better say, "I don't want to be a burden to anyone else. I'm happy to carry on living as long as I can look after myself, but as soon as I become a burden I would rather die." But this is wrong. We are all designed to be a burden to others. You are designed to be a burden to me and I'm designed to be a burden to you and the life of the family, including the life of the local church family, is of mutual burdensomeness.' [7]

And as frailty gradually takes over, we need to hand back to God those gifts and abilities we will not need in the life to come.

Yet there are many positives about growing older. Billy Graham said:

'Don't resent growing old. Many are denied the privilege. Remembering what God has done for you invigorates old-age. It is not how weak we are, but how strong He is. Forget not the anchors that stabilized, the lighthouse that directed, and the Word of God that calmed the treacherous waters.' [8]

The Bible is full of examples of men and women who were active in their old age, and a biblical study of old age is a fruitful occupation.

Abraham at 75 set out from Ur on a journey in faith, not knowing where he was going, not knowing what he would find, but knowing in whom he trusted. [9]

Moses spent 40 years training as a shepherd for his father-in-law before taking up his final vocation at 80, shepherding God's people to the Promised Land. [10]

Naomi found comfort in caring for King David's grandfather when he was a baby [11] while Simeon and Anna discovered their life's fulfilment in their old age as they held the Messiah in their arms. [12] All of us can find comfort in God's words through Isaiah to Israel: *'Even to your old age and grey hairs, I am he, I am he who will sustain you. I have made you and I will carry you; I will sustain you and I will rescue you.'* [13]

Rev Tom Smail who died in 2012 and spent his final years in a nursing home with John Stott, reflected on the fact that while Christ shared many aspects of our earthly life, he never experienced old age. Yet in his meditations, he felt that Jesus did grow old in Gethsemane. [14] Bernard of Clairvaux suggested the same in the words of the hymn attributed to him *'O sacred head sore wounded'*.

'Death's shadows rise before you,
the glow of life decays;
yet angel-hosts adore you,
and tremble as they gaze.
Your youthfulness and vigour
Are spent, your strength is gone,
and in your tortured figure
I see death drawing on.
What agony of dying!
What love to sinners free!
My Lord all grace supplying,
O turn your face on me.'

Rev Alec Motyer and John Stott were both active well into their 80s. In 2007 they shared the platform at the Keswick Convention for the last time with Alec Motyer writing: *'It is a fact. Never in the history of the Keswick Convention have two speakers enjoyed a combined age of 168 years! My elderly eyes were blind with tears as I watched my beloved friend make his slow way to the platform, marked his resolute stance at the lectern, and thanked God with the thousands present for the best evening meeting of the week. And now we both turn, to what Charles Simeon described as "running with all our might now that the winning post is in sight". Running! My Zimmer frame trails far behind his, I fear, but I long with all my heart to be identified, however feebly, with his legacy. To know, love, read, study and proclaim the Word of God as long as the Lord gives life and his grace gives strength.'* [15]

May this be our prayer too as the evening draws on, the shadows lengthen, and we look towards an eternal future. And while as a Christian we should not fear death, for many there is an understandable apprehension about the process of dying. But Christ has gone before, and as Aslan says to Lucy in the *Voyage of the Dawn Treader*:

'I will not tell you how long or how short the way will be; only that it lies across a river. But do not fear that for I am the great Bridge Builder.' [16]

David Cranston *is Associate Professor of Surgery at the University of Oxford and an Honorary Consultant Urological Surgeon at the Oxford University Hospitals Foundation Trust*

the years between 60 and 75 can be some of the most profitable times of one's life

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David G Smithard explores what Scripture and clinical science tell us about our approach to ageing, frailty and infirmity

AGEING & FRAILTY

A BIBLICAL OVERVIEW

key points

- Men and women have aged since time began, but frailty was not part of God's plan.
- Frailty is not a new phenomenon and was recognised by writers of the Scriptures long before the scientific and medical community. Isolation is a real risk and may separate the older person from their spiritual family, both physically and socially.
- Thoughtful and straightforward interventions can make a real difference, ensuring ongoing involvement in church activities for these members of our congregations.

The biblical narrative is unclear about the functional status of many of the Old Testament heroes. However, becoming old and frail does not seem to be part of God's blueprint. In Genesis, he created man and woman to be companions to each other and himself. They were meant to live in peace forever. But after the fall, things changed; the relationship was broken, and humanity was ejected from Eden to '*work the ground from which he had been taken*' (Genesis 3:23). Life became a struggle and a fight for survival, destined to be limited until the Messiah came and death was defeated. As we read the Old Testament, the age of death decreases from hundreds of years (attributed to many Old Testament heroes) to tens of years.[1]

Age and lifespan

Life span was short until recent times, due to trauma (including war), poor nutrition and disease. The population is ageing due to increased survival into adulthood, and then people living longer into old age. The population aged over 65 years is rising; in the UK this is now 15 per cent of the population, while in Japan this figure is as high as 27 per cent.[2] Lifespan in the UK has now increased to 90.2 years and 87.6 years,[3] with women outliving men. There were only about 100 people aged 100 years and over in the UK around the time of the First World War, but the total has steadily risen, doubling every year since the Queen came to the throne in 1952. Now, there are around 14,570 centenarians in the UK and a significant surge in people reaching their 105th birthday and beyond. In 1985 there were 130 people aged 105 and over, whereas last year saw 850 reaching their 105th birthday.[4]

The Old Testament provides many references to age. Some are vague; '*he lived to a ripe old age*' (Isaiah 46:4) and Psalm 139:16 states that the number of days is written in God's book. Others are more specific, '*three score and ten*', and the lifespan of a king was 70 years.[5]

Is there a maximum lifespan that we could hope for? Science has suggested that living to 120 years is possible, with healthy living, including dietary restriction. This aspiration, interestingly, is in line with the biblical line that '*but with a maximum of 120 years and then the time to die comes*'.[6] At this time the oldest person in the world is a lady from Japan of 117 years.

Frailty

Frailty is a biological state, comprising weakness, loss of muscle strength and fatigue. The presence of frailty and its severity is assessed using a myriad of scales.[7] As people get older, they are more likely to be dependent on others and have multiple medical conditions, either due to pre-existing conditions from childhood, or newer, but just as debilitating as long-term conditions (dementia, stroke, heart disease, diabetes, renal disease).

The prevalence of frailty increases with age. 30 per cent of those aged over 85 years will be frail. This does not sound like many but bear in mind that Western

populations are ageing; the fastest-growing cohort is those who are very old (over 85). Frail people have a limited physiological reserve, such that they are unable to respond adequately to minor insults such as medication changes, constipation and infection. Decompensation occurs resulting in delirium, immobility, dysphagia and functional decline, full recovery from which is far from certain.[8]

For example, when David was old and in his last years of life, he could not keep warm despite the use of covers, suggesting that he had little body fat and perhaps could not regulate his own temperature.[9]

Frailty is one of the latest NHS buzz words. Resources are devoted to it, with the Acute Frailty Network driving change[10] as if this was all a new concept. In reality, it is just a rebranding, enabling geriatric medicine to get back to its roots. Geriatricians have been looking after frail people for many years. They are rediscovering community care and Day Hospitals, though of course they are now called Frailty Units and Frailty Clinics. Once you rebrand something, everyone jumps on the bandwagon. Networks spring up, charging hospital organisations a lot of money to teach them to 'suck eggs'.

Old age and frailty are commonplace in the biblical narrative. At times God used age to demonstrate how great he was. Examples include the births of Isaac to Abraham and Sarah[11] and John to Elizabeth and Zachariah.[12] Isaac was almost blind and on his death bed when he blessed the wrong son, Jacob.[13] Simeon was old and waiting to see the saviour before he died.[14] Paul also alluded to his infirmities including (possibly) his eyesight.[15]

One of the characteristic features of frailty is the presence of comorbidities. The writer of Ecclesiastes provides a description of frailty that could have been written today.[16]

The slowing of ageing and frailty

Can ageing and frailty be reversed? Nutrition, sarcopenia (loss of muscle mass) and frailty are interlinked. It is possible to prevent or reverse frailty if people are identified early when they are either mildly or moderately frail. The provision of good nutrition and supplements combined with exercise can reduce muscle loss, increase strength and minimise fatigue. Such intervention could extend life by 14 years for women and twelve years for men; if this is continued women could live 34 and men 31 healthy years after the age of 50.[17]

The writer of Psalms tells us that *'A man's days shall be 70 years, 80 if he has the strength'* [ie is in good health and is still able to exercise] (Psalm 90:10). Yet in Isaiah 65:22, God says that those who live to less than 100 years will be accursed and he who dies at 100 will be considered youthful. Moses is a good example, he lived until he was 120, yet his eyes were not weak, nor his strength gone.[18]

Health consequences of age and frailty

Frail older people will have multiple medical problems. Physically, their ability to rise from a low chair may be limited, gait speed reduced and risk of falling increased, and continence may be an issue.

Many old people will often say, *'I was alright until ... and then everything went downhill!'* Frailty, sarcopenia, diabetes, cancer, heart failure are all associated with pro-inflammatory states and a reduction in immunity which contributes to recurrent illness and admissions to hospital. Each hospital admission is associated with a steady downward spiral of increased dependency and frailty. By the time geriatric medicine services become involved, people are often severely frail (7-9 on the Clinical Frailty Score[19]) and sarcopenic, and it is too late to reverse the underlying problems. People presenting with severe frailty will have significant mortality over the ensuing six months.

Social consequences

There was a time when old age was seen as a marker of wisdom and knowledge. Old people were to be revered and respected. *'Do not rebuke an older man harshly, but exhort him as if he were your father.'* (1 Timothy 5:1)

In more modern and enlightened times, being old is seen a curse; people are side-lined, ignored, abused and forgotten. People have become more isolated and alone. Families are smaller, more disparate and less able to provide support. Slowly the circle of friends and family may decrease due to social mobility and death. This may result in loneliness and the dangers associated with old age increase, *'...pity the man who falls and has no one to help get him up!'*[20] Many old people become house-bound or need to move into a care home, which may be away from friends and their local church, adding spiritual isolation to their sense of loss and despair.

What can we do?

We will meet frail and aged people in all kinds of places and situations. We need to act as a mirror reflecting God's glory to them and showing his love in our actions. Be prepared to listen to stories that you may have heard before and offer support when required. Offer advice to church leaders on how to adapt buildings (ramps, contrasts, lighting and accessible toilets). Providing higher chairs for those with difficulty getting out of a low one and removing rugs and loose wires to prevent accidental falls are all essential considerations.

Full engagement in a church service requires reasonable hearing and eyesight. In the days of hymn books, you might have found a braille edition, today with the reliance on visual aids, computers and screens, the blind and partially sighted could become isolated within the congregation. Encourage preachers and presenters to speak clearly and not too rapidly for people with hearing loss. Hearing loops are not always working, and there may be a background hum.

Simple changes and accommodations can help older members of our congregations remain practically, mentally and spiritually engaged with the worship and life of the church, and so help reduce the risks of frailty.

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Remember your Creator in
the days of your youth,
Before the days of trouble come
and the years approach
when you will say
'I find no pleasure in them' –
Before the sun and the light
and the moon and the stars
grow dark,
and the clouds return after
the rain;
When the keepers of the house
tremble,
and the strong men stoop,
And the grinders cease because
they are few,
and those looking through
the windows grow dim;
When the doors to the street
are closed
and the sound of grinding fades;
When men rise up at the sound
of birds.
but all their songs grow faint;
When men are afraid of heights
and of dangers in the streets;
When the almond tree blossoms
and the grasshopper drags
himself along
and desire is no longer stirred.
Then man goes to his eternal home
and mourners go about the
streets. Ecclesiastes 12:1-5

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Jennie Pollock considers two narratives about personhood and how they view the ageing process and older people

PERSONHOOD & AGEING

A POSITIVE CHRISTIAN ALTERNATIVE

key points

- Because our culture values what we can do rather than who we are, being old and infirm is often seen as failure, and the old can very easily see themselves as worthless, de-personalised or an unnecessary burden.
- A biblical understanding of humanity and personhood does not separate these concepts and offers a radical, positive alternative view of old age.
- This understanding should lead us to approach the care of the elderly and our relationship with older members of our family, church and local community in a profoundly counter-cultural way.

We live in a culture in which to age is to fail. We prize education and disregard wisdom. We value potential, celebrate achievement, but despise experience. We pour love, energy and resources into younger generations, helping them grow to independence, and dreading the day when we might become dependent on them.

There is a loneliness epidemic among the elderly, not because they don't have loving families but because, all too often, they feel that to express their need would be to be that most fearful of all things – a burden. Just last year an 81-year-old woman took her own life because a clerical error had deprived her of her pension and left her almost penniless. She had a loving son but didn't want to trouble him with her financial worries, so she ended her life instead.[1]

Youth is idolised. Independence is considered the noblest goal. Age is to be fought, resisted, hidden from view, denied at all costs. Until at last its clutches can be ignored no longer, and we surrender to obsolescence.

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No wonder so many of us fear it.

In God's eyes, however, to age is emphatically not to fail. Our bodies were designed to age. If they weren't, God would have created us with a different method of procreation than producing babies. Sickness and spiritual death are a result of the fall; ageing isn't. This gives us an insight into how Christians can offer a radically different perspective on both our own ageing and that of our patients.

While our bodies are changing minute by minute, one thing that stays constant is our inherent value as a unique member of the human race. In philosophy, this is referred to as our 'personhood'.

The idea that the word 'person' means something distinct from 'human' dates back to the philosopher John Locke in 1694. He defined a person as 'a

thinking intelligent Being, that has reason and reflection, and can consider its self as itself, the same thinking thing in different times and places'.[2]

This idea has been hugely influential, and has obvious implications for bioethical questions, the most obvious being around beginning of life issues – does the unborn child 'have reason and reflection'? Can it 'consider its self as itself, the same thinking thing in different times and places'? How could we know?

To many people, it seems obvious that the unborn child does not have these capacities, so while it may be demonstrably *human*, they argue that it does not have the morally relevant characteristics to be considered a *person*. While we may counter that it has the potential to attain personhood, and thus should be given the appropriate rights and protections, this argument doesn't help us at the other end of life. As one's memory and other cognitive abilities fade, does one's personhood diminish? And what of those in comas or other disorders of consciousness? What about when we sleep? Do we lose our personhood every night?

Any concept of personhood that relies on capacity – and the ability to communicate that one has that capacity – risks creating a subset of humans who have access to greater rights and privileges than others. It also opens the door to the possibility of granting personhood to non-human beings such as chimps, dogs or robots.[3,4,5]

The biblical view is that humans are both categorically different from animals, and inherently worthy of honour, provision and protection. There is no biblical distinction between a human and a person.

Another significant point is that the philosophical understandings of personhood are entirely individualistic. They are based on the person's understanding of him- or herself in the world and make no reference to his or her relationship to others. The Bible, on the other hand, sees us as deeply relational beings. We were created by a relational God, '*in our image, in our likeness*' (Genesis 1:26), and thus we were created by persons to be in relationship with persons. We are all interrelated and interdependent beings. These points form two of the seven characteristics that describe aspects of what it is to be a person put forward by theologian Louis Janssens [see box]. These form a helpful framework for building a Christian understanding of personhood.

In 1 Corinthians 12, Christians are described as all being part of one body. Not only do our capacities and competencies not matter, but we are also all equally needed and valued. '*In fact, God has placed the parts in the body, every one of them, just as he wanted them to be.*' (1 Corinthians 12:18) Furthermore, we all need each other. '*The eye cannot say to the hand, "I don't need you!" And the head cannot say to the feet, "I don't need you!". On the contrary, those parts of the body that seem to be weaker are indispensable*'. (v21-22) '*Nor, for that matter, can one part or another say, "Because I am not a hand [or an eye], I do not belong to the body"*'. (v15-16)

Seven aspects of what it is to be a person, as described by theologian Louis Janssens:

- **A subject**: A biblical understanding of personhood starts with the acknowledgement that human beings exist as creatures who are under the rule of God their creator. They are subjects of his authority.
- **An embodied subject**: As subjects, human beings are also defined by having a human body.
- **Part of the material world**: The first chapters of Genesis place humankind firmly within the created world.
- **Inter-relational with other persons**: In Genesis, God recognises that Adam is insufficient on his own and creates a companion, Eve.
- **An interdependent social being**: Personhood expresses itself in the way that we relate as social beings. [When on earth,] Jesus showed us an interdependent concept of relationship.
- **Historical**: Individual people exist within a historical framework.
- **Equal but unique**: Each person has equal rights, yet we are not all the same.
- **Called to know and worship God**: One feature of a person is his or her ability to know and respond to God.

Adapted from: Moore P. What is a person? *CMF File 10*, 2000. *cmf.li/31S48aP*

This last is particularly relevant for our dealings with those who are ageing. Paul recognises that even if it weren't for the external pressures, we often discount our own value. We look at the abilities and capacities of others and quickly conclude '*because I am not like that, I do not have value*'. This can cut particularly deeply when considering things we used to be able to do with ease. To feel we *no longer* have the value we once saw in ourselves is sobering and upsetting. As believers, we can give huge value and significance to others by refusing to accept that assessment of themselves and their worth.

Of course, this passage is speaking about the particular case of the body of Christian believers, but every human being is equally loved by God and should be treated with the same attitude of indispensability and honour.

Much of ageing is about loss: loss of faculties, loss of mobility, loss of dignity, loss of community, loss of purpose. But it doesn't involve any loss of personhood, even in cases such as dementia where it may seem as though the person we once knew is no longer present. In a world that tells us to age is to fail, we can witness to the radical way of Christ simply by refusing to let ourselves, our patients or their families believe it.

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Anne Merriman recounts her journey from Ireland to pioneering palliative care in rural Africa

AN AFRICAN JOURNEY

key points

- The distinctive approach of palliative care is how we bring our own vulnerability to the care of our patients. This was one of the first lessons that the founder of palliative care, Dame Cicely Saunders, learnt from her patients.
- The author recounts how she was called and equipped to take the ethos of palliative care that she learnt from Cicely Saunders to the poorest in Africa.
- It was her relationship with Christ that gave her the spiritual strength to provide open-hearted care to the dying – and this is the challenge to us all.

'If you want to go fast, go alone; if you want to go far, go together'. African proverb

Maria: a recent case story

Maria is seven and the second youngest of eight children born to two schoolteachers, a middle-class Ugandan family.

She was a vivacious child and very popular with her siblings and classmates alike until she was struck down with progressive neurological defects which turned out to be a brain tumour. After an initial debulking operation she returned to school, but within a year the symptoms returned indicating that the tumour was extending in her brain. The surgeons recommended another operation. After many struggles, the family raised the money for this only to be told that nothing more could be done.

Now Maria is blind and spastic in all four limbs, aphasic and has difficulty swallowing.

Her siblings (aged from five to 18 years old) have not been told her prognosis. They are all acting as if Maria is going to get better, but they are all supporting her with total care.

Their neighbours, however, are accusing the family of offering Maria as a sacrifice in exchange for money, as she is their best child. This is an added strain for the family as they are no longer receiving support from the community. Financially, Maria's illness has brought them to their knees.

The family was originally Catholic and more recently attached to a 'born again' church. They have a strong belief in God and gain spiritual support in the knowledge that he is with Maria and the family in these difficult days.

How do we manage Maria in a lower-income African country, even though she is one of the lucky five per cent that receives treatment?

We certainly need to understand both economic and cultural attitudes wherever we are delivering palliative care. But we also need to offer something more, something of ourselves.

Your vulnerable, wounded heart

We are all vulnerable and therefore wounded healers. Wounded by life in so many different areas, but each of them a gift to increase our under-

standing of others. Are we ready to disclose, in a comforting and appropriate way to our wounded patients, our inner selves; what is in our hearts?

When the young almoner, Cicely Saunders met him in 1948, 40-year-old David Tasma was dying of cancer. A Polish Jew from the Warsaw Ghetto, he was now facing the end of his life in a strange land. Cicely watched as the professors and doctors on rounds passed by his bed, she knew she wanted to do more for him.

When Cicely offered to pray the twenty-third Psalm with him, he replied: '*I only want what is in your **mind** and in your **heart***'.[1]

Mary Baines, the first doctor to work with Dame Cicely in 1968, says '*This short sentence... came for Cicely to embody the two essentials of what was to become palliative care; the application and wisdom of the mind plus the vulnerable friendship of the heart.*'[2]

My story

Unlike Cicely, Christ has been central to my life since childhood. Cicely found God as an adult and became wholly dedicated to the example of Christ in her concern for the poor and suffering. I was born into a traditional Irish Catholic family. I had declared aged four when seeing pictures of dying children in a missionary magazine, that I would go and help them when I was older. It is only looking back that I can see God's plan for me and those I've met in so many specialities across Africa and Europe.

I went to Nigeria as a newly registered doctor in 1964. It was with the Medical Missionaries of Mary that I learnt to relate to Christ in others, and this has helped me in some of the significant decisions in my life. I found that our relationship to God and his Son is the key. This relationship with the Son of God has been my stabiliser in difficult times. And there have been many such times in the path he chose for me. This relationship has given me the strength to carry on using my vulnerability to help others, knowing this is God's work.

In 1973, I returned from Nigeria to Liverpool to care for my ailing mother. After working in two universities and as a consultant in geriatric medicine, I was now equipped to see needs in different cultures and to seek solutions that were affordable and culturally acceptable, even to the government. It was a real leap of faith to travel from the UK through Malaysia and Singapore, to Nairobi. Together with pharmacists in the National University Hospital of Singapore, we had made up a simple formula of pure morphine for use in the home as well as health facilities. With volunteer nurses, I was commencing a home care programme, later to become the Hospice Care Association (HCA). It was in Nairobi that the vision came to fruition through Cicely asking me to write an article about our work there, for an edition of the Christian journal *Contact*. This article brought letters from seven African countries, asking me to help bring such a home care service to them. These invitations resulted in a feasibility study in 1993, seeking an African country in which to demonstrate this model of care.

We chose Uganda, a nation just out of war, poverty-stricken and with a vast HIV epidemic that had doubled the cases of cancer. The Minister of Health, Dr James Makumbi told me, '*My people are suffering, please come*'. He had no problem importing the morphine powder for oral liquid morphine, without which I could not commence a service. Also, Uganda was then near the bottom of the corruption list and their president-soldier, Museveni, was the darling of donors, and we felt we could get the financial support.

Soon after, we commenced the model for Africa in Uganda and started moving into other countries; Cicely was very supportive.[3] Her work had come to Africa, and her example of managing total pain, her spirituality and ability not to be afraid to come close to suffering, has helped us in our journey since.

What are you asking of my African team and me?

But we each need to recognise in our hearts and our minds, that this is a special calling. As Christians, we look to Christ as our example in the way that he showed compassion to the poor and the suffering.

Here in Uganda, we are caring for some of the 95 per cent of cancer patients who do not receive curative therapy. Our community volunteers in the village identify those in need and bring us to see them at home. Many are in a terrible state; isolated by their malodorous, open, fungating wounds, crying in severe pain that is exacerbated by loneliness and rejection, as well as poverty and spiritual longing. Without the means to reach health care, they turn to traditional healers. If the bread-winner is the carer, children stop going to school and there may be no food on the table. Cancer brings a huge spiral down into greater poverty.

My patient needs love and understanding as well as expert treatment of her condition. She needs something of me in the care that I give. Am I prepared to provide this? Am I able to look beyond the disease to the person she is, with the family she loves? Do is I seek to understand her needs with empathy while thanking God for the suffering experienced in my own life that has allowed me to understand this pain and do something about it?

Where next?

Can palliative care bring this approach to decision makers, carers and families? How can it influence professional and international bodies?

Let us make an *Alumn-ethos*, a guiding ethos to help us to work together within our vocation and professions to heal, even without a cure, bringing to peace those who are suffering.

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Martin J and **Margot R Hodson** consider how a Christocentric ethic can shape a genuinely Christian response to the environmental crisis and its impact on human health

A CALL TO CHRISTOCENTRIC ETHICS

key points

- The environmental crisis, and in particular climate change, are very much in the news, and the science shows that we face real challenges in the coming years, principally in the impact upon human health and well-being.
- Scripture lays a strong responsibility upon us, not only for our stewardship of the Earth, but also to place Jesus Christ as Lord of creation at the centre of our relationship with the environment.
- The authors consider how such a Christocentric environmental ethic should shape our approach to healthcare mission in the coming decades.

The environment has been much in the news recently. David Attenborough has raised the profile of many problems, including single-use plastic and the climate crisis. The school climate strikes and Extinction Rebellion demonstrations brought climate change and environmental issues to the newspaper front pages. But what is the science behind the news headlines? Johan Rockström and colleagues in 2009 proposed 'Planetary Boundaries' to provide a 'safe operating space for humanity'.[1] Three boundaries were already over the safety limits: climate change; biodiversity loss; and the nitrogen cycle, and the situation has continued to worsen.

At the Paris climate change meeting (COP21) in 2015, governments agreed to try to keep global temperatures from rising 1.5°C above the pre-industrial temperature.[2] They consulted the Intergovernmental Panel on Climate Change (IPCC), who suggested that we have a very short time, maybe 10-12 years, to cut carbon emissions for this target.[3] Beyond 1.5°C scientists fear our climate system will become increasingly unstable, risking dangerous tipping points and runaway climate change. The 2018 WWF '*Living Planet*' report suggested population sizes of wildlife had decreased by 60 per cent globally between 1970 and 2014.[4] The Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services (IPBES) report in 2019 found that around a million species were now threatened with extinction and that the health of ecosystems was seriously threatened.[5] In addition to climate change and biodiversity loss, there are a host of other problems, such as soil degradation, that also need our attention. We reviewed this whole area in our 2015 book.[6]

Environmental impacts on human health

The third of the United Nations Sustainable Development Goals (SDG3) is 'Good Health and Well-Being',[7] but progress on this goal will be seriously impeded if the natural environment continues to be degraded. At present, air pollution likely represents the most significant global environmental health hazard.[8] It is estimated that in the outdoors environment, fine particulate matter is responsible for 4.2 million deaths a year, with ozone contributing an additional 254,000. Indoor air pollution from cooking and heating causes 3.8 million deaths, mostly in poorer countries. In 2015 the Lancet Commission on Health and Climate Change was formed, stating that 'tackling climate change could be the greatest global health opportunity of this century.'[9] Climate change has both direct and indirect impacts on human health. Among the direct effects are increased heat stress, and the impacts of floods, droughts, wildfires, hurricanes and other storms. Indirect effects include increased air pollution (eg. from forest fires), the spread of diseases such as malaria as their vectors change in distribution, and food insecurity in famines. Often climate change leads to displacement and migration, which can be very hazardous for those affected. There is increasing evidence that climate change can lead to mental ill-health, both in those directly affected and in those pondering a bleak future: 'climate change anxiety'. Finally, climate change is likely to lead to increased political tensions and potentially major wars, with

untold suffering and health implications.

Perhaps the most obvious medical reason for protecting biodiversity is because it has provided medicines in the past and has the potential to do so in the future.[10] Many medicines are originally derived from plants. So, digoxin and digitoxin originally came from foxgloves and aspirin came from willow. The worry is that drugs which may help in treatments for cancer or AIDS may be lost as species go extinct before they are investigated. In the longer term, there are fears that the loss of biodiversity may lead to the collapse of ecosystems, and this would undoubtedly be bad for human health.

In conclusion, space does not allow us to consider all the environmental problems and their impacts, but it is undoubtedly the case that almost any that we might consider will have either direct or indirect effects on human health.

Starting points in ethics

Medical and environmental ethics gravitate towards different natural starting points. Medical ethics are anthropocentric, understandably focused on humans and the medical implications of a wide range of factors, including environmental impacts on human health. The environment is more likely to be perceived as an external issue, though one that can have considerable implications, for example, with pollution. Because the environment is not the focus of attention, action towards it will often be to mitigate possible difficulties or enhance potential benefits. Environmental ethics have the natural environment as the primary focus of concern. These ethics tend to be either 'ecocentric' where the ecosystem is the primary focus, or 'biocentric', where each living creature is seen to have intrinsic value. These ethics have a capacity for understanding potential positive and negative impacts on all planetary life, including humans, and this can have enormous potential for resolving complex environmental challenges. Their weakness can be in putting the right level of priority on the complexity of human concerns alongside environmental ones. Human need can be externalised and ways found to mitigate difficulties that impact on the environment rather than tackling the fundamental causes. For example, where poverty pushes communities to degrade their environment, financial incentives to protect it can be effective in the short term but for long term benefit, the roots of human poverty need to be tackled.

When we seek to combine medical and environmental ethics, we need to find a fresh approach. A Christian approach is to be theocentric, seeking to act in a way that honours our creator God.[11]

Genesis 1 is a helpful starting point for such a theocentric ethic. Here the relationships between God, people and the rest of God's creation are set out. The word 'good' is used seven times as God's act of creation is described. This is the biblical source of our understanding of the intrinsic value of all creation. Humans are wholly earthly creatures but also made in God's image. This makes us both part of his creation but also distinct from it. God gives us responsibility for creation (1:28) and in Genesis 2, this is put in the context of tending the Garden of Eden (2:15). This leads us to conclude that a truly theocentric ethic would seek to balance human and environmental concerns for the good of all. This is the basis of a biblical stewardship approach to the natural world, and it is reflected in some recent secular approaches, including the Sustainable Development Goals. We considered environmental ethics in greater depth in a Grove booklet on this theme.[12]

Biblical ethics and the environmental crisis

The root of the environmental crisis is human exploitation of the natural world for our own gain. We have neither provided responsible leadership for the rest of creation or worked it and taken care of it in a responsible manner. In Isaiah 24, the prophet declares judgement on those who act unjustly, and the environmental implications are starkly described.[13] The portrayal is of a society where people have broken their relationships with God, other people and the natural world. Isaiah's call is to repent and return to God. The later chapters of Isaiah provide a view of the world where people have returned to a dynamic relationship with God and relationships are restored between people and God, each other and the natural world. As Christians, we know that true reconciliation is found in Christ, who came '*to reconcile to himself all things... by making peace through his blood, shed on the cross.*' (Colossians 1:20)[14] Christ holds creation, and we as the church are his body. A Christocentric ethic is a prophetic challenge to hold creation with him as a profoundly missional endeavour.

At the end of his book, Isaiah foresees a new heavens and earth, and this is mirrored at the end of Revelation. In both cases, the word for 'new' implies a renewal or restoration of the earth. In Isaiah 65:17-25, the picture painted is a rural one with fruitful agriculture, food and health. In Revelation 22:1-2, we find an urban description of a restored Jerusalem, an abundant River of Life, and the Tree of Life, whose leaves are for the healing of the nations.

Conclusion

In these texts, we see a glimpse into a restored and renewed creation where humans live healthy lives in harmony with God, one another and a restored and renewed heaven and earth. As we look towards that future, let us seek to hold creation wisely and partner with those with an integrated understanding of caring for people alongside the earth to find the good of all. There is a long and respected history of Christian medical mission, established in the nineteenth and twentieth centuries. In the twenty-first century, we also need to develop an environmental mission, and holistic projects combining care for both humans and the rest of creation.[15]

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Sarah Wright looks at why we need to take more care of ourselves as carers and at some practical tips for doing so

SELF-CARE AS A MEDIC

It was some years ago now when I noticed that mental health support was almost non-existent in my medical school. I had gone through a rough patch of failing exams, and I was wondering if medicine was actually what God was calling me to. My medical school, unfortunately, didn't enquire as to whether I needed support and so I was left alone to prepare for resits. Blessedly my friends from church rallied round and helped me through. It was then that I realised the need for self-care for my mental health.

In October 2018 the BMA conducted a survey into doctor's mental health. They found that three in ten respondents had been diagnosed with a mental health condition and nine in ten stated that their working, training or study environments had contributed to their condition. [1]

So as doctors, how do we look after ourselves?

Since that time, I have been increasingly interested in the growing fascination with 'mindfulness' and 'self-care' in the medical world. It seems that every other post I see on Facebook or Instagram is about how to care for one's self.

Mindfulness is '*knowing directly what is going on inside and outside ourselves, moment by moment*' according to Professor Mark Williams, former director of the Oxford Mindfulness Centre. [2] Many people advocate the use of mindfulness to combat mental health problems or just to keep a healthy mindset. The All-Party Parliamentary Group on Mindfulness wrote that they '*hoped that mindfulness will become as popular for improving mental health as jogging (only popularised in the 1970s) has become for improving physical health.*' [3]

The evidence for mindfulness is at best similar to that of other relaxation techniques. James May in *CMF Files* 64 outlines the evidence for mindfulness, both its positive and its potential negative effects. [4] So while the world seems to take it for granted that it is an overwhelmingly positive activity, we should use it wisely.

When we look at Scripture, we see that David advocated a type of mindfulness when he said '*Blessed is the one... whose delight is in the law of the Lord, and who meditates on his law day and night*' (Psalm 1:1-2). Use of meditation is also found in Joshua 1:8, '*keep this Book of the Law always on your lips; meditate on it day and night, so that you may be careful to do everything written in it. Then you will be prosperous and successful*'. So what does Biblical mindfulness look like?

James May in *CMF Files* 64 suggests that '*Meditation in this sense involves a type of awareness which is intentional*' and can identify desires and thoughts that distract from our awareness of God. [5] But it should not be taken as a distraction in itself from spending time one-to-one with our God. Meditating on Bible verses is a good thing, and David promotes '*ponder[ing] all your work and meditat[ing] on your mighty deeds*' in Psalm 77:11-13 and again in Psalm 119:14-16. However, it is not just reading the Bible, but spending time going into the deeper meaning of Scriptural passages and using them to focus on God.

Mindfulness remains both a tool for self-discovery and a tool for self-destruction if misused. Where it can build up good thoughts and our awareness of God, it can also let us dwell on negativity and distract us from the one person who can help. In his *CMF File*, James May concludes that, '*The lack of robust evidence for the effectiveness of mindfulness, accumulating criticisms, and evidence of possible harms should make us doubly cautious.*' [6]

Practical tips for looking after your mental health:

- **Above all, take time to spend with God** – '*Be still, and know that I am God.*' (Psalm 46:10)
- **Seek help** – whether from your GP or from a friend, talk about what you're feeling and going through.
- **Read**. *CMF Files* 64 on mindfulness is an excellent place to start. *Living Life To The Full* (*llttf.com*) is a website offering self-support for those going through mental illness, and *Losing God* by Matt Rogers (*mattrogers.us/books/losing-god) is* a book which really helped me through my most difficult times.
- **Meditate** – pick one verse of the Bible to think about during the day, especially if you're feeling stressed.
- **Be yourself** – whether that's as an extrovert being around people or an introvert needing time alone, make sure you take time to relax and refuel.
- **Be involved** – make time to involve yourself in hobbies and interests outside of medicine.
- **Be honest** – cultivate friendships where you can be authentic with people and share concerns and troubles.
- **Be healthy** – eating a healthy, balanced diet and exercising has been shown to help with mental health conditions – even if it's taking one flight of stairs extra per day!
- **Observe** – know your triggers for declining mental health and have a strategy for relieving them.
- **Learn to say no** – I know rota co-ordinators can be scary people, but learn to say no to extra shifts/swaps if it will adversely affect your mental health.

***Sarah Wright** is a CT1 trainee in Internal Medicine & Medical Oncology*

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PSYCHIATRY & THE GREAT COMMISSION

Claire Wilson looks at some helpful ways that we can include spiritual care in the support we offer patients with mental illness

Psychiatric disorders are now one of the leading global contributors to burden of disease.[1] So, how can I best serve my mentally unwell patients? And what unique contribution can I make as a Christian?

Last year Christian psychiatrists met for a CMF day conference to explore this question. The theme was '*Psychiatry and the Great Commission*'. The Great Commission in Matthew[2] tells us to 'go and make disciples of all nations'. As healthcare providers, we are in a privileged position to advocate for the integration of a spiritual approach to routinely delivered healthcare. As Christians in this sphere, we can also use opportunities to demonstrate Christ's love and share the Good News. Here I consider how the Great Commission may apply to mental healthcare.

Assessing a patient with mental illness

Gaining an initial insight into a patient's spiritual journey is pivotal to understanding how we can support them. It is important for all healthcare providers of any faith background, but I would argue that it is particularly crucial for us as Christians if we are to integrate the Great Commission into our clinical practice.

One way of doing this is spiritual history-taking, with which some readers may be familiar. In *Good Medical Practice*, the GMC states that we should: '*Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values.*' It also states: '*It may, therefore, be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs or the absence of them.*'[3]

The Royal College of Psychiatrists has some excellent resources on spiritual history-taking.[4] However, a single question such as 'do you have a faith that helps you when you are struggling?' can suffice and may provide opportunities for further conversations about faith. We must also be mindful of not underestimating the value of bringing our patients to our God in prayer and of the power that he has to open hearts and minds.

Supporting a patient with mental illness

As Christian healthcare professionals seeking to live out the Great Commission, are there any other resources which we can offer our patients with mental illness who are Christians or exploring the Christian faith, having first explored issues of faith through sensitive conversation and supporting them in prayer? This was the focus of much of our afternoon discussions at our day conference.

As psychiatrists, we have worked with CMF to compile a list of some Christian resources which may be helpful to patients who are mentally unwell. Another source of resources is the Mind and Soul Foundation website[5] and of course, the CMF website. We hope that readers, as fellow Christian healthcare professionals, will feel able to signpost their patients to them.

***Claire Wilson** is an Psychiatric Clinical Research Training Fellow in London*

Books

- ***Lament for a Son*** by Nicholas Wolterstorff provides an account of grief and suffering from a Christian philosopher who is also a father who has lost his son.
- ***Little Book of Chaos*** published by Lifewords is a brief, easy to read and free resource which can be requested online. It discusses how God is present throughout life's difficulties.
- ***Battlefield of the Mind*** by Joyce Meyer provides a biblical perspective on managing challenging emotions.
- ***I'm not supposed to feel like this: a Christian approach to Depression and Anxiety*** by Chris Williams et al. Chris is a Christian psychiatrist and leading academic, known for his work in the early development of CBT (cognitive behavioural therapy). In this book, Chris and his colleagues provide Christians with practical support in managing anxiety and depression.
- ***Mindful of the Light*** and ***Finding the Yes in the Mess*** by Stephen Critchlow. Stephen is also a Christian psychiatrist known for his work in raising awareness of mental ill-health among the general public. In these books, he brings his skills as a lay communicator to explain a range of psychiatric disorders through a Christian lens.
- ***First Steps out of Eating Disorders*** and ***First Steps out of Anxiety*** by Kate Middleton is a Christian psychologist's guide to navigating anxiety and eating disorders within a biblical framework.
- ***The Worry Book***, ***The Guilt Book*** and ***The Perfectionism Book*** by Will van der Hart and Rob Waller. Will and Rob (also a Christian psychiatrist) also provide a Christian perspective on making sense of difficult feelings and offer suggestions on managing them.

Websites

- *biblicalcounselling.org.uk* provide not only signposting to sources of biblical counselling support but also free online resources.
- *llttf.com* offer a range of free online CBT resources from Chris Williams (book mentioned above), including 'Living Life to the Full with God'.
- *hope4mentalhealth.com* from Pastor Rick Warren. Somewhat US-centric but with several helpful resources and videos.
- *CMF file 64: Mindfulness* by James May *cmf.li/37AEsS2* is a considered analysis of the implications for Christians of what is becoming an increasingly popular tool for mental well-being.
- *drsunil.com* Sunil Raheja is a Christian psychiatrist; his blog and podcast series discusses ways to navigate life's difficulties.

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4. Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group. *bit.ly/2P2AOo2*
5. Mind and Soul Foundation. *mindandsoulfoundation.org*

John Caroe asks us to think about how we care for ourselves and our colleagues as much as for our patients

COMPASSION WITHOUT BURNOUT

key points

- The Enlightenment severed the age old, close link between caring and curing, compassion and science. The biblical understanding of people, sickness and healing allows for no such division.
- How can we become the sorts of doctors, nurses or midwives who show such compassion alongside technical skill when we find ourselves stressed and burnt out?
- The author encourages us to build networks of Christian friends locally and nationally to support and encourage one another and to support and encourage our non-Christian colleagues; to be refreshed and renewed regularly in order to be salt and light in our workplaces.

'Do to others what you would have them do to you.' Matthew 7:12

For many centuries medical care was an expression of the love of God, a ministry of the church. However, the Enlightenment ushered in the dominant idea that knowledge was king: spiritual care was no longer foundational. Education separated science and the humanities and medicine no longer needed the 'softer' touch. That mindset, fully grounded in the Kingdom of this world, has persisted for a considerable time.

Paul Tournier, a Swiss Christian physician, was perhaps the most famous voice crying out for the restoration of personhood within medicine.[1] His influence touched the heart of the profession, so that spiritual care of the whole person is gradually being restored to its foundational role. In recent years whole-person care has become central in the curriculum of medical schools, and publications relating to whole-person or spiritual care now number in the tens of thousands.

Why is it so important?

The evidence for such whole-person care can be stark. Hopelessness can triple the risk of myocardial infarction (MI) or double the risk of cancer in symptomless middle age:[2] truly personal care brings a notable improvement in the lifespan of metastatic breast cancer. There are innumerable other examples where such care outweighs the benefits of stopping well-publicised risks such as smoking.[3]

But its qualitative aspect is as vital as its quantitative.

'If you were in real medical trouble, what sort of doctor or nurse would you like to see?'

PRIME tutors often ask this question when visiting groups of colleagues, both in other cultures and here at home. It is always remarkable how similar the answers are: words such as caring, compassionate, listening, or humble are frequent.

Studies show that such qualities have a significant positive outcome for patients: recovery times improve, patient satisfaction is better, advice is embraced rather than ignored, and people take their prescribed pills.[4,5] Emotional health is better even two months later. In the eyes of the patient,

a 'good' doctor or nurse is by no means the one who has passed the most exams.

The benefits extend beyond the patient. Far from paying a heavy price, the compassionate carer reduces the risk of personal burnout and even improves his/her own personal immunology.[6] Our managers may smile to discover fewer requests for expensive tests and referrals, shorter admissions and a significant reduction in agency fees for sick leave due to stress. Improvement in staff survey scores from 20 per cent below average to 20 per cent above average can save an average UK Trust £1.7M per year.[7]

It's win-win all round. Or it should be. The absolute prerequisite of compassionate whole-person care is the well-being of the carers themselves. This is one thing that is by no means guaranteed these days.

The current levels of stress in our NHS are so well documented. Seldom a week goes by without reading words such as 'NHS crisis' in the newspapers. Sick leave, mental health issues, addiction, emigration enquiries, early retirement, self-harm: we all know the issues. The Stafford disaster shook us all to the core.[8]

What is our Christian calling at this time? Are we here for a time such as this? We face a significant challenge. As we said during the original conception of PRIME, it's all very well discussing what's wrong, but what are we called to do about it? We may feel we only have five loaves and two small fish: are we prepared to offer our meagre contribution towards such a seemingly impossible task? The Lord's authority and blessing once fed 5,000 recipients from such an offering.

The popularity of Schwartz rounds[9] clearly tells us that people wish to hear about, and reflect on, the inner tensions of NHS work. Everyone needs the opportunity to be heard when needed. What might each of us do in our small locality?

Is there not a call for retired Christian professionals to volunteer as hospital chaplains? It is a wonderful way to express the presence of God within a place with such a high concentration of spiritual angst. On paper, it is a role to stand alongside patients. But there is a substantial extra benefit in the opportunities to befriend and support staff in the corridors, or by popping one's head around a secretary's door. Often it is a senior nurse or manager who most appreciates friendship and understanding.

These senior people are aware of the importance of the wellbeing of their staff: it is often discussed in board meetings. But they also come up against the age-old question: what can one do practically?

Such is the background to a project developed by PRIME called *Compassion Without Burnout*. In this activity, supportive seminars are offered, as simple loaves and fishes, to do what we can. The sessions are designed to reawaken, re-legitimise and nurture the natural compassion of individuals who chose the profession for this very purpose and yet have found it increasingly hard to express this motivating driver in the current NHS. *Compassion Without Burnout* aims to counteract the institutional demotivation that is a powerful factor in the quality of care.

A scaffold of PowerPoints sets the context for exploring both the physiology and evidence for compassionate care and catalyses personal reflection on the pressures of NHS life. Considerable time is allocated to small group interaction, particularly on the threat of burnout, how to recognise it, and how to help ourselves and our friends. It is noteworthy how the well-known stress curve is, in fact, far steeper on the right side than the more familiar bell shape might suggest.[10]

No two sessions are the same. Our pilot seminars have matured over two years as we share times with groups of students, young doctors or multidisciplinary established teams.

Feedback has been overwhelmingly positive. There is tremendous encouragement to be drawn from remarks such as 'I wish the session could have been longer': that particular session had lasted two hours! The enthusiasm of managers is equally welcome.

We are encouraged to persevere and to seek opportunities to expand the ministry. This word itself encapsulates the vision of a kingdom work for our time. Thus far the Lord has opened doors in four teaching hospitals on the South Coast, with others taking an active interest elsewhere in the UK.

Our vision is to encourage small groups of Christian friends throughout the country who are called to support and bless their stressed colleagues. Those of us who have retired already have established local friendships and speak the language of the NHS. Can we see this experience as a resource for the Kingdom? Do we see a possibility of reinvesting it at the core of the local caring community?

The greater challenge is to touch the heart of the whole system. We often hear the remark that it is this system, not the individual carers who work within it, that really needs oiling. Others are leading the drive to compassion within education. We must support the Lord's people in administration. He does have his people in strategic positions of influence.

Meanwhile, our immediate concern is for those at the front edge of caring, on the 'pavement of ordinariness'.

The Lord often calls us to go out to leave the safety of an inward-looking Christian life. We have a God-given responsibility to reflect the love of Christ and to be good Samaritans out there in the workplace when colleagues are hurting.

Whether in seminars or regular chaplaincy, our Christian presence on the corridors can hold open a door for God's presence to be manifest at the core of hospital life. We must never underestimate the value of friendship, of 'presence'. It may feel unstructured, even vulnerable. But in the apocryphal words of Cicely Saunders, our role may be simply '*to hang around in a messy sort of way and see what happens*'.

We have a God of surprises.

John Caroe *is a retired GP, serves as a volunteer chaplain to NHS staff, and is a trustee of PRIME International. prime-international.org*

the absolute prerequisite of compassionate whole-person care is the well-being of the carers themselves

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Dementia from the Inside

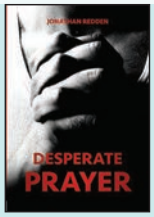
A Doctor's personal journey of hope
Dr Jennifer Bute with Louise Morse

- SPCK Publishing, 2018, £9.00, 116pp, ISBN: 9780281080694
- Reviewed by **David G Smithard**, Visiting Professor, University of Greenwich and Consultant Geriatrician

This small book provides a rare insight into the onset and progression of dementia. The first seven pages are comments/reviews by people from the medical and theological fields. There is little I can add to these.

Not many people would accept the diagnosis of dementia as a gift from God, an opportunity to be a witness. It is a reminder to many of us that God can use any situation that we are in for the good of ourselves and others. Dr Bute provides a window for us to share her life both before and after her diagnosis. She demonstrates a fantastic ability to share her faith and reflect God's glory to all those around her. With the help of her family, she has developed leaflets and online resources for those caring and looking after people with dementia. It is a book of hope and opportunity rather than one of despair.

I have tried to remember her comments when I am undertaking my ward rounds and when teaching my trainee doctors.



Desperate Prayer

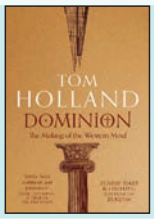
Johnson Redden

- John Ritchie Publishing, 2019, £7.99, 112pp, ISBN: 9781912522507
- Reviewed by **Mark Houghton**, a retired GP

As a much-loved relative was dying, I reached for this book and heard the voice of God speaking to me – immediate help! It is a genuinely easy read in bite-sized chapters of about two pages each. Every chapter stands alone, because each is a short, desperate prayer by someone in the Bible, flowing out of their relationship with God. For example, the chapter 'God Is Just,' is based on, 'And Cain said to the Lord, 'My punishment is greater than I can bear…" (Genesis 4:13)

It's written for the many who desperately want to pray more and need to pray when desperate. The author, a retired orthopaedic surgeon and experienced Bible teacher, writes a moving Preface, '*... when I uttered the most desperate prayer of my life...*' during illnesses in both himself and his wife. His personal experiences reappear at times. It is practical, compassionate and to the point.

This is a worthy addition to a niche in everyone's library on prayer. Perhaps wisely, the author avoided the Psalms, 'since many preachers and writers have commented on the Psalms... Full of desperate prayers which deserve a fuller separate treatment.' It's a book to wait on your shelf for your moment of need, with a brief ready-made prayer at the end of each chapter.



Dominion

The Making of the Western Mind
Tom Holland

- Little, Brown Book Group, 2019, £16.16, 624pp, ISBN: 9781408706954
- Reviewed by **Steve Fouch**, CMF Head of Communications

In his introduction, Holland admits he is a bit like the character from the 90s British sketch show, *Goodness, Gracious Me!*, who points to everything in British society and proclaims that it is really Indian before proceeding to give a detailed exposition for his claim.

In this case, Holland claims that almost everything we can say and understand about Western culture has deep, nearly invisible Christian roots. His starting point is the history of Christianity, and throughout this massive tome, he shows us how the Scriptures, church practice and the thinking of Christians down the ages have shaped everything around us.

The sacred/secular divide? Look to St Augustine and his ideas about *religio* (the realm of the church) and *seculae* (the realm of the state), and at the catastrophic falling out between the Holy Roman Emperor Henry IV and Pope Gregory VII, for the separation of church and state. 'Intersectionality' in modern identity politics and social justice movements? Go back to the struggles of Wilberforce and the abolitionists who saw their biblical arguments against slavery applicable to everything from women's rights to animal rights (Wilberforce founded the RSPCA, and others in his movement greatly influenced the suffragists and suffragettes). And the list goes on and on.

Central to the Christian impact on the West, Holland argues, is the idea of a God who dignified the human form by the incarnation and raised the value of all humanity by dying on the cross for it. These events revolutionised our understanding of what it was to be human and the intrinsic value of everyone, regardless of race, gender, age or social class.

Dominion is a long and detailed read that demands commitment from the reader. However, Holland is a consummate storyteller, drawing you into obscure tales about little-known characters from Christian history and bringing them to startling life. He is someone who clearly loves the stories he tells and the implications they have for how we live today.

Holland is an agnostic who struggles to reconcile Christianity with science, yet who sees a profound truth in the stories and outworking of the Christian faith in which he clearly wants to believe.

Gender Ideology

What do Christians need to know?
Sharon James

- Christian Focus, 2019, £7.99, 132pp, ISBN: 9781527104815
- Reviewed by **Ashley Stewart**, CMF Associate Head of Student Ministries

Sharon James sets out to do two things: firstly to explain in an accessible way what gender theory is and the intense danger it presents to society, and secondly to enable the reader to feel more confident in the truth that we are created male and female. She achieves exactly what she intended.

She presents a clear argument that gender theory, which teaches that a person's true gender identity is determined by their feelings and internal sense of self rather than by their biological sex, is a false and deceptive ideology. She explains how this belief has spread like wildfire, been accepted almost without question, impacted laws and policies and has rapidly become embedded in our children's education.

Importantly she makes a distinction between the ideology itself and the people who have been deceived by it and are the victims of this sexual revolution. While this way of thinking, she argues, must be rejected and opposed by Christians, the person suffering the effects of it should be met with compassion and respect.

However, Sharon's exploration of gender theory, whilst illuminating, does feel at times as if the complexity and the challenges it presents have been lost in the interest of brevity and simplicity. Likewise, whilst I agreed overall with her message, I would have chosen more sensitive and compassionate language when talking to a gender dysphoric or transgender patient. As someone who works in youth mental health, I found it a helpful introduction to the topic. However, I am still left with many questions about how I should respond in practice to a struggling individual or help a parent to support their child. The CMF *1st incision* podcasts on caring for transgender patients[1] offer a helpfully introduction to a highly complex issue which requires much further consideration.

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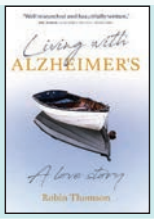


Living with Alzheimer's

A love story
Robin Thomson

- Instant Apostle, 2020, £8.99, 186pp, ISBN: 9781912726196
- Reviewed by **Tim Billington**, a retied GP

Do we need another book from someone who has lovingly looked after his wife with Alzheimer's? I would say 'yes'. In this book, Robin not only tells his story of caring for his wife, Shoko, but has the insight not to assume that his experience is the same as others.

Some people, he realises, prefer to know everything well in advance, while others prefer to deal with problems as they arise. Robin comes into the first category of wanting to be as informed as early as possible.

In the Appendix, he has some constructive suggestions under the heading of 'What I wish I had known sooner and done better'. In particular, body language is more important than what you say to someone with dementia; realising that it best not to 'Disagree but instead Distract and Divert'; and discovering that Alzheimer's affects different aspects of the brain – cognitive, emotional and functional, helped change the way he dealt with Shoko.

Predictably, he has a lot to say about the need for someone with authority, along with a warm relationship, who can interpret the different stages as they pass through them. For Robin and Shoko, this was someone from the Alzheimer's Association who had an excellent relationship with their GP. When we make the diagnosis of Alzheimer's, it is essential to direct the carer to such a person, if at all possible.

This book is a useful one to offer to a carer of a patient with Alzheimer's early on in their diagnosis to provide a roadmap for the future.

Setting Up Community Health and Development Programmes in Low & Middle Income Settings (4th Edition)

Ted Lankester and Nathan Grills (eds)

- Oxford University Press, 2019, £24.79, 544pp, ISBN: 9780198806653
- Reviewed by **Marko Kerac**, Clinical Associate Professor in Public Health Nutrition, London School of Hygiene & Tropical Medicine

The first edition of this classic book was written by Ted Lankester in 1992 and the fact that it is still in demand and going strong almost 30 years on is a testament to its quality and importance. It is targeted at a broad audience ranging from front-line healthcare workers to students to government and civil society policymakers and programme managers; there's lots of valuable material here for everyone working towards 2030 Sustainable Development Goals.

As well as extensively updating current chapters, the new editorial team have added seven new chapters focusing on topical issues such as non-communicable disease, disaster reduction, disability mental health and use of information & communications technology (ICT). With this expanded scope, it's great, however, that two things remain constant:

- A focus on working with and empowering local communities which it sees as core to the 'global health jigsaw'.

- A highly practical and applied approach with plenty of frameworks, illustrations and examples which both help communicate key messages and can be used in teaching and training for a wide variety of audiences.

In summary, this is an excellent resource for all interested in global health. With many challenges remaining, it will certainly stay in individual and organisational 'core reading' lists for many years to come.

eutychus

Altruism makes you less susceptible to pain

According to *The Times*, we should forget painkillers and do something kind instead, after a study at Peking University showed that cancer patients experienced less chronic pain when they helped to care for others on the same ward. Experiments also showed that healthy subjects who had recently acted selflessly experienced less physical discomfort from needle jabs and electric shocks! Doing unto others as you would have them do unto you would seem to have more comprehensive benefits. Who knew? *The Times* 2 January 2020 *bit.ly/2w5T9P8*

Why marriage makes you stronger; quite literally

Growing old together in a happy marriage makes couples stronger. Quite literally! A study from last year has shown that men and women over 60 were found to be more physically capable than their unmarried, widowed or cohabiting peers, according to University College London. Everything from the strength of grip to how fast one walks improves among married couples compared to their unmarried peers. However, once factors relating to wealth were taken into account, the benefits of marriage diminished, suggesting that the greater physical wealth of married couples was the main reason for their health gains. Nevertheless, the words of the Philosopher spring to mind, '*Two are better than one, because they have a good return for their labour… A cord of three strands is not quickly broken*.' (Ecclesiastes 4:9-12) *The Telegraph* 23 January 2019 *bit.ly/2v6jJYD*

Italian 'Doctor Death' jailed

Leonardo Cazzaniga, who dubbed himself the 'Angel of Death' has been given a life sentence for murdering ten patients. Administering lethal cocktails of anaesthetics and morphine at ten times the recommended dose, he killed ten elderly patients at a hospital in Varese, northern Italy over several years. He named this the '*the Cazzaniga protocol*', arguing he was simply seeking to alleviate the pain of patients who were already dying '*to make their death dignified*'. Prosecutors said the doctor suffered from a 'delirium of omnipotence'. The concerns raised by nurses were ignored by a medical panel, the doctors on which were also prosecuted for the coverup. *The Times* 29 January 2020 *bit.ly/390B9nX*

Italian doctors hopeful for brain-damaged girl

In last autumn's Eutychus, we reported on the case of Tafida Raqeeb, a brain-damaged girl who was taken to Italy for treatment after her parents won a High Court battle to prevent her life support being switched off. Her NHS medical team said further treatment was not in her interests, but her family disagreed. The BBC reported in January that she is now out of intensive care and breathing for up to an hour without assistance. The long-term aim of her medical team in Genoa is that she will be weaned off the ventilator in the coming months in order to be cared for at home. What degree of recovery she will achieve in the long-term is uncertain. *BBC News Online* 10 January 2020 *bbc.in/2vvoATd*

South Korean sect at the heart of COVID-19 outbreak

The controversial and unpopular South Korean sect, Shincheonji has been at the centre of the COVID-19 outbreak cluster in the country, bringing further fear and hatred towards the group. About 80 per cent of the cases in the South Korean outbreak have been connected with the sect, who believe their founder, Lee Man-hee, is the second coming of Christ and has unique gifts in interpreting the true meaning of the Bible. Their practice of not using face coverings of any kind during intense and regular prayer meetings is thought to be one of the reasons why the virus spread so quickly through the group. Lee publicly apologised for the outbreak, getting on his knees at a press conference. *The Guardian* 28 November 2020 *bit.ly/2TsLoLi*

Racist patients to be denied access to care

Racism in the NHS is no laughing matter, and staff from black and minority ethnic backgrounds regularly report abuse from patients. So it is that the government have announced that from April 2020, any patient or hospital visitor found to be inflicting discriminatory or harassing behaviour on staff could be barred from receiving care, unless the case is an emergency. Of further concern is that even more ethnic minority staff report that racist discrimination comes from colleagues and managers – although it is less clear how the government intends to tackle this. *The Telegraph* 18 February 2020 *bit.ly/2TtODlQ*

Scotland's bid to end period poverty

Holyrood looks set to pass a bill this spring that would oblige the Scottish Government to provide free sanitary products to women who need them. For years it has been a cause of outrage that VAT or sales taxes are imposed on sanitary products, often meaning that women and girls from poor backgrounds have to ration their use. If (as seems likely) this bill becomes law, it will be a world-first and could have a real impact on women from lower-income households. It will also mean that Scotland has added to its free social care and minimum per-unit alcohol pricing, the ways in which its health and social policies radically differ from England. These differences will provide plenty of material to keep social scientists and clinical researchers busy in the coming decades. *The Economist* 29 February 2020 *econ.st/32FRvQy*

L'Arche founder in sexual abuse scandal

The ministry of Jean Vanier, bringing dignity and compassion to the care and empowerment of people with disabilities through the many L'Arche communities that he founded, has been globally praised. But now L'Arche has released a report less than a year after his death that shows Vanier was involved in at least six coercive or non-consensual sexual relationships with women between 1970 and 2005. Does such a shocking revelation diminish the work and example of L'Arche? Rather, it reminds us that we are all sinners, and not even the most sainted cannot fall. It is also a reminder of why we must be ever vigilant in our safeguarding of the vulnerable and in our accountability to one another. *The Economist* 29 February 2020 *econ.st/32FgFyW*

Steve Fouch reflects on how we use precious time to bless others

DISTURBING THE PEACE

Then Mary took about a pint of pure nard, an expensive perfume; she poured it on Jesus' feet and wiped his feet with her hair. (John 12:3)

We are very goal orientated in the health professions at times. That's not a bad thing, but as resources get squeezed, and workloads go up, the pressure to achieve outputs and throughputs increase. Time becomes a precious resource and wasting it becomes a crime.

Mary had a precious resource – nard. Nard is an aromatic oil, believed to have medicinal properties, and highly valued for its strong and distinctive perfume that clings to skin and fabric. It was incredibly expensive, so only a small drop was ever used (or needed). This jar may have been an inheritance – all Mary had that was of value, so using it like this was extraordinarily extravagant. No wonder Judas was outraged. [1]

Mary may have had a foreshadowing of Jesus's imminent arrest and execution, but she certainly knew that in the view of her peers, 'wasting' this much perfume on one man's feet was hardly a good use of her precious resource. But to Jesus, this was the most loving, precious gift any of his disciples had given him. [2]

When we offer time to people, it is a precious gift. Especially when we give it to those not esteemed in our society. Time spent with the dying, the very young, those with disabilities, the foreigner and the homeless. That extra time at the end of a shift or appointment schedule to listen to a patient who just needs to offload; going out of your way to talk to that awkward or demanding person at church or in your street; giving your time to stand up for and campaign for those the world does not esteem. These bless not only those people but are an offering of worship to the Lord himself. [3]

Others (especially colleagues and managers!) may see us wasting time. Others still will feel uncomfortable that we are focusing energy on people that they would rather were not in the public eye. But as Sheila Cassidy put it '*there will always be those who find themselves called like Mary of Bethany to disturb the peace by pouring out over some dead loss to society that which could have been sold for three hundred denarii.*' [4]

references

1. John 12:4&5
2. John 12:7&8
3. Matthew 25:31-40
4. Cassidy S. *Sharing the Darkness: The Spirituality of Caring.* London: Darton, Longman & Todd Ltd, 1988

WRITE

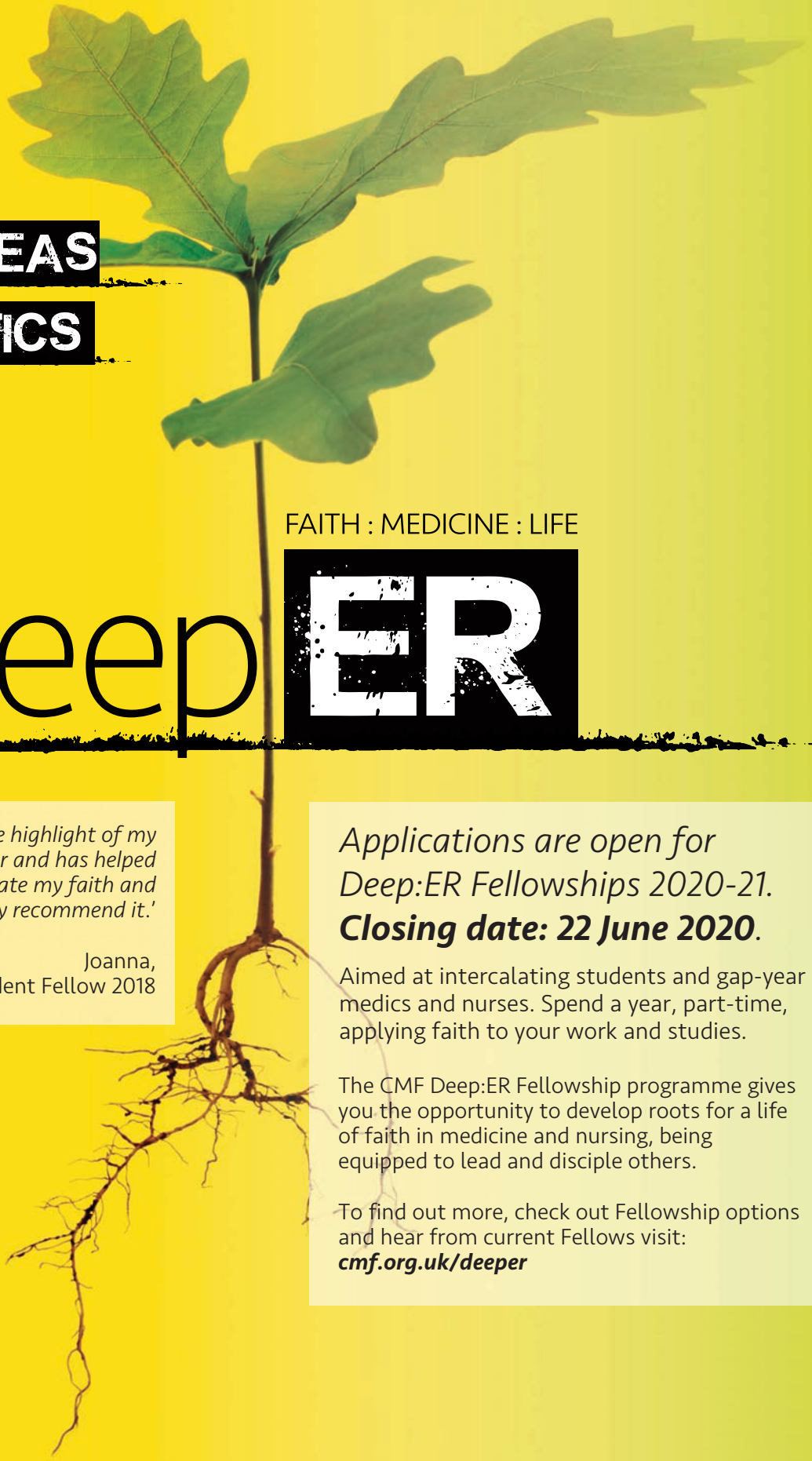
ETHICS

GO OVERSEAS

APOLOGETICS

SPEAK

LEAD



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