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for today's Christian doctor

triple helix

conscience

freedom of conscience, euthanising Hippocratic medicine in Canada, catalyst teams, advocating for the disadvantaged, the wonder of wisdom, positive thinking

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contents

Stand up and be counted

Medicine has always been an ethical and legal minefield for Christians. One of the greatest dilemmas remains deciding who does or does not receive medical care. In every healthcare setting, decisions are made daily concerning access to care. During the COVID-19 crisis, guidance emphasised a utilitarian approach[1] without recognising a need for virtue, distributive ethics, and justice.[2] Micah reminds us that the '*Lord requires us to act justly and to love mercy*'. (Micah 6:8) All health care systems have limitations, usually dictated by the ability to pay or, where health is funded via taxation, the availability of resources. The question is: how do we allocate those resources justly and equitably?

We now live in a disposable, secular society, where objects can be broken, thrown away, and replaced. Human life has come to be treated similarly. There have been repeated attempts across the Western world to destroy lives in their earliest moments and then snuff them out once their usefulness has finished. But both abortion and euthanasia may not be as successful as many believe. They may be painful and result in psychological harm, facts often ignored by proponents.

We have observed the mission creep that has occurred following the 1967 Abortion Act, introduced to end back street abortions. In 2019[3] a quarter of all pregnancies resulted in abortion, with nine million lives lost since 1967.

In the Netherlands and Belgium, the remit for physician assisted suicide and euthanisia has increased from its narrow base with 'safeguards' limiting it to mentally competent, terminally ill adults, to involuntary euthanasia of infants and those with dementia, and to those without life-limiting conditions. There are, yet again, current attempts in England, Scotland, and the Channel Islands to bring such legislation to the British statute books.

Freedom of expression and conscientious objection are being limited. The Government wants to set up areas around abortion clinics that will stop people from sitting down and reading the Bible and praying. The courts in some provinces of Canada have removed the right to object to partaking in euthanasia.

The right to healthcare, free at the point of delivery, is sacrosanct in the UK. But public policy is making it increasingly difficult for those on the margins of society – the homeless and those with insecure immigration status to access care. The right to health is a fundamental human right. Yet, many in society appear happy to see this denied to some. Scripture reminds us to '*Love your neighbour as yourself*' (Luke 10:27) and that '*God…loves the foreigner residing among you, giving them food and clothing.*' (Deuteronomy 10:18), and that we are to '*…love those who are foreigners…*'. (Deuteronomy 10:19)

It is time that Christians stood up to be counted. The Church needs to take a more vigorous stance, and we as healthcare professionals need to consider our position. Do we watch and do nothing, or do we stand up to be counted? Do we seek to act justly (Micah 6:8), defending the vulnerable and standing up for our right to do so? Consider your role in advocacy and what form that may take within your workplace or in society.

Triple Helix publishes a diverse and eclectic mix of articles in each edition that often coalesce to form a theme. In this edition, articles explore the meaning of Micah 6:8 in practice, discussing freedom of conscience globally and the Canadian experience around its limitations due to the legalisation of euthanasia. We look at advocacy and what it means for us as Christian health professionals.

We hope these stories will inspire and challenge.

Future editions of *Triple Helix* will have broadly planned themes. We will be accepting articles for the Spring and Autumn 2022 editions on the themes of 'justice' and 'transitions'. If you want to write on either of those themes, please get in touch. But if you want to write on totally different topics, we will still consider articles on any theme that is both Christian and health related.

We look forward to hearing from you!

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

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news reviews

BMA neutralised:
on assisted suicide and euthanasia

Review by **Mark Pickering**
CMF Chief Executive

'*Doctors Drop Opposition to Assisted Dying*!' were the predictable headlines when the British Medical Association (BMA) narrowly voted to move from 'opposition' to 'neutrality' on 'assisted dying, including physician-assisted dying' (PAD), at its online Annual Representatives' Meeting (ARM) on 14 September.[1]

The vote was incredibly close, with just four votes (one per cent) in it; 302 voted, with 149 for, 145 against with eight abstentions. This represents just over one per cent of those voting in the BMA's 2020 member poll on PAD, where almost 29,000 responded. The poll itself showed marked diversity, with support for assisted dying most popular (40 per cent), ahead of opposition (33 per cent). However, that headline is misleading.[2] Students and retired doctors (who do not care for patients) were most in favour of PAD, whilst those in palliative care, oncology, geriatrics, and general practice (who routinely discuss end of life care with patients) were most opposed. The closer people get to 'assisted dying', the more they tend to recoil.

Strikingly, due to a loosely worded motion, the BMA is now not only neutral on assisted suicide (which had significant support in the members' poll), but also neutral on euthanasia (which did not). The vague catch-all campaign phrase 'assisted dying' covers both.

This slim margin is predictably being trumpeted as a major victory by campaigners. Excellent speeches against the motion, including some by CMF members, made the point that the only thing this really achieves is to hand a simple, seductive soundbite to campaigners as they press on to Parliament, where Baroness Meacher's Bill is due for debate on 22 October.

Much better would have been to focus Parliament's attention on the details of the BMA's poll, with nuanced data on where support for assisted dying actually lies (and does not lie) within the medical profession. The idea that the BMA must be 'neutral' in order to represent diversity is patently false – delegates also spent a whole hour in closed session, debating how the BMA can represent members' diverse views, irrespective of their overall position on PAD.

There is much to do. But there were some clear encouragements from this year's ARM. CMF members were able to pass policy on Clinically Assisted Nutrition and Hydration, on conscience and moral injury, and on reducing sexual abuse of children. It was incredibly heartening to see members and allies working together to be salt and light in this challenging environment.

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Reforming the Mental Health Act
giving a more personalised approach

Review by **Ruth Butlin**, a retired medical missionary & member of the *Triple Helix* committee

The involuntary detention of people with serious mental illness is currently controlled by the Mental Health Act of 1983, as amended in 2007 (MHA 1983/2007).[1] An Independent Review of the Mental Health Act[2] grappled with balancing patient autonomy against the protection of individuals and communities. It also addressed the fear associated with the MHA 1983/2007 in patients' minds. The review panel reported in 2018, but COVID-19 delayed the Government's response, now published as a white paper,[3] a public consultation on which closed in April.[4]

The government is ready to accept most of the recommendations of the Independent Review. In particular, to utilise the framework of four proposed principles, namely Choice and Autonomy, Least Restriction, Therapeutic Benefit and the Person as an Individual. Most of the proposed changes will be in the direction of stricter criteria for detention, more right to appeal against involuntary treatment, more control for detained patients over who can act on their behalf and more support for all patients with mental illness in the form of specialist advocacy services (for voluntary as well as detained patients). There is a marked emphasis on the non-discriminatory application of the legislation, given the evidence that the impact of MHA 1983/2007 has fallen disproportionally on people of Black, Asian, or ethnic minority backgrounds. The new criteria for imposing detention or community treatment orders will require evidence of a higher level of risk to self or others. The duration of detention will be more tightly controlled. Learning disability or autism alone will no longer be justification for detention.

Until now, each detained patient's 'nearest relative' (as defined in the MHA 1983/2007) had certain rights to object to or appeal against detention, as well as a right to be kept informed. This role will be replaced by a Nominated Person (NP), who the patient can choose. Many patients whose family members are not their closest confidantes have welcomed this change.

Under the new Act, neither a police cell nor a prison can be classified as a 'Place of Safety' for a person detained under the MHA. Imprisonment happened all too often to the detriment of the patients concerned.

More controversial will be the proposals for Advance Choice documents, which would give patients opportunities to specify their preferences for future management. These would be somewhat similar to Advance Directives, but it is unclear why a different system is needed.

We need to pray for the Government to make the right decisions as they draft this new Mental Health Act, which affects some of our most unfortunate and marginalised citizens.

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Vaccine tyranny?

Covid vaccine controversies rage on

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

At the time of writing, Westminster has just dropped its 'vaccination passport' plans for crowded venues in England,[1] but has rolled out a voluntary vaccination programme for twelve to 15-year-olds.[2] Meanwhile, vaccine passports will be introduced in Scotland from 1 October,[3] and Westminster's ruling that all care home workers must be fully vaccinated by 11 November is still in place. Workers who are not exempt needed to have their first dose by 16 September to be fully protected in time.[4]

In addition to these statutory plans, some universities, airlines and businesses are starting to make vaccination a condition for education, employment and social interaction.[5]

While many of those at greatest risk from the coronavirus remain, understandably, anxious about restrictions easing even as hospital admissions continue to rise,[6] others are urging governments to help us move to a phase of learning to live with the virus responsibly.

In a culture that sets a high value on personal autonomy, it was heartening to see how readily we obeyed the 'Stay home' mandate in March 2020. However, there is a growing sense that the Government is now overstepping the boundaries of what is reasonable and necessary for the protection of the public. Concerning the vaccine rollout for children, for example, the risk vs reward data remains unclear,[7] and many are concerned that we are putting our children at risk for the sake of adults.[8] The fact that children deemed 'Gillick competent' can overrule their parents' decision on the vaccine[9] has also raised concerns.[10]

Fear, mistrust and an overload of complex information make it very hard for anyone to see the intricacies of the vaccine debate clearly, and the harder the Government pushes, the more entrenched resistance is likely to become. Meanwhile, across the world, millions are still waiting for access to the vaccine, while the UK and US are throwing away hundreds of thousands of expired doses.[11] With the autumn booster jab programme already starting,[12] Covid vaccines look set to be a contentious issue for quite some time.

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NHS data grab

betraying confidence?

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

Data is the new gold – the most valuable commodity in the digital world, and the NHS holds a vast amount of this asset. Data about almost every British resident's medical history, demographics, and healthcare interactions. This information is estimated to be worth nearly £10 billion, according to Ernst & Young.[1]

In May, the Health Secretary issued a legal direction to every GP in England to upload their patient records to a central database.[2] The plan was for this data to be made available to private companies and research bodies, albeit 'pseudo-anonymised'. But the campaign group openDemocracy, fearing this would breach GDPR, issued a legal challenge in June.[3]

Only at this point did most of us become aware of what some called the 'NHS patient data grab',[4] or more officially, the General Practice Data for Planning and Research scheme (GPDPR).[5] The subsequent outrage from patient groups, Royal Colleges, and others caused the implementation date to be pushed back from 1 July to 1 September. That date has now been postponed indefinitely, as over a million people living in England have opted out. The government is now about to go into an extended consultation process with all those involved.[6]

Data mining of patient records is nothing new – in fact, it goes on all the time. It is invaluable in medical research and health service planning.[7] Even then, it remains controversial, despite access being restricted and anonymised.[8,9] GPDPR would have centralised data in a way that is useful but would have arguably weakened the link between patient and GP.

The principle of confidentiality is central to all healthcare. Patients share the most intimate details of their lives with health professionals, especially GPs. And we do so on the understanding that it will only be used for the purposes of our care and treatment. This widely shared value is also profoundly biblical. As the Scriptures remind us, we are not to 'betray another's confidence'. (Proverbs 25:9-10)

The marketability of our personal data drives commerce, social media and most of the Internet. We should be wise in how we approach utilising this data. Trust is essential, and the lack of consultation, transparency, and public awareness of the implementation of GPDPR has dented that trust. This is another area where we will need to maintain vigilance in the coming years.

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Melody Redman looks at why and how we should exercise our consciences in professional practice

FREEDOM OF CONSCIENCE

WHAT IS THE CURRENT ROLE OF CONSCIENTIOUS OBJECTION IN HEALTHCARE?

key points

- Conscience is a universal human quality, recognising right and wrong based on worldview and deeply held convictions, whether faith-based or secular in origin.
- Scripture is full of examples of believers refusing to compromise their deepest values and acting according to their conscience, often at significant personal cost.
- We need to be sensitive to our colleagues and patients as we exercise our freedom of conscience and aim to do so in as peacemaking and winsome a manner as possible.

'Conscientious objection (CO) is the refusal to perform a legal role or responsibility because of personal beliefs. In health care, conscientious objection involves practitioners not providing certain treatments to their patients, based on reasons of morality or conscience.' [1]

Everyone has a conscience. Everyone has a worldview. Unsurprisingly, 'everyone' includes healthcare professionals, students, and patients. Looking back over our studies, careers, or personal lives, I am sure we can all think of times where we have been asked to do or say something with which we are unhappy. That deep discomfort – sometimes like an automatic reflex, sometimes like a churning within. That sometimes-palpable feeling or thought that *something about this situation does not feel right*.

With our Christian worldview, we may feel certain things we are asked to do in the health service are wrong and that we should not be involved in them. Typically, people think of conscientious objection around beginning and end of life issues – such as abortion and euthanasia. However, there are many other areas where we may feel we need to conscientiously object. What we are or are not comfortable with might not necessarily look the same for every Christian. For example, different Christians may feel differently about prescribing various types of contraception.

One key theme is that CO is fundamentally linked with integrity and the ability to act according to your beliefs and principles. It is something we should strive to protect. However, CO is regularly under attack from different angles and different groups. [2] We do have some rights to CO, which we should be grateful for and seek to preserve.

What does the Bible say?

We see many examples in Scripture where followers of God stand up against what they were being asked to do, as it conflicted with their service to God. We can find a classic example in chapter three of the book of Daniel. This chapter recounts how King Nebuchadnezzar had made an image of gold and decreed that when the sound of music was heard, everyone had to fall down and worship that image. However, Shadrach, Meshach, and Abednego refused to worship the image, despite being threatened with a blazing furnace. They knew that worshipping a false god was wrong; they objected and refused to bow down. They were ultimately saved from the heat of the burning furnace, but not until after they had been chucked into it!

Flicking through the next few pages of our Bibles, in Daniel chapter six, we see another example. Daniel was faced with a choice. He could either follow the King's decree to stop praying for 30 days, preserving his life, or continue to pray to God and face the death

penalty in a lion's den. The decree had been purposefully introduced to catch Daniel out since he was a distinguished government official on a career pathway to ruling the kingdom. Daniel got cast to the lions, but despite this, God miraculously rescued him.

If it is possible, as far as it depends on you, live at peace with everyone. (Romans 12:18)

Clearly, there are times when our Christian values will cause us to object to things we are asked to do. The two examples from the book of Daniel demonstrate where obeying God meant breaking the law and facing the death penalty. We need to be firm to abide by our values but also peaceful in our approach when we can – this is no easy balance!

My conscience is clear, but that does not make me innocent. It is the Lord who judges me. (1 Corinthians 4:4)

However, it is important also to remember that our consciences are fallible.[3] Romans 14 talks about not going against conscience or forcing others to go against theirs. We should keep prayerfully reflecting on the Scriptures, continue to seek wisdom, and train our consciences to be sensitive to 'God's values'.

What does the law say?

There is currently a statutory right to CO in two areas of healthcare – participation in abortion[4, 5] and participation in technological procedures to achieve conception and pregnancy.[6] What exactly *participation* entails remains the subject of much debate. When it comes to abortion, the Doogan case[7] led to narrowing the definition of 'participation' (a 2014 *CMF blog* by Philippa Taylor explores this in more depth[8]).

What do the medical organisations say?

Guidance from the General Medical Council (GMC) is generally helpful when it comes to CO, recognising that everyone has personal beliefs that affect their day-to-day practice.

'*We recognise that personal beliefs and cultural practices are central to the lives of doctors and patients, and that all doctors have personal values that affect their day-to-day practice. We don't wish to prevent doctors from practising in line with their beliefs and values, as long as they also follow the guidance in* Good medical practice.'[9]

Therefore, it is vital to be aware of the *Good medical practice* (GMP)[10] guidance surrounding conscience. For example, '*Patients have a right to information about their condition and the options open to them*'. We should explain the available options and not obstruct them. However, as individual health professionals, we do not necessarily have to provide them with full information or an onward referral (as long as we abide by GMP guidance).

The British Medical Association (BMA) – as a professional body and trade union representing doctors – supports a '*limited right*' to conscientious objection'.[11] In addition to the statutory rights of CO, '*the BMA would support a request by a doctor seeking to exercise a conscientious objection to withdrawing life-sustaining treatment from a patient lacking capacity – where another doctor is available and willing to take over care.*'[12] It goes on to say that reasonable, lawful requests for CO should be considered but are not a right.[13] The Nursing and Midwifery Council has its own guidance on CO.[14]

Not all things we object to in healthcare might be seen as a typical conscientious objection. For example, when it comes to honesty and truth-telling, we might feel we have to object to something we're being asked to do or say. For example, some of us may have been asked to put something on an imaging request which was not an accurate record of the patient's symptoms or signs. It is still essential to maintain our integrity and politely object to what we are being asked to do in these situations. The way we handle this is key and requires wisdom and discretion; there may be a negotiable way forward where you do not have to compromise your personal value of honesty.

Can we tell our patients?

The GMC says: '*You may wish to mention the reason for your objection, but you must be careful not to imply any judgement of the patient*.'[15]

The BMA says: '*doctors should not share their private moral views with patients unless explicitly invited to do so*.'[16]

Realistically, different situations will require different approaches. We should seek wisdom and be careful here, but always be prepared with an answer in case we are asked! A full explanation may not be necessary or welcome. Still, a brief, winsome sentence or two may help to put things in context. They may even act as a positive 'faith flag' rather than imply a negative judgment of the patient.

Can we tell our colleagues?

The GMC says: '*You should also be open with employers, partners or colleagues about your conscientious objection. You should explore with them how you can practise in accordance with your beliefs without compromising patient care and without overburdening colleagues*.'

It is generally much better to have these conversations before you encounter the thing you want to object to. Whatever stage of your career you are at, you can have a conversation with your colleagues about how to practice in accordance with your beliefs. This conversation often gives a natural opportunity to discuss the *why* behind your position. There is also an important aspect of 'give and take' – offer to take on something else (that your colleagues don't want to do) if your CO would mean additional work for your colleagues.

Conclusion

We must act with integrity throughout our career and Christian walk, and CO is integral to that. We should be grateful for current protections around conscience and seek to uphold those. We should communicate wisely with our colleagues to find ways around some of the challenges that our CO might introduce. Occasionally it may be appropriate to share our reasons with patients, but we must do this with great sensitivity and wisdom.

Melody Redman *is a Clinical Genetics Registrar in Leeds*

We should continue to seek wisdom, and train our consciences to be sensitive to 'God's values'

CMF will be publishing a new booklet this autumn with practical guidance on exercising freedom of conscience as a Christian health professional.
See *cmf.org.uk/bookstore*

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Larry Worthen and **Stephanie Potter** examine how Canada opened the door to ever more drastic euthanasia laws and the erosion of freedom of conscience

EUTHANISING HIPPOCRATIC MEDICINE?

CANADA'S ATTEMPT TO KILL CONSCIENCE

key points

- A society that hides from suffering, disability and death is more and more likely to accept the deliberate ending of human life by health professionals.
- Despite attempts to challenge the legalisation of euthanasia and defend freedom of conscience, disability rights and Christian organisations have found the legislature and wider society unwilling to defend the vulnerable or make reasonable accommodation for those with conscientious objections.
- Christians and other people of conscience must continue to take a stand on these issues.

From mercy killing to death on demand

In the early 1990s, the death of a twelve-year-old girl captured the attention of Canadians. Tracy Latimer, who was only a month shy of her 13th birthday, lived with cerebral palsy and loved music, horses, and the circus. Her life was like that of many who have complex disabilities – filled with medical treatments and surgeries, but also with school, her family, and joy. Tracy's father chose to end her life out of a desire to end her pain. After a series of trials that garnered much public attention, he was convicted of second-degree murder. He began serving his sentence in 2001, and by 2010 he was granted full parole. A 1999 poll revealed that 73 per cent of Canadians thought Tracy's father should have received a more lenient sentence. Forty one per cent of respondents believed that 'mercy killings' should be legalised.[1] The issue was debated on television screens, in homes, and in classrooms across Canada. Were those with disabilities better off dead? Who should make the most final of all decisions?

> Were those with disabilities better off dead?

Twenty-two years after Tracy's murder, on 6 February 2015, the Supreme Court of Canada brought down their unanimous decision in *Carter vs Canada*,[2] striking down sections of the *Criminal Code of Canada* that made euthanasia and assisted suicide illegal. In doing so, they reversed the precedent the Court had set in 1993 in the *Rodriguez* case. When parliament passed legislation a year later, the initial requirements of the law were that the patient must be a competent and clearly consenting adult who

has a grievous and irremediable condition, for whom death is reasonably foreseeable.

Six years after legislation, euthanasia in Canada continues to expand its impact on the Canadian population. In 2020, deaths by the euphemistically named medical assistance in dying (MAID), which includes both euthanasia and assisted suicide, increased by 34.2 per cent after a 26.4 per cent increase the previous year. From 2016-2020, 21,589 Canadians have died by MAID, 7,595 of whom died in 2020 alone. The percentage of all deaths attributable to MAID continues to climb to 2.5 per cent in 2020. In British Columbia in 2020, four per cent of all deaths are attributable to MAID. These numbers are expected to climb at an even greater rate with recent national legislative changes.

On 12 March 2021, Canada received Royal Assent to expand access to euthanasia to those with disabilities, chronic illnesses, or mental health concerns, even if their deaths are not reasonably foreseeable. There is still a two-year delay for those with mental health concerns as there is currently no protocol for those patients.

By passing this into law, Canadian legislators removed safeguards like the ten-day waiting period when death is reasonably foreseeable. Even the waiting period for euthanasia when death is not reasonably foreseeable (90 days) is not as lengthy as waiting periods for the services needed to encourage the patient to continue to live. In addition, the waiting period can be waived when the patient is in danger of becoming incompetent.

Throughout the lead up to this expansion, disability and mental health advocates publicly called for Members of Parliament to vote against the legislation. They shared their stories of the challenges they currently face to access adequate healthcare before legislators and via social media. They streamed a days-long filibuster with voices from across the country. Their repeated cry was: '*nothing without us*' – no governmental decision about their lives without consultation and support. Despite their compelling and consistent pressure, the Government passed the Bill, declaring it a victory for personal autonomy. We conceal our disregard for those living with different disabilities and medical conditions with phrases like 'medical assistance in dying' and 'mercy killing', but the reality is that, as a country, we would rather offer death as a final solution for those who are suffering than get into the expensive and challenging business of providing real support.

The Council of Canadian Academies was commissioned to convene an expert panel on MAID. A series of reports were released in December 2018, covering MAID for mature minors, advance requests, and patients whose sole underlying condition was a mental disorder.[3] Already the subject matter of the last report has been incorporated into law.

Within months of the report, Canada's leading paediatric hospital, Toronto Sick Kids, had drafted a policy for euthanasia for youths over 18 that could one day apply to minors.[4] As of 2017, 22 per cent of Canadians over the age of 15 are living with one or more disabilities.[5] Nearly 13 per cent of Canadians report two or more chronic illnesses.[6] Nearly half of Canadians can be expected to be diagnosed with cancer in their lifetime.[7] By the age of 40, half of Canadians will have or have experienced a mental illness.[8] We no longer theorise the slippery slope in Canada but seem to have enthusiastically jumped off a cliff.

Tracy Latimer's murder and her father's trial consumed the news cycle for years, but in the end, the name most Canadians know isn't hers; it's that of her father. No one championed her dignity and value. The debate was whether his punishment was too lenient or too harsh, not whether Tracy's life had been beautiful and worth living.

The same perspective that certain lives aren't worth living underlies the opinions of Canadians today. In a July 2021 public opinion survey, 62 per cent of Ontarians acknowledge that some see the lives of those living with disabilities as less valuable. We've eased our national conscience by talking about autonomy and self-determination. But one wonders how easy it would be to convince us that we can euthanise another person like Tracy without their consent, so long as we all agree their life is one we can't imagine living.

Regulators, courts and legislators: the battle for conscience rights

In this context, we turn to the state of conscience rights of healthcare professionals in Canada. In the Supreme Court ruling and the preceding euthanasia legislation, there was language to the effect that physicians could not be compelled to participate in euthanasia against their conscience. This well-intentioned wording, however, was not enough to protect the conscience rights of healthcare professionals.

In Canada, healthcare is funded federally but managed, implemented, and regulated by each province. This separation of jurisdiction allowed for a tapestry of different frameworks for MAID in each province and territory. In Canada's most populous province, Ontario, the provincial regulatory body for physicians created a framework that was, in essence, adopted by the province. Their policy regulated the implementation and reporting of MAID but also included requirements around conscientious objection. The College of Physicians and Surgeons of Ontario (CPSO) requires physicians who cannot participate in MAID, including the assessment process, to provide an effective referral to another willing physician. The Ontario government has subsequently created a direct access system allowing patients to self-refer by calling the provincial telehealth line, making referral unnecessary.

As the need to protect the conscience rights of Ontario physicians became increasingly urgent, the Christian Medical and Dental Association of Canada (CMDA Canada), along with two other organisations and five individual physicians, joined together to launch a legal application to challenge the CPSO's policies.

The debate was whether his punishment was too lenient or too harsh, not whether Tracy's life had been beautiful and worth living

In many ways, we feel like John the Baptist, crying out in the wilderness. We are announcing truths that no one wants to hear

On 31 January 2018, the Court declared that the CPSO's policies violated freedom of religion by requiring physicians and surgeons to make referrals when their consciences do not allow them to perform a procedure or treatment.[9] The court made several findings that are difficult to reconcile with each other.

The court held that:

1. The CPSO policy violated the right to freedom of religion.
2. Other protocols were in place in other jurisdictions that were less restrictive on freedom of religion, but the CPSO policy framework was reasonable. The Court failed to insist that the CPSO use the least restrictive option to achieve the goals of the policy.
3. While there was no proof that the exercise of conscientious objection has ever affected access to treatment, the apprehension that it might affect access was sufficient to justify the policy.
4. The effect on the applicants of the policy was not trivial and was held to be substantial. However, the court indicated that since there was no right to join the profession, the physicians in question could alter their practice or leave medicine entirely. The court failed to understand that almost all specialties can face requests for euthanasia. Furthermore, it is practically impossible for a graduate doctor to re-train in another specialty to avoid the challenge to their conscience.
5. The policy had no discriminatory effect, as the class of persons in question was not a disadvantaged group.

CMDA Canada *et al* appealed, but on 19 May 2019, the Ontario Court of Appeal upheld the lower court's decision.[10] It was decided not to pursue an appeal to the Supreme Court of Canada.

In 2016, we worked with other like-minded organisations, both medical and religious, to form a coalition to amplify the reach of our advocacy. The Coalition for HealthCARE and Conscience[11] is a group of diverse organisations opposed to legalising euthanasia and assisted suicide. Together our Coalition represents over 2,000 physicians across Canada. The Coalition advocates for respect for the sanctity of human life, the protection of the vulnerable, and individuals and institutions' ability to provide healthcare without having to compromise their conscience. This Coalition helped create visibility for this issue among Canadian citizens and now has a database of over 45,000 Canadians concerned about the expansion of euthanasia and the contraction of conscience rights.

With our Coalition partners, we continue to pursue legislative relief. We have been successful in the province of Manitoba, where conscience legislation was passed in 2017. However, in Ontario, where the need is the most urgent, there is a pronounced disconnect between public support for conscience protection and goodwill from legislators. As of July 2021, a public opinion survey commissioned by CMDA Canada shows 85 per cent support for conscience legislation in Ontario.

In many ways, we feel like John the Baptist, crying out in the wilderness. We are announcing truths that no one wants to hear. We are called as Christians to see our place with those at the margins. Patients at risk of losing their hope due to lack of support, fear of pain, fear of being a burden, or other reasons benefit from healthcare professionals who are willing to accompany them and give them hope. One cannot help but look at the current state of conscience rights and wonder with great fear how many years it will be until healthcare professionals who see the value in patients' lives beyond their diagnosis are pushed out of the system or not even admitted to medical school.

In listening to the voices of the disability community over the years, we see the plague of ageism and ableism has set down pernicious roots. As a society, we have lost the ability to recognise that all lives, even lives that don't look like ours, have implicit value and are sites of real encounter with God. In Canada, human dignity is under attack. Our government has enshrined our ableism and fear of death in ever-expanding euthanasia legislation. The treatment for the rot in our culture is for Christians to stand up and be faithful in our mission, to seek out those at the margins, and act as a refuge for those in need of care.

By fighting for conscience rights across our country, we are fighting for our patients, who desperately need healthcare professionals who will offer life and not death. Not every patient has family and friends to speak hope to them. Not every patient has a Church community to offer prayers, sustenance, and respite care. The same people that regulators are worried don't have adequate support to access euthanasia on their own are the exact patients who most need the support offered by healthcare professionals who still believe their lives are worth living. These patients need the grace of God in their healthcare professionals to touch them when they face a challenging diagnosis.

In our experience, healthcare professionals can feel somewhat self-serving fighting for conscience rights. However, when you fight for conscience rights, you are fighting for your patients to access healthcare professionals who will not transform a fearful cry for help into death at the end of a needle. The same community who protested at being targeted by euthanasia laws are the ones who need conscientious objectors throughout the medical system, shining a light on the path ahead. They need champions who acknowledge their human dignity in a world that has lost its way.

Stephanie Potter *is the Communications Manager of the Christian Medical and Dental Association of Canada*
Larry Worthen *is the Executive Director of the Christian Medical and Dental Association of Canada*

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John Greenall shares the stories of six Catalyst Team leaders from around the UK to help explain their role at the core of CMF's ministry to members

WHAT ARE CATALYST TEAMS?

key points

- Catalyst Teams are local or regional networks of CMF members volunteering to work together to bring the vision and mission of CMF to life at a local level.
- While there are common aims and vision across all 13 teams currently running, each team works out what this mission and ministry looks like locally, within the team members' needs, gifts, and capacities.
- Setting up a Catalyst Team in your area is a rewarding and exciting opportunity to see God work among health professionals in your workplace and community.

CMF is global, national, and local. Our mission is broad and inspiring as we seek to see gospel transformation in our nation, our hospitals, our GP surgeries, our universities, and above all, in the lives of individuals. But mission and activity happen through people who live in real places with real connections. In this article, you will read about the experience of our team leaders in three Catalyst Teams.

But what are Catalyst Teams about, and why are we so keen to see one in every region of the UK?

Catalyst Teams are local teams of volunteers who carry a **VISION** of what CMF can look like at a local level and work it out in practice. They recognise the diversity of geography, emphases, gifts, and passions of our members around the British Isles. Currently, we have 13 teams from Kent to the Highlands and Islands. Extending Catalyst Teams across the country is one of the ways we aim to go 'Wider' in our current three-year plan, as well as bringing CMF' Closer' and more relevant to local needs.

> Catalyst Teams are not simply a means to an end but... a vibrant community of people

Catalyst Teams are also true **TEAMS**, where we see people working to their gifting and strengths. It is also where we invest in people. They are not simply a means to an end but are meant to be a vibrant community of people who encourage and sharpen one another.

To help understand this, I wonder how many of you followed the England football team's progress in this year's Euro football tournament? I was struck watching successful teams (of course, we include the UK's other national teams in this!) and how we can learn from them at CMF.

Catalyst Team Christmas initiative in the Highlands

Shona McClure, Highlands & Islands Catalyst Team Leader

We decided to deliver gospels to people in the run-up to Christmas: firstly, to be a blessing to our colleagues and co-workers; secondly, to remind people about the real meaning of Christmas; and thirdly, to distribute information about local church services.

We used an established WhatsApp group to find out about local church services and liaised with the Hospital Chaplain who was happy for us to include chaplaincy contact details. Others volunteered to distribute the packs, and yet others volunteered to finance the materials. Many were praying – so everyone was working together to distribute 500 gospel packs around our area. This included the local hospital, GPs' surgeries, the community hospital, and remote district general hospitals.

The packs were enclosed in a Christmassy paper bag and included a copy of Luke's Gospel – a special edition with cartoons and quotes from children about Christmas and information about local churches and the chaplaincy. We even put some chocolates in as well!

The Christmas packs were generally very well received, and we are confident that seeds were planted. It was a good initiative where everyone could play their part.

- **The aim** – what does it mean for our team to win? What are our 'goals'?
- **The rules** – do our team members know the rules of the game and know when they are being broken?
- **The end** – when is halftime? Full time? How do we mark when things are completed or come to their conclusion? Do we know what and when to celebrate?
- **The tactics** – how do we want to play the game? How do we build a 'team'? And how do we adapt CMF's mission to local circumstances and people?
- **The players** – are our people in the correct positions that play to their strengths? Do players support one another and work together?

At present, we have developed ten team roles which we are increasingly supporting and networking. That leads to our third principle of **EQUIPPING**. The Catalyst Team network is characterised by connecting those in team roles to be equipped in the following ways. These are all optional, as our aim isn't to add meetings to busy schedules but to help people fulfil their calling and roles:

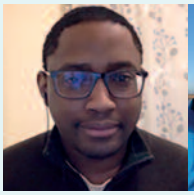
- **Training** – we offer online training for all those in the Catalyst network. This includes a half-day online conference every six months and bi-monthly webinars on a weekday evening.
- **Joint events** – by networking together, we can more easily coordinate joint events, eg regional online retreats adapted to the region's needs.
- **Resources** – we are growing resources for different team roles, such as developing and leading Workplace Groups, supporting Juniors, Pastoral Care, and more. Being in the 'Catalyst Family' makes being aware of these and accessing them easier.
- **Ideas** – linking to the wider Catalyst network means new ideas and resources become available to all. 'Stealing' ideas for sessions and local work is strongly encouraged!

If you would like to learn more about Catalyst Teams visit our website and you can email *volunteer@cmf.org.uk* or visit *cmf.org.uk/catalyst-teams* to start a conversation about starting a team in your region, or to be put in touch with an existing team near you.

Next you can read my interview with four Catalyst Team Leaders about their role, the challenges and the rewards.

WHY BECOME A CATALYST TEAM LEADER?

Team leaders included:



Becks Bayana in West Yorkshire

Ed & Sarah Tulloch in SE Scotland

Angela Wilkinson in Mersey

Why did you take on the role?

Sarah: I had some involvement with local CMF already but felt the need for a coordinated effort to bring people together with a common purpose – recognising the potential for good through the work of CMF, fulfilling a role that churches alone can't. I also saw it as a way to actively think about the connection between work and faith in my own life.

Ed: Yes, I realised I had become quite cynical about my work, and to a degree, I was going through the motions. Other Christian friends in healthcare were feeling the same way, so I wanted to think creatively about cultivating a culture of living and speaking for Jesus in healthcare.

Angela: I can relate to the cynicism – when John first asked me to be a Catalyst Team Leader, I had to laugh. I had been a Regional Team Leader for a couple of years, and the group felt quite tired with only two or three of us at our monthly meetings. But actually, starting a Catalyst Team allowed us to ditch the old meetings that were not serving much purpose and start again. It was exciting and daunting at the same time as I am not a natural leader, but God has been incredibly faithful.

Becks: I've been part of CMF for the past 16 years, and it's been an incredible journey – I've been inspired by those who have walked this road ahead of me. CMF has been a point of connection and stability as I've moved around the country. So, I've been happy to serve the fellowship in this way and give back.

What does it mean in practice?

Becks: It looks like conversations – catching up and connecting with people working in the region. I'm really excited to meet up and pray with those involved in student work in the city. They also bring together people from other organisations like UCCF working within the city to discuss their plans to extend God's kingdom. It's exciting now, as a Catalyst Team Leader, to play my part in connecting, supporting, and praying with other members, both students and those in the

workplace. I find it amazing that God can use all of us, with our different strengths and passions, to do the same thing – and that is to bring him glory.

Angela: As a team leader, you are involved in coordinating your local team and linking up regularly with CMF and the other CTLs around the country. It is challenging to make a group of busy people doing busy jobs and different things for CMF really feel like a team. However, it is great when we meet to know that we are working together for the region. Like Becks, I'll try to meet or speak to each of them once or twice. The monthly Zoom meetings with other CTLs are a wonderful source of support, encouragement, and wisdom. It really feels like there has been a revitalisation of regional groups. This is really exciting, especially in the current climate where healthcare workers are exhausted and overstretched.

Ed: As Angela said, the monthly CTL Zoom meetings are really helpful, as we encourage one another, share ideas, and hear from someone on a topic of interest to us – for example, something on developing pastoral care locally or thinking about Christian staff networks in hospitals. I always come away from these times encouraged and filled with ideas for how this could play out locally. We also have less frequent nationwide Catalyst Team coaching for all team leaders and team members, which is a morning online meeting considering a topic of relevance to everyone on Catalyst Teams.

Sarah: I echo what has been said by the others and would add to that the challenge of recruiting people to your team – enjoyable but requiring patience, as Becks has highlighted.

What would you say to someone considering the role?

Angela: I would say go for it! It is what you make of it. God will use anything you can give. It did take an initial investment of time to get the team up and running, but once established, the team leader role will work with as much or as little time as you can give. I always feel there is more that I could or would like to do, but God has been incredibly faithful in using my feeble attempts to lead and grow a great network in our region.

Sarah: I agree! Being a CTL is encouraging and helps spur you on in combining faith with work. As Angela said, it's as much work as you want it to be, but as ever, the more you put in, the more you get out.

Becks: When you first step into the role, it feels like you've got to be the brain and nervous system and figure out everything. But in fact, you're just one part of the whole thing. God is able to inspire and to bring people to you on that journey, so you don't have to figure out everything alone. A little bit of it is just being patient and waiting for God to raise up people who want to get on this journey with you in terms of serving where you are, so I've been encouraged to see that start to happen.

Ed: Yes, there are challenges and patience is needed, but it's such a joy to lead a local team with a bigger vision. Each team has the freedom to be a product of the people's passions who are part of it locally. I suppose each of us makes time for what we feel is important, and once I caught the vision of Catalyst Teams, I saw this is a priority for my time. I saw this as one way to participate in God's work in the NHS.

***John Greenall** is CMF's Associate CEO and a paediatrician in Bedfordshire*

[un]burden: West Midlands CMF day of prayer, 5 December 2020

Rod MacRorie, West Midlands Prayer Catalyst

The West Midlands CMF Catalyst Team was concerned about the fatigue and sense of being burdened amongst members because of the sustained pressure and challenges of COVID-19. Our team leader James highlighted Jesus' invitation to the burdened and wearied, his invitation to come, learn from him and find rest. So, we initiated a series of '[un]burden' events, which will run over the next six months.

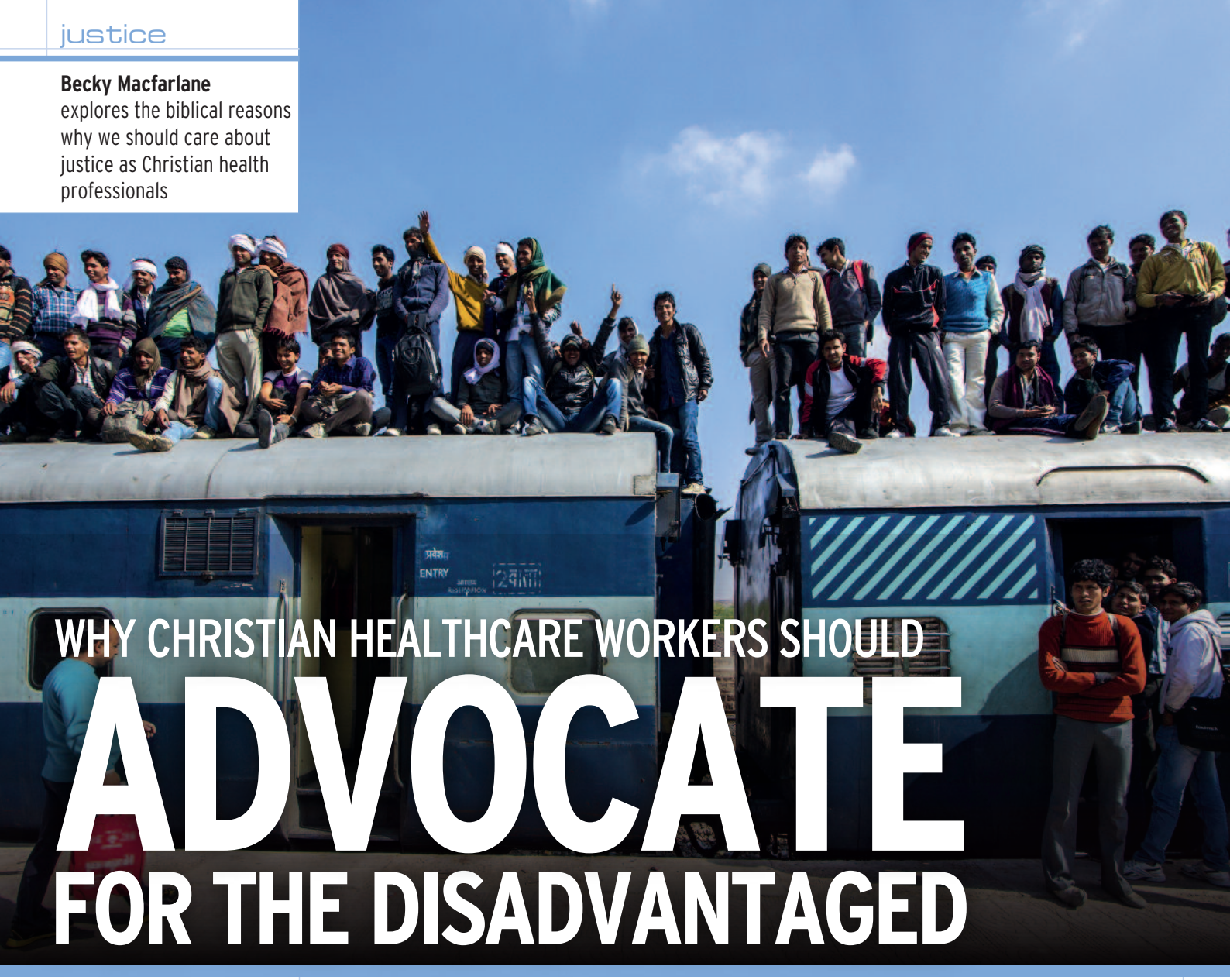
We started with a 24-hour day of prayer, using some brilliant online resources our Birmingham student members had created for a similar event. Student and graduate members in the region could sign up as individuals, host their own Zoom prayer gathering, or pair up for a socially distanced prayer walk.

A website provided resources and ideas for prayer; we set up three *padlets* to share prayer needs and encouragements. We put together an '[un]burden' playlist on Spotify to accompany prayer. We organised prayer gatherings via Zoom at the beginning and end of the 24 hours.

Over 90 people signed up covering all 24 hours, with more than 250 page views. Afterwards, many shared the value of being encouraged to draw aside in prayer. One participant shared that after the last prayer Zoom, they had a picture of a spirit level where pressures had pushed the bubble off-centre, and that spending time in prayer had helped the bubble return to the centre.

Since then, we have started facilitating seminars and plan an online retreat on the [un]burden theme.

Becky Macfarlane
explores the biblical reasons why we should care about justice as Christian health professionals



WHY CHRISTIAN HEALTHCARE WORKERS SHOULD ADVOCATE FOR THE DISADVANTAGED

key points

- Lamenting the sin, suffering, and evil in the world should act as a spur to the believer to take action and speak up for the poor and oppressed.
- While the Western church has often separated social action from the proclamation of the good news of Jesus, the Bible makes no such distinction.
- The author explores what the letter of James tells us about how to act justly as part of our discipleship.

Lament at sin and its effects as the impetus for advocacy

Advocacy always springs from lament. As our hearts are grieved by suffering, injustice and the chaos and confusion of our fallen world, we yearn for change and long for what is better.

There has been a tendency among evangelical Christians, particularly in North America, Europe, and Australasia, to focus on personal salvation through Christ's atoning death, his resurrection, and the coming of the Holy Spirit into the believer's life. For the individual believer, the penalty of sin is paid, the power of sin is overcome, and when with Christ for eternity, the presence of sin will be no more.

However, it is clear from the Bible that God is concerned not just with the individual's own sin but with the impact of sin on the whole created order and on the lives of those who are sinned against. Those who love and serve him must inevitably share in his grief and yearning.

If we share in God's grief at the lies, injustice, and violence in our world, we surely cannot be silent or collude with these. We have a responsibility to speak up to those with power and influence whose actions or inactions result in the suffering of the oppressed and exploited.

A historical recognition of the responsibility for advocacy

We need to grasp our role as individual Christians, churches, and Christian agencies in advocacy.

A sense of responsibility for both serving the poor and speaking up regarding the underlying injustices that cause, maintain, and deepen their poverty characterised many Christians in the 18th and 19th centuries. They were motivated and sustained by their faith in Christ and their experience of his protection and guidance in their work. Some of their names are still familiar today. John Newton and William Wilberforce were well-known for their campaigning against the transatlantic slave trade. Elizabeth Fry worked on behalf of women prisoners and their children and for prison reform. Sojourner Truth risked her life to advocate for the abolition of slavery and the rights of African Americans and women. Lord Shaftesbury fought for proper treatment of the mentally ill and to replace child labour with education. Harriet Tubman escaped slavery and spent the rest of her life leading hundreds of slaves to freedom and fighting for abolition. Charles Finney, an American pastor and evangelist, stood against racism and slavery and for women's rights.

In the late 19th and early 20th centuries, however, evangelical leaders in the USA and the UK separated evangelism from social action and social justice, a change coined 'The Great Reversal'. This was apparently due to concern that liberal theology had created a social gospel that denied the need for personal repentance and faith. However, this change in perspective fitted conveniently with a more individualistic approach that tended to focus more on personal morality and less on responsibility for our neighbour.

There has been a renewal of awareness of responsibility for social action and social justice among evangelical Christians in western nations over the past fifty years. This has been expressed in consensus documents, including the Lausanne Covenant (1974),[1] 'An Evangelical Commitment to Simple Lifestyle' (1980),[2] ' Transformation: the church in response to human need' (1983)[3] and the Micah Declaration (2001).[4]

'...work among the poor must embrace work on the causes of their poverty. Often these causes have to do with structural injustice and the abuse of power...This should be no surprise to those with a biblical doctrine of sin, for sin is deep and pervasive. It is both personal and structural…we are discovering afresh the Bible's condemnation of social injustice and its call to speak up for the oppressed.'[5]

The Bible's teaching as the basis for advocacy

It is impossible to read the Bible without a sense of responsibility to the poor and disadvantaged. The New Testament writers take for granted their readers' knowledge of the Old Testament. God commanded his people Israel throughout their history to defend, protect and support the poor, the orphan, the widow and the stranger.[6] Those who oppress and exploit the vulnerable or show indifference to their suffering are under his judgement.[7] Those who belong to Christ, whether Jew or Gentile, are no longer under the Old Testament ceremonial law but are still under the moral law.[8] Jesus commanded his disciples to do good. The New Testament writers constantly remind their readers of this.[9] Love always delights and rejoices in truth and justice.[10] God's people who have influence are specifically commanded to speak out on behalf of the voiceless.[11] They should not be surprised when their concern for the disadvantaged makes them unpopular.[12]

Personal discipleship to Christ as the foundation of advocacy

The letter of James, the brother of Jesus, causes us to reflect on our own lives and how we respond to poverty, discrimination, and oppression.

Response to God's Word

We must humbly accept the Word of God, which rescues us from self-righteous, hypocritical anger and must constantly loath and repent of our own sin, especially of evil and foolish words which make our claim to be a Christian worthless, (James 1:19-26, 3:1-12, 4:7-10).

Reality of faith

We must demonstrate our faith's genuineness and wisdom by giving humble, practical help and comfort to those in need, striving for peace, being teachable, considerate, and impartial and refusing to align ourselves with godlessness (James 1:26-27, 2:14-26, 3:13, 17-18).

Repentance from self-interest

Not all complaint is correct in God's eyes. Fighting our own corner, envy, nationalistic or ethnic pride, and the pursuit of power and prestige are all demonic and bring disorder (James 3:14-16, 4:1-6). God will judge a grumbling, complaining attitude (5:9) and any lack of integrity or transparency (5:12).

Rest and trust in God in suffering

When we ourselves suffer, are oppressed, or exploited, we are to demonstrate patience, determination, and contentment, looking forward to Jesus' return, confident in the Lord's compassion and mercy, prayerful, thankful, and living in supportive and honest fellowship (James 5:7-11).

Riches are a danger

The Bible's words should always be uncomfortable for those of us who have wealth. We can easily be presumptuous, self-confident, and arrogant (James 4:13-17). God is not blind to the exploitation of the poor that sustains our lifestyles (5:1-6). Showing partiality in our lives and churches towards those with wealth, power and influence will incur his wrath. We must not lord it over others (2:1-13).

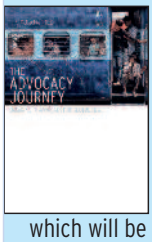
Conclusion

As Christians, God calls us to share his heart as revealed in his Word for the poor, vulnerable, and oppressed. He calls us to speak for others while not being surprised when we suffer and are excluded in this world.

Our awareness of our own need for a Saviour, our commitment to Jesus Christ as Lord, our dependence on him in our vulnerability and pain, and our confidence in his coming Kingdom, enable us to have a distinctive approach to the evil and suffering in our world.

As we see the need of our fellow human beings, we identify with them in humility rather than being indifferent to their plight. We grieve and repent as we become aware of how our lifestyle or actions contribute to their suffering. We plead with God on their behalf, coming to him broken by their anguish and loss. We speak up for them with courage to those who have the authority to change their situation. We follow the crucified Saviour and relinquish any claim on worldly influence or power, rejoicing in the expectation that when Christ returns, the meek will inherit the earth.

Becky Macfarlane *is a GP in Glasgow who is actively involved in caring for the health needs of asylum seekers and refugees. She is Chair of the CMF Global Advocacy Group*



CMF's Global Advocacy Group has produced a resource on advocacy in global health called *The advocacy journey*, which will be published later in October. See *cmf.org.uk/bookstore*

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7. Psalm 10; Psalm 12:5; Psalm 14:6; Psalm 26:9-10; Psalm 37:14-15; Psalm 49; Psalm 50:16-21; Psalm 52; Psalm 53; Psalm 58; Psalm 64; Psalm 76:7-9; Psalm 82:1-2; Psalm 94; Psalm 109:16-17,31; Psalm 120; Psalm 139:19-22; Psalm 146:6-9; Isaiah 2:11; 5:23; 26:5-6; Jeremiah 5:26-29; Jeremiah 22: 13-17; Ezekiel 16:49; Ezekiel 22:7; Amos 2:6-8, 5:10-13, 8:4-7
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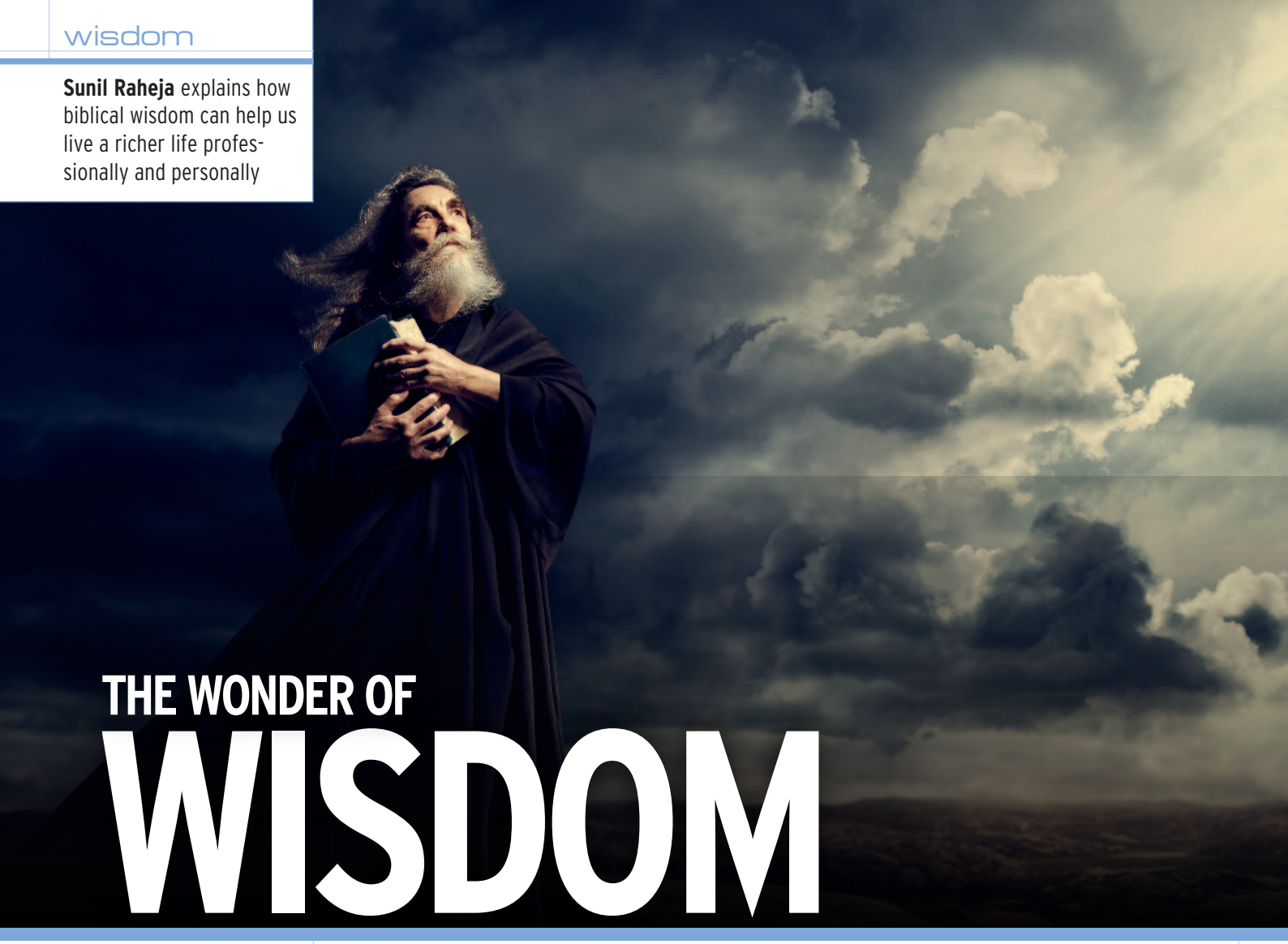
10. Proverbs 31:8-9; Isaiah 1:17; Jeremiah 22:16; Daniel 4:27
11. Isaiah 30:9-12; 1 Peter 2:20, 3:13-16, 4:19
12. Psalm 37:7; Matthew 5:5

Sunil Raheja explains how biblical wisdom can help us live a richer life professionally and personally



THE WONDER OF WISDOM

key points

- We have an innate hunger for wisdom and understanding about the best way to live, but this can lead us to seek answers from the wrong sources.
- Biblical wisdom draws us to focus on God as the source of all wisdom. The author draws on three books of biblical wisdom to explore the breadth and subtleties of scriptural insight into how we should live.
- The right way to live is centred in our relationship with Christ, out of which all wisdom ultimately flows.

The need for wisdom

In the early 1990s, I was just starting as a trainee psychiatrist. The woman booked to see me was one of the first patients with depression for whom I was responsible. I had about 20 minutes to evaluate how she was doing, review her diagnosis, and decide treatment options. But this particular lady did not seem to be getting any better despite all the different medications she was taking. I went through her history, feeling something was not quite right. I must have been about the fourth or fifth junior doctor she had seen in the previous two years.

One of the things we are taught in medical school is that when you feel stuck, go back and review the diagnosis for anything that might have been missed. I found myself saying to her, '*Is there something we are unaware of or missing?*' This was an invitation to drop the bombshell.

'*I have been having a prolonged affair with a neighbour who lives across the road. His wife does not know. In fact, she's my best friend. She's the friend who brought me to the clinic today. She's sitting outside the room right now!*' I was one of the first people she had told.

Her unresolved depression now made complete sense – she was living in guilt and out of congruency with herself. As sensitively as I could, I attempted to explain that no medication in the world could satisfactorily help her. To make progress, she would have to go through the difficult and painful task of facing up to what had happened. From there, she would have to deal with the uncertain consequences of the decisions she had made. She did not need additional or different medications or therapies.

We could waste a lot of time going down those mistaken paths. But now she had a choice to make; to turn back from the direction she had taken. As a psychiatrist, I could have kept on the path of adjusting the dose and type of her antidepressants. But I am convinced that she needed wisdom. Her experience and understanding of how life functions had hit a dead end. The only way out was to take a different turning and seek to live in wisdom with the choices she had made.

The hunger for wisdom

Human beings are innately curious about our world. It goes back to the first man and woman in the Garden of Eden in Genesis.

After the creation of the heavens and earth (which in Proverbs 8 is by the Person of Wisdom), Scripture tells us about the creation of a garden and the arrival of the first man.[1]

The man is told he can eat anything in the garden except fruit from the tree of the knowledge of good and evil, which will lead to certain death.[2]

God then states that it is not good for the man to be alone and that he will make a suitable helper for him. Following the creation of the animals and

birds, we read of the creation of the woman. At this point, the serpent arrives, described as '*more crafty than any of the wild animals the Lord God had made*'. (Genesis 3:1)

The word 'crafty' used to describe the serpent is related to the word for wisdom but describes indirect and deceitful ways to achieve one's aims. The serpent asks the woman about what God had said. The shrewd use of the question begins to lay doubt in her mind about the good intentions of God. It also serves to take attention away from all God has provided onto the one thing he has prohibited.

The woman's reply to the snake is even stricter than what God had said to the man, adding that they must not even touch the tree.[3]

Now the serpent craftily focuses on what is prohibited and inserts the blatant lie that they will not certainly die, but '*your eyes will be opened, and you will be like God, knowing good and evil*'. (Genesis 3:5) The serpent causes the woman to doubt what God has said and listens to him rather than God. We are intriguingly told the fruit was '*desirable for gaining wisdom*'. (Genesis 3:6)

The consequences of the deceit of the serpent have been unleashed. The rest of Scripture, it can be argued, is about reversing that terrible decision and learning to desire wisdom on God's terms and not the lie of the serpent.

The promise of wisdom

The concept of wisdom is rich and deep in both life and the Scriptures. The Person of Wisdom described in the Old Testament is the means by which God creates the universe in all its beauty and greatness. On a more personal level, it is also how we learn to live life well in all its complexity and confusion. The three Old Testament books of Proverbs, Ecclesiastes, and Job examine wisdom through different, complementary voices.

Proverbs presents wisdom as a brilliant teacher, Lady Wisdom, who is smart and full of insight about a wide range of life's issues relating to work, relationships, sex, and spirituality. In Proverbs 3:18 she is described as '*a tree of life to those who embrace her*', bringing an echo of what was lost when the man and woman were expelled from the garden.

However, as we get older and experience life, we discover many contradictions, confusions, and challenges. This is the theme of Ecclesiastes. The writer is personified as a sharp, middle-aged, somewhat cynical critic who challenges the thinking that using wisdom will simply bring you success. He is disturbed by the relentless progression of time, meaning people and things that are important today are quickly forgotten for new people and things tomorrow.

Then there is the mystery of death, leading to a sense of pointlessness, as we are all ultimately going to die. And finally, from a 'this-world-perspective' life 'under the sun' all appears so random, making Proverbs' simple solutions unsatisfactory and almost a cruel joke.

After a long journey to find meaning in education, employment, enjoyment, and enrichment, the writer concludes the only thing that really matters is a life that remembers we will have to account to God for all our seen and unseen choices and decisions.[4]

So, while there is a God who knows and sees everything, there is still much that is mysterious about life. Why is there so much suffering, cruelty, and unfairness? That leads to the third voice of wisdom from the book of Job.

He is the seasoned old man who has experienced the good, bad, and ugly of life in extreme measures. He is also, unwittingly, the one who is brought into a cosmic test involving the serpent in the form of Satan.

The big question of the book of Job is '*Does Job fear God for nothing?*' (Job 1:8) That is the question Satan cynically puts to God when they discuss Job's devotion and reverence for God. Job, through his fear of the Lord, is living in wisdom. But is he doing so only because he knows that is the best way to live a good life? It's the question all of us have to grapple with in our own pilgrimage with the Lord. Do I obey God for what I can get out of him, or because I truly love him?

At the end of all his suffering, Job is brought face to face with the awe and wonder of God, who concludes by showing Job two wondrous beasts (chapters 40 and 41), proclaiming how great they are. God admits they are dangerous with the power to kill. His big surprise is to say they are not evil because they are a part of his good world. And that is all God says to defend himself. The response to the mystery of life is awe, wonder, and worship.

The quest for wisdom

A quest is a long search for something difficult to find or to achieve. It is different from an adventure, where you go out on an exciting journey. It spices up your life, and then you come back home to pick up where you left off. By contrast, a quest is not something you choose. The quest chooses you. You are called to it because of what is going to be demanded of you. In many ways, the person you are at the beginning never really comes back from a quest. Either you die on the quest, or if you do come back, you are so fundamentally changed that you are not the same person as when you set out.

The wonder of wisdom is in navigating all the chaos, complexity, confusion, cynicism, and mistrust of the world as disciples of Christ. We are called into a deeper and richer relationship with the embodiment of wisdom, the Lord Jesus Christ. He is our wisdom. He calls us to include him in all the uncertainty and confusion we find ourselves in.

Thus begins our own personal wonder of wisdom that will take us to the end of our lives and beyond. This is the biblical hope that is founded on the resurrection of Christ from the dead. Grasping the implications will truly transform everything. I believe it could also transform that patient's life, who I met all those years ago.

Sunil Raheja *is a consultant psychiatrist, speaker, podcaster, and author*

The wonder of wisdom is in navigating all the chaos, complexity, confusion, cynicism, and mistrust of the world as disciples of Christ

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3. Genesis 3:2
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Ruth Eardley explores the pernicious effect of 'positive thinking' theology

POSITIVE THINKING

key points

- Positive mental responses to illness and suffering are often helpful but can become pernicious when they deny reality.
- The Power of Positive Thinking theology of Norman Peale and others offers a false gospel and a diminished view of God, with him relegated to the role of helper to the self rather than Lord.
- The author explores constructive ways we can engage with patients who espouse positive thinking as a cure for serious illness.

Every day, in every way, I'm getting better and better![1]

Self-improvement by autosuggestion was already a recognised technique when Norman Vincent Peale (1898-1993) published his book *The Power of Positive Thinking* in 1952. A hugely influential preacher, motivational speaker, and writer, Peale combined Christian hope with a kind of general optimism and had a massive worldwide following (he still does, judging by the reviews on Amazon). Peale claimed that his book was '*applied Christianity*',[2] but his claims were grandiose: '*you can experience an amazing improvement within yourself…you can modify or change the circumstances in which you now live, assuming control over them…you will become a more popular, esteemed, and well-liked individual…you will enjoy a delightful new sense of well-being…you will wield an expanded influence.*'[3]

A man of his time, Peale was certainly well-intentioned, but his teachings were a sort of early 'prosperity gospel'. God was side-lined into a helpful supporter who wanted you to succeed physically, spiritually, and financially.

I found myself thinking about positive thinking as I listened to the local radio whilst driving to work one day. Sandra was raising money for charity in the wake of treatment for breast cancer. She told her story with candour. It was great to hear our local Breast Care Centre praised and the specialist nurses described as 'brilliant'. Then Sandra's partner, Dave, was speaking: '*She's always been a fighter. Tackles things head-on and never lets anything get her down. Amazing attitude. She's going to knock spots off this disease. Anyone can beat cancer if they really want to. It's just a matter of positive thinking!*'

I groaned. It was just weeks since I had attended the funeral of a gloriously positive and hopeful Christian friend who died of ovarian cancer.

Now don't get me wrong: I love an upbeat attitude. And when positivity motivates someone to dust off their trainers, join a slimming club or call Quitline (NHS stop smoking support), then I am all for it. Empirical research shows that optimism tends to be associated with good health and long life, but it is hard to differentiate between cause and effect since the optimism is self-reported. Patients often say, 'Don't worry, Doctor, I won't let this thing beat

me!'. I feel pleased that they have come to terms with a chronic or debilitating illness; I know they will do all they can to live life to the full.

But sometimes, I am less confident. A terminally ill patient might say, forcefully and passionately, 'This cancer won't beat me! I'm made of stronger stuff!' And their agonised spouse echoes the same mantra: 'Yes, we'll fight it. We'll fight it together and we'll win.' But this positive thinking is wishful thinking.

Peale's books were not a hit with everyone. Influential reformed theologian Reinhold Niebuhr called his brand of positive thinking '*dangerous...it hurts people...it helps them to feel good while they are evading the real issues of life.*'[4] The then Dean of Yale Divinity School, Liston Pope, called it a 'cult' where '*God becomes sort of a master psychiatrist who will help you get over your difficulties...The constant reiteration of such themes as "You and God can do anything" are very nearly blasphemous.*'[5]

American bishop John M Krumm espoused a few heresies of his own, but he too criticised Peale: '*Very little is said about the sovereign mind and purpose of God; much is made of the things men can say to themselves and can do to bring about their ambitions and purposes*'.[6]

So how should we view 'positive thinking'?

Be wise. Recognise the limitations of positive thinking. From a biblical perspective, a 'you can do it' mantra never saved anybody. From a medical one, it can even be detrimental. If Sandra has an off day, possibly when she feels sick and loses her hair on chemotherapy, is she allowed a good cry on Dave's shoulder, or will this be classed as 'giving in'? If she wants to write a will and settle her affairs, will the family remonstrate with her for capitulating? And if, someday, she is weak and weary and admitted to the local hospice, will she feel a moral failure because she has succumbed? Maybe she did not try hard enough?[7] If a terminally ill patient feels obliged to maintain a cheery front and pretend that death is not imminent, how dare they reach for the Gideon Bible or ask for a visit from the chaplain?

Be clear in your own mind. When a patient puts faith in positive thinking, as if by their own force of personality and strength of conviction they can overcome organic illness, then this is a false gospel, an illusion. They are trusting in themselves.[8]

Be kind. If a patient talks about the power of dubious psychology affecting real organic change (such as visualising superhero T-cells killing evil cancer cells), then there is no need to pour scorn. Such mental exercises at least promote a desire to use remaining time well. It is better to avoid a flat contradiction.

Be hopeful. '*A cheerful heart is good medicine.*' (Proverbs 17:22) We all need encouragement when we are ill. Many downcast patients need reassurance that things may improve, that treatments are available, that you will support them through the illness.

Be bold. A holistic consultation acknowledges the spiritual dimension.[9] Ask about faith if it seems appropriate but do not exploit a patient's vulnerability by pressing your own beliefs. A Christian patient may be glad of your shared faith, but this should only find expression where it is relevant to the consultation. A retired vicar told me that he had peace about his palliative care because Christ upholds each of our lives every day anyway. '*Yes,*' I replied,' *for in him we live and move and have our being.*' (Acts 17:28) Then we moved on to discuss pain relief.

Be truthful. Do not endorse positive thinking as a means of tackling malignancy. There is no evidence that a positive attitude affects recovery from cancer.[10]

Beware. There is a sort of Christianised positive thinking. An elderly couple were both seriously ill but a member of their church convinced them that God intended to heal them. So convinced were they of the truth of this prophecy that soon the whole community knew of the miracle God was doing in their lives. They died in quick succession. The church explained that God had provided the ultimate healing by taking them to be with him. This was true but not what people had explicitly been led to believe.

Such positive thinking – trusting in my faith that God will heal me, is still 'all about me' and when it fails, it brings the gospel into disrepute. Yes, God can – and does – work miracles but he does not promise us a trouble-free life. Quite the opposite![11] An old man I visited was very weak physically but his spirit was strong. '*It's what God wills*', he whispered to me, '*Thy will be done*'.

Peale's 1974 title *You Can If You Think You Can* sounds awfully like 'name it and claim it' and has inspired the devotion of many disciples. Donald Trump cites Peale's influence in his success.[12] In contrast, writing on the perils and drawbacks of self-esteem interventions and 'boosterism', Professor Glynn Harrison notes that '*the gospel insists that we deal in reality and truth. It confronts the idolatry of self and refuses to conspire with our ego-absorption*'.[13]

Positive thinking has its place. Believers have a real and lasting hope, and counting our blessings will make us thankful and joyful. But let us be biblical; let us have confidence, not 'in confidence alone'[14] but in our sovereign heavenly Father and his Son, our Saviour. '*For God has said, "Never will I leave you; never will I forsake you".*' (Hebrews 13:5)

Now that's what I call positive thinking!

Ruth Eardley *is a GP in Market Harborough and a member of the* Triple Helix *committee*

[this] brand of positive thinking [is] 'dangerous...it hurts people...it helps them to feel good while they are evading the real issues of life.'

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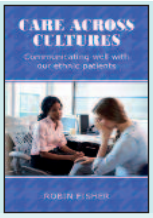


Care Across Cultures
Communicating well with our ethnic patients
Robin Fisher

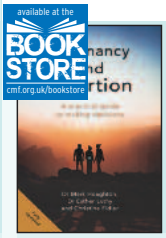
- New Generation Publishing, 2020, £8, 114pp, ISBN: 9781800319752
- Reviewed by **Steve Fouch**, CMF Head of Communications

There are three traps that any book on cross-cultural communication can easily fall into. The first is 'othering' those from a different culture, making the reader see them as somewhat outside the norm. The second is the assumption that the readers are all from the same culture as the author and therefore share the same perspectives and views. The last pitfall is to express the idea (even unintentionally) that every culture is monolithic and that all people from a given ethnic background are tied into it in the same way and to the same degree – all Americans say this, all Germans believe that etc.

The author largely avoids all these pitfalls, recognising that his readers will be from multiple cultural backgrounds. He even does some reverse anthropology in places, seeking to give insights into British culture for non-UK trained professionals. He also admits from the start that this is no more than a primer. It's a starting point to help the health professional avoid making assumptions. He aims to help us understand the questions and different values to consider when working with patients whose cultural backgrounds may be different from our own.

While some generalisations in the book are unavoidable, Fisher does his best to get inside the values and perspectives of different cultures in the healthcare setting without stereotyping. While not an academic treatise on world views and cultural assumptions, the book does a good job of opening up the value systems that may, at times, clash with NHS culture. Furthermore, Fisher is clear that many people (especially second and third-generation immigrants) live readily across these cultural boundaries and can be allies as 'cultural translators'.

Many younger health professionals will have done some cross-cultural training in their student years. This book will still be a helpful little refresher or starting point.



Pregnancy and Abortion
A practical guide to making decisions
Houghton MH, Luthy E, Fidler C

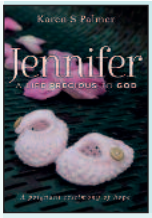
- Grace & Down, 2020, £9.99, 265pp, ISBN: 9781912863198
- Reviewed by **Laurence Crutchlow**, a GP and CMF's Associate Head of Student Ministries – a version of this review appeared in the June 2021 edition of *Nucleus*

How can we navigate the minefield of evidence around the effects of abortion? Challenging enough for any health professional, let alone the teenager with an unexpected pregnancy, or the counsellor with limited medical background trying to help her work this through.

Drawing together the evidence in a way that is accessible to all these groups, this book is divided into three sections. The first deals with how decisions about an unplanned pregnancy are made. The next deals with the three fundamental options in this situation (parenting, adoption, or abortion). The final section tackles some of the more complex and controversial areas, including the effect of abortion on mental health, future fertility, premature birth, breast cancer, and mortality. Appendices give a brief overview of the positions of major religions on abortion, and link to a host of mainly web-based resources offering help.

The authors all bring considerable experience to this field, which shows through particularly in the first section of the book; the tools and exercises suggested would be very helpful either to a patient thinking through a decision independently, or to a healthcare professional supporting them. I can see this being helpful in my own work as a GP, although consultations where someone is genuinely weighing up a decision about an unwanted pregnancy are increasingly rare. But it is also likely to help if we have to deal personally with someone close to us facing the challenge of an unplanned pregnancy.

The layout is straightforward and clear, and the language largely accessible to the educated layperson and avoids the angry rhetoric or condemnatory language that can be so unhelpful when discussing this sensitive subject. The book is also well referenced. This is particularly helpful for the more sceptical reader who may want to check the source of figures on more controversial topics.



Jennifer
a life precious to God
Karen S Palmer

- Instant Apostle, 2020, £8.99, 123pp, ISBN: 9781912726271
- Reviewed by **Sarah Germain**, Medical Writer and former Specialist Registrar in Obstetric Medicine

Many books seek to describe the grief process and offer advice from a theological, medical, or psychological point of view. In contrast, Karen Palmer offers her very personal story as the mother of a particular baby girl, Jennifer, who died a few hours after birth. Yet, she also powerfully brings to that moving testimony her insight as a doctor and her faith as a Christian.

Karen and her husband Gordon discovered during pregnancy that their eagerly awaited first child had multiple abnormalities, but they decided not to terminate and to carry on with the pregnancy. Based on her diary entries from that time and supportive letters from friends and family, Karen interweaves the story of Jennifer's life with insights into a good and faithful God who considers every life previous to him. She can bear witness that he loves us and wants to be intimately involved in our lives.

Gordon reflects that they may never be able to explain why this had to happen to them, but they could testify to the lasting good that has come out of this personal tragedy. Jennifer was loved by many and touched numerous lives, even in her short life.

I recommend this book to anyone facing the loss of a baby or walking alongside those who are. John Bell (Iona Community), who dedicated his '*A Cradling Song*' to Jennifer, describes the testimony of faith that shines through the Palmers' experience: '*faith is not an insurance policy against disaster, but the means by which we can walk through the darkest of valleys and believe that there will yet be light*'.

Dancing with Wisdom

A Sacred Quest to Restore Meaning, Purpose and Fun to Your Life and Work

Sunil K Raheja

- Author Academy Elite, 2021, £14.99, 248pp, ISBN: 9781647463465
- Reviewed by **Steve Fouch**, CMF Head of Communications

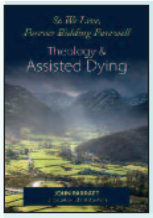
'Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?' – T S Eliot.

The gap between our highly informed, data-saturated lives and living genuine, wise, and authentic lives has driven more and more people to seek wisdom from different sources. It has fuelled the massive popularity of authors like Jordan Peterson or the dive back into the ancient philosophy of the Stoics.

Raheja takes us on a different course. Looking at the complexities and challenges to living aright in the modern world, he leads us, unapologetically, back to biblical wisdom. Drawing from his experience as a psychiatrist, and his own, often painful life experiences, he lays bare the futility of much modern thought.

The problem is that we look for quick fixes and simple rules for living that can set things right. But these superficial solutions cannot deliver the goods. Instead, delving first into the wisdom literature of the Hebrew Scriptures and then into the New Testament, Raheja brings us back to the root of wisdom – the living God, whose very creative nature is wisdom. If we are to live aright, he argues, it is only through the gospel of Jesus, the foolishness of the cross, and a profound, day-by-day walk with the risen Christ, that we may find true wisdom by which to live.

A book you could easily put in the hands of a colleague or friend seeking wisdom, this is also a clear exposition of the gospel and why it makes sense of the modern world like nothing else.



So We Live, Forever Bidding Farewell

Theology & Assisted Dying

John Parratt

- Sacristy Press, 2020, £3, 130pp, ISBN: 9781789591095
- Reviewed by **David Smithard**, a consultant geriatrician, and *Triple Helix* editor

John Richardson (Bishop of Portsmouth 1994-2002) comments that this *'...book sets out clearly and brilliantly the way...we should be beginning to think'*.

When I accepted the offer to review this small tome, I expected it to examine the theology surrounding assisted dying. Sadly, the book does not live up to this, nor to the eulogy offered by Richardson. I was left baffled and, at times, exasperated.

John Parratt has written this book to support the assisted dying cause. I struggled to understand the angle from which he was approaching this. Was it Christian or was it not? I finally came down against it being either a Christian or a medical approach. In fact, he dismisses arguments put forward by thinkers such as John Wyatt as '*shallow and unsubstantiated*', showing neither biblical nor theological rigour.

When the author discusses pain, his main focus is on physical pain. He barely acknowledges spiritual pain, psychological pain, and the pain of separation or despair. Consequently, he is at a loss as to how arguments for improved palliative care can be sustained.

Parratt also confuses martyrdom with suicide, rather than acknowledging that the loss of life in defence of one's faith is an act of courage rather akin to the defence of one's colleagues in war despite overwhelming odds.

To me, this book is written as a personal opinion, selectively referencing Scripture to support his arguments. It is not a dispassionate view of the facts and lacks theological rigour.

Wrestling With My Thoughts

A doctor with severe mental illness discovers strength

Sharon Hastings

- IVP, 2020, £9.99, 208pp, ISBN: 9781789740882
- Reviewed by **Ruth Eardley**, a GP in Market Harborough

Sharon Hastings sang her heart out at her baptism. She was a medical student, and she was going to devote her life to God and the service of others. Within three years, she was detained in a psychiatric hospital and denied a licence to practice despite passing her finals. This is Sharon's story, grippingly told with desperate scenes, terrifying hallucinations, hilarious conversations (in her manic phase) and a surprisingly touching ending. No spoilers here!

As her doctors struggle to pinpoint a diagnosis, Sharon lurches from deep despair to florid psychosis. Hijacked by the additional torment of an eating disorder, suicidal urges and a manic episode that sees her building a seven-foot snowman called Trevor, Sharon is eventually diagnosed with schizoaffective disorder. A student from her class at medical school (now a consultant) delivers the anaesthetic for her electroconvulsive therapy (ECT). *'I recognise him immediately...Consultant anaesthetist, psychiatric patient. How our paths have diverged.'* (p158)

Sharon openly sets forth her suffering. She talks about her struggle with shame and grief over the change in her prospects. Such plain speaking does much to dispel the stigma and fear surrounding this subject. Particularly useful are the highlighted factual 'inserts' that punctuate the text and explain mental illness and treatment straightforwardly. Examples include: 'What exactly is a psychiatrist?' 'Should a Christian have CBT?' 'What are antidepressants and when are they helpful?'

God seems distant for much of the story, but there is a lovely reflection on his power at the end. Verses of Scripture proved precious to Sharon, and there is even a list of things to be thankful for. The appendices (FAQ & Contacts & Resources) are brief but helpful. Overall, this is an easy-to-read eye-opener that will benefit pastoral teams and sufferers alike.

eutychus

US diplomats not Havana a great time

In 2016, US diplomats and intelligence operatives based at their recently reopened embassy in Cuba began reporting a mysterious cluster of symptoms reminiscent of concussion – headaches, memory loss, a sense of pressure in their heads, nausea, and fatigue. There was no obvious cause. Some suggested that it was sonic weapons, others that was some kind of weaponised microwaves. All blamed the Russians (because that's what you do). Then US officials posted in other parts of the world started to complain of similar clusters of symptoms in what was now being dubbed 'Havana Syndrome'. While outside influence is not ruled out, a theory that is gaining ground is that it is a form of mass psychogenic illness among US embassy staff around the world. Whatever the cause of this baffling syndrome, it was enough to deter the US Vice-President's recent visit to their Embassy in Hanoi. *The Economist*, 23 August 2021 *econ.st/3kQNeU7*

'Zero Covid' policy shuts major trade route

For two weeks in mid-August, global trade routes through Asia faced significant disruption as the third biggest port in China, Ningbo, was partially closed after a single dockworker tested positive for Covid. China's policy is to keep China totally Covid free, a policy that many in the region are abandoning in the face of the Covid delta variant's very high infectivity. The result has been a significant hold up in global trade that may have longer-term effects, especially if such closures happen again. The difference between 'Zero Covid', and a policy driven by mass vaccination will become apparent over the coming months. *Forbes* 14 August 2021 *bit.ly/3jJIgt0*

A not so big hand for the latest in prosthetics

A bionic limb that looks and feels human and is practical and easy to use? Well, we may not be there yet, but for the millions who have lost a hand or arm, that dream may be one step closer. Gu Guoying and his team at Shanghai Jiao Tong University have developed a powered, articulated hand that responds to brain signals and sends sensory feedback. It is lighter than all current alternatives (and even lighter than many real hands at under 300g) and runs on pneumatics. You do still need to wear an external pack to run it, but this is the least bulky and difficult bionic limb to date. And you won't need six million dollars – the model costs a mere $500 compared to the $10,000 for most alternatives. *The Economist*, 21 August 2021, *econ.st/2VyMASw*

Sharpen up with tea

In recent years, the UK has become famous for its creative output – in TV, films, music, and literature. It turns out our national obsession with boiling the leaves of *Camellia sinensis*, and drinking the infusion many times a day, may be the source of this creativity. Researchers at Peking University found that it does not seem to be caffeine (or tea's unique stimulant, theanine), but the act of making and drinking tea that released creativity and focused the mind. So, the next time you need to clear out the cobwebs and focus, making a cuppa, caffeinated or otherwise, really might be what you need. *The Times*, 15 August 2021, *bit.ly/3A6EXSg*

It's a bug's life...

We may be used to the idea that dogs (and even some humans) can smell diseases before they present clinically, but it now transpires that insects may be the next diagnostic breakthrough. Giovanni Galizia of the University of Konstanz, in Germany has been using genetically modified fruit flies to detect breast cancer from urine samples. Hirotsu Takaaki, of Kyushu University, in Japan, has been using worms to detect up 15 types of cancer using blood and urine samples. Meanwhile Aria Samimi in the Netherlands has been using bees to detect COVID-19. Could the future of diagnostics rely on some of the smallest creatures God put on the earth? Time will tell, as all these approaches are still experimental and have yet to have any regulatory approval. *The Economist*, 31 July 2021, *econ.st/3AOCngl*

Resisting the return to the office

While pregnant women are at no greater risk of COVID-19 than anyone else, a Covid infection can cause pregnancy complications. The Royal College of Obstetricians and Gynaecologists recommend that employers recognise this as the demand to return to office work mounts. Many mothers and mothers-to-be have discovered the benefits of home working and have begun to resign as employers increasingly demand a full return to the office with few options for flexible working. Family life and safety have become higher priorities for many during lockdown, both women and men. The traditional workplace, with the lengthy commute and the costs and hassles of school runs and childcare, are making the traditional workplace increasingly unattractive for women in particular in the post-Covid world of work. *The Guardian*, 4 September 2021, *bit.ly/3I7C25w*

Cancer vaccines are almost here

Before COVID-19, the team at Oxford University was working on cancer vaccines. That work is now moving forward again and is about to move to human trials on non-small cell lung cancer. Animal studies have shown that using viral vectors to carry genetic information to trigger an immune response against cancer cells has a significant impact in slowing tumour growth or shrinking cancers. In combination with anti-PD-1 immunotherapy, which triggers anti-tumour T-cells, this approach could revolutionise cancer treatment in the coming decade. *The Times*, 3 September 2021, *bit.ly/3E9drWw*

Climate friendly labour

Entonox has been the friend of many a woman in labour for decades. However, the nitrous oxide that is its active ingredient is also a powerful greenhouse gas. An NHS trust can contribute the equivalent of 3,000 tonnes of CO_2 in the exhaled nitrous oxide from a labour ward over a year. A new device, called a Mobile Destruction Unit (MDU), collects, and destroys the nitrous oxide exhaled by the user. It's been used in Sweden for a while but is now being trialled at the Newcastle Birthing Centre here in the UK. Expect to see more and more labour units across the UK declaring their lowered carbon footprint in the years to come! *BBC News Online*, 10 September 2021, *bbc.in/3npzDpw*

Patricia Wilkinson reminds us of the importance of simply being, laughing, and resting as part of our walk with Christ

LAUGH OFTEN

It has often been said that laughter is the best medicine. After the events of the last 18 months, it seems as though there hasn't been a lot to smile and laugh about. And when we do, there can almost be a sense of guilt that we enjoy things when people around us are dying and suffering.

The Gospels give us glimpses of Jesus teaching, healing, and challenging. He was always serious, spending nights in prayer. When he was invited out for a meal, it was constantly disrupted by unexpected and uninvited guests or as he challenged his host's thinking and beliefs.

Is this really who Jesus was? If it was, would the disciples have followed him for three years and become friends? There would have been plenty of ordinary evenings that are not recorded; times spent around a campfire or in the houses of friends, relaxing with a cup of wine; time just to be.

The disciples and Jesus were doing what friends do. Swapping stories about what had happened recently, Andrew getting lost, Thomas forgetting to buy the bread, and a goat eating Thaddeus's cloak. There would be times of reminiscence: Bartholomew saying, '*tell us the one about the camel trying to pass through the eye of a needle again*'. They would just enjoy being together; laughing with, not at, each other, telling jokes – everyday things.

This is what we have missed during the pandemic. It is not quite the same over Zoom. There have been lighter moments at work, chances to relax, humour in the situations in which we have found ourselves, but this is not the same as being together as friends. It is possible to think, '*can we, should we be enjoying this moment?*' I would say yes, we all need humour and laughter. The Companions and Community of the Scargill Movement promise to '*enjoy giving and receiving lots of treats – and laugh often*'.[1]

May we take our faith seriously but never be too serious about it. In the words of one of the Iona Evening Prayers: '*Come Lord Jesus, you too were tired when day was done; you met your friends at evening time...you too enjoyed when nights drew on; you told your tales at the close of day*'.[2] May we follow the example of Jesus and his friends. May we never feel guilty about being together, enjoying each others company, telling stories, and laughing together.

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1. *scargillmovement.org/community/rule-of-life*
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