Spring 2021

for today's Christian doctor

triple helix

medicine in conflict

touch – a healing gift, Arthur Rendle Short remembered, a career for Christ, Physician Associates, a heavenly reason to care for bodies

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contents

Stand up for those without a voice

In Christ, all people are equal; neither male nor female, slave nor free.[1] God treats us all the same. God also expects us to act justly, to love mercy, and to walk humbly with our God.[2] In Isaiah, God tells us that he expects us to '*share [our] food with the hungry and to provide the poor wanderer with shelter*'. (Isaiah 58:7) Throughout the Bible, God demonstrates his love and protection for the poor and vulnerable.

Since it started in China at the back end of 2019, COVID-19 has killed more than two million people and this is expected to hit three million by April. The approach to COVID-19 has varied between countries, from denial to complete lockdown and everything in between.

COVID-19 has laid bare government policies and human selfishness that have widened the gap between those that have and those that have not, between wealthy and developing countries.

People have been holding their collective breath, waiting for the arrival of a vaccine. Then, like London buses, three came along almost at once, with more to follow. We should praise God that several vaccines are now available worldwide and that people are starting to be immunised.

However, rather than the world rejoicing and heaving a collective sigh of relief, we instead see political fighting and self-interest. Many high-income countries have over-ordered, with Canada leading the way with nine doses per head of population. Over half of the vaccines in production have been bought or pre-ordered by five countries and the European Union, representing just 13 per cent of the world's population. It is predicted that residents of low- and middle-income countries will have to wait until 2023 or 24 before they are vaccinated.[3]

Predictably, the political recriminations followed. The World Trade Organization chief has criticised global vaccine inequalities.[4] President Macron has suggested that countries should donate four to five per cent of their own supplies to COVAX,[5] a UN initiative to distribute vaccines to developing nations. Prime Minister Johnson has offered a substantial amount of the UK's excess vaccine,[6] and President Biden has offered $4 billion towards COVAX.[7] The scheme has so far raised $6bn (£4.3bn), but 'says it needs at least another $2bn (£1.4bn) to meet its target for 2021.'[8] Meanwhile, Russia and China have begun to send their own vaccines to Latin American and African countries in so-called vaccine diplomacy.[9]

Within countries, there have been debates about who should be vaccinated first. Healthcare and other front-line staff or the weakest and most vulnerable? In the UK, those living in nursing and care homes and their staff were in the first in line. Yet still, one-third of staff have not been vaccinated.[10]

The structure and prioritisation of the vaccination tiers have come in for criticism, especially from those caring for people with learning disabilities.[11] Adults with Down syndrome are considered '*clinically extremely vulnerable*', so have been placed in category four.[12] Adults with 'a severe or profound learning disability' are in group six, but those with a less severe learning disability will be vaccinated with their age group. However, the *Nursing Times* reports that a study by Public Health England, released last November, found that people with learning disabilities are '*four times more likely to die from COVID-19 than the general population.*'[13] For those in the 18-34 age group, the risk is 30 times greater than for the general population of the same age.

The politics around any international problem, let alone a pandemic, is always very difficult. However, the world will not be safe until everyone has access to Covid vaccines. If justice is to be done, then all people who are at similar risk should have the same access to the vaccine at the same time. Is it right that very low-risk people should be vaccinated before more vulnerable people in the same country or other countries? Especially when for some, this may mean waiting years and not weeks.

'*Blessed is he who has regard for the weak.*' (Psalm 41:1)

'*For the needy will not always be forgotten.*' (Psalm 9:18)

'*Whoever gives to the poor will not want, but he who hides his eyes will get many a curse.*' (Proverbs 19:17)

As Christians, we need to be a voice for the voiceless and take a stand where we can; to support a fair and equal system for everyone, wherever and whoever they are, as all people are made in the image of God.

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news reviews

'Puberty blockers' for transgender children

High Court rules they are 'innovative and experimental' treatments

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

In December, the High Court ruled against The Tavistock and Portman NHS Foundation Trust, finding that puberty blockers and cross-sex hormones are 'innovative and experimental' treatments, to which it is unlikely that young people would be able to give informed consent.[1] An appeal will be heard later this year.

Then in January, the Care Quality Commission (CQC) released its inspection report in which it rated the GIDS (Gender Identity Development Service)[2] 'Inadequate' (CQC's lowest rating). The service's safety, effectiveness and responsiveness to people's needs were all criticised in the report, as was its leadership. Criticisms include: 'Staff did not develop holistic care plans for young people'; before January 2020, '*Staff had not consistently recorded the competency, capacity and consent of patients*'; and '*Some [staff] said they felt unable to raise concerns without fear of retribution.*'[3]

The GIDS Executive leadership team has been disbanded already,[4] and the Tavistock is bringing in '*senior clinical and operational expertise from outside the service*'[5] to help them make the necessary changes.

On 2 February, the results of the GIDS's research into the effects of puberty blockers on teenagers were finally published.[6] The study revealed that puberty blockers '*stunted the height and impaired the bone mass density*' of participants, and '*brought no improvement in psychological function, quality of life or gender dysphoria.*'[7] All but one of the 44 participants' elected to start cross-sex hormones' at the end of the study.[8]

The Cass Review[9] into the use of puberty blockers and cross-sex hormones in children and young people is ongoing, but it seems likely that it will be similarly critical. Hopefully, better support and outcomes for children struggling with their gender are on the way.

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Opting out of organ donation

The effect on minorities

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

Under a law that became effective in May 2020,[1] all adults in England are considered to have agreed to post-mortem organ donation after their death unless (a) they have actively opted out or (b) they are in an excluded group. This change had been under consideration for many years. The Chief Medical Officer in 2006[2] proposed amending legislation to create an opt-out system with proper safeguards and a good public information programme. CMF has considered the issue from a wide range of ethical and biblical perspectives over the years.[3,4,5]

In reality, presumed consent equals no consent unless there is an effective, diverse, extensive, sustained, and comprehensive public information programme. Such a campaign would need to capture the entire adult population, including those on the margins of society who might, because of disability, illiteracy, internet access, linguistic or cultural problems, be less likely to receive, digest or act on the information.[3,4]

Within the first four months of the law coming into effect, of the two per cent of the population (1.7 million people) who had already opted-out, those from ethnic minorities numbered 1.47 million. 47 per cent of these were Asian, and 14 per cent were black (compared with 7.5 per cent and 3.3 per cent, respectively, in the general population).[6] Taking into account the fact that 32 per cent of patients on the waiting lists for transplant are Black or Asian and that someone from a similar ethnic background is more likely to be a good tissue type match,[7] this suggests there will be a much lower chance of someone from either of these groups receiving a timely transplant compared with an ethnically 'white British' patient.

Religious as well as other cultural factors may be at play. The authorities have offered leaflets and short videos in various languages, explaining the transplant system in England, including some religious aspects.[1,8,9] However, the coverage is by no means comprehensive. For example, the Christian leaflet is only available in Polish or English. Not all have been updated with the legal changes of May 2020. The soundtracks of 'other language videos' are spoken in English, so one must be able to read the subtitles to benefit from the translation. It may well be that people from ethnic minorities chose to opt-out without having first understood the issues at stake. It is also quite possible that many who would wish to do so fail to opt-out because they do not yet know about the new legislation.

To be morally acceptable, the opt-out system must be accompanied by a long-sustained, more extensive, more prominent publicity campaign, with both oral & written communications in many languages reaching people on the margins of British society.

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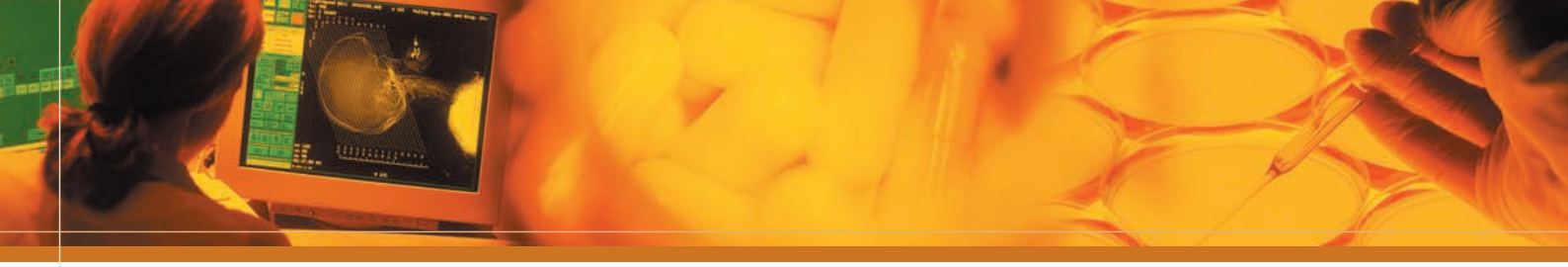

‘DIY home abortion’ regulations in the UK

Are they set to stay despite safety concerns?

Review by **David Smithard**, Triple Helix editor &
Jennie Pollock CMF Associate Head of Public Policy

In March 2020, new temporary legislation was rolled out allowing for women to have Early Medical Abortions (EMA) at up to nine weeks and six days’ gestation ‘*in their own homes, without the need to first attend a hospital or clinic*’.[1]

CMF and many others have repeatedly raised concerns about the safety of this ‘home abortion’ scheme. Within weeks it was revealed that police were investigating the death of a baby ‘*after its mother took abortion drugs at home while 28 weeks pregnant*’.[2] An undercover investigation by Christian Concern revealed that women were able to obtain the pills after giving false names and gestations.[3]

Data from an FOI request to the Care Quality Commission (CQC) revealed that between April and November 2020, 19 women received hospital treatment for complications following early medical abortion ‘*in which the gestational age (GA) of the pregnancy was greater than the legal limit for EMA... including four cases in which the GA was beyond 24 weeks*.’[4] Eleven of these cases involved women using the ‘pills by post’ scheme.

In a poll of Scottish adults conducted by SPUC, an ‘overwhelming majority’ of respondents expressed concern that without a face-to-face consultation, women might be pressured or coerced into having an unwanted abortion.[5]

The current arrangement was to be temporary, for the duration of the coronavirus pandemic.[6] Now the Department of Health and Social Care (DHSC) and the Scottish and Welsh governments have consulted on whether to extend the provision beyond its original timescale. CMF has responded to the consultations, setting out our concerns around women’s safety, the risk of coercion, and the lack of appropriate record-keeping. You can read our submissions on the CMF website.[7]

CMF is working with other organisations to gather further evidence and challenge this legislative creep. We encourage our members to keep abreast of this situation and the increasing evidence of the dangers of keeping and extending the current emergency legislation. Do pray for the safety of women and newborns to remain uppermost in the minds of legislators across the four nations.

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End of life developments

BMA poll and Irish bill yet again put pressure to legalise assisted suicide in the UK

Review by **Mark Pickering**
CMF Chief Executive

Pressure to legalise assisted suicide continues. The BMA members’ poll, taken in February 2020 but only released in October 2020, is very significant, representing the views of 29,000 BMA members. As noted at the time: ‘*40 per cent of respondents wanted the BMA to actively support attempts to change the law to legalise assisted suicide, 33 per cent favoured opposition, and 21 per cent felt the BMA should adopt a neutral position*.’[1]

Behind those headlines lies more nuanced detail. Students and retired doctors (ie those not making clinical decisions) were most likely to support legalising assisted suicide, while those in specialities such as palliative and elderly care (where regular end of life discussions and decisions take place) were least likely to support law change. Nevertheless, this is the first time that a formal UK medical poll has put legalising assisted suicide as its most favoured choice.

The results do not change BMA policy, leaving the Association in an uncomfortable limbo. With COVID-19 cancelling the usual four-day annual meetings for both 2020 and 2021, it is still uncertain when the BMA will be able to give these results the proper attention to debate and agree a policy.

Meanwhile, heavy pressure continues in both Westminster and Holyrood. Another bill is expected soon after the Scottish elections in May. Supporters of assisted suicide in Westminster regularly put questions to ministers, call for reviews, and lay plans for either amending government bills or placing a private members bill. Continual vigilance is required, but we are encouraged by a renewed degree of collaboration between our partner groups and both MPs and Peers who oppose the legalisation of assisted suicide.

The Republic of Ireland’s ‘Dying with Dignity’ Bill’[2] is currently at committee stage in the Irish Parliament, the *Oireachtas*. Even more worryingly, the bill extends eligibility to those ‘resident on the island of Ireland’ for one year. This would include UK citizens living in Northern Ireland and would therefore bring in assisted suicide to part of the UK without ever passing in a UK Parliament or Assembly! The bill is currently considering submissions by a range of groups, including CMF.[3] We must pray that Irish lawmakers will at least amend that clause, and hopefully reject the bill as a whole.

We urge CMF members to pray and engage with colleagues, politicians, and the BMA as appropriate. Contact *jennie.pollock@cmf.org.uk* to get more involved or to sign up for our regular Public Policy e-News.

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David Cranston reminds us one of the most important but overlooked aspects of our professions and our faith

TOUCH – A HEALING GIFT?

key points

- COVID-19 has had a significant impact on social contact over the last year, and in particular on touch as a central part of human interaction.
- In all health professions, touch is a central part of the patient/professional relationship.
- In Scripture it is also clear that touch is central to Christian ministry – our physical bodies and human contact are essential to our spiritual lives.

COVID-19 has dominated all our minds for most of 2020 and 2021, and despite the arrival of several vaccines, it is not going to disappear quickly. In many respects, we are going to have to learn how to live with it. However, this pandemic has had another effect that has never been seen before to the same extent, or on such a global basis, namely social distancing and a lack of physical contact.

People have been socially isolated due to epidemics before. Villages isolated themselves for months when the plague ravaged the land in 1665. For example, the Rector of Eyam, a small village of a few hundred souls in the Peak District, asked the villagers to isolate themselves during the plague. Between a quarter and half of the inhabitants died.[1] But not until 2020 have all the churches, schools, pubs, and restaurants been closed across not just the United Kingdom but across most of the world.

Most of us are blessed with at least five senses. As age creeps up on us, some of those senses start to fade. In this pandemic, all our senses have been affected. One of my daughters-in-law who has

> one of the saddest effects has been the inability to touch or hug

recently recovered from COVID said that her sense of smell was like following a diesel lorry for three days! The other senses are affected too. There are limits to seeing and speaking to friends, as a smile disappears under a mask and hearing speech becomes more difficult.

Yet one of the saddest effects has been the inability to touch or hug, dramatically increasing the feeling of loneliness and isolation for all of us over the last year.

This inability to touch made me look up that word in the Bible, where I found that it occurs over 50 times in various settings.

In some situations, touch brings reassurance. After his experience on Mount Carmel, Elijah was tired and depressed. Then an angel touched him and said, '*Arise and eat*'.[2] On the Mount of Transfiguration Jesus came and touched James and John saying, '*Rise, have no fear*'.[3] After the resur-

rection, Jesus appeared to Thomas and said, '*Touch me and see*'.[4] The very sight and touch of Jesus was enough to quell Thomas' doubt. The apostle John begins his first letter reassuring his readers of Jesus and his message in the words, '*That which... we have touched with our hands, concerning the Word of Life*'. (1 John 1:1)

Isaiah and Jeremiah were both commissioned by God's touch upon their mouths.[5,6] In love and servitude, Jesus washed the disciples' feet, an act impossible to do without touching.[7] And of course, there are many instances of Jesus' healing involving his touch or others touching him, including the woman with a haemorrhagic problem.[8]

When a leper approached Jesus in desperation, Jesus did not simply offer a healing word from a safe distance, he stretched out his hand and touched him. He felt deeply for people with leprosy, cut off from all human contact. He touched the untouchables.

The Prodigal Son's father did not wait at the door or offer a reluctant handshake; he ran – something that respectable people did not do – falling on his son's neck and kissing him, enfolding him with forgiveness.[9]

Touch can reduce pain, anxiety, and depression, and there are occasions when one can communicate far more through touch than in words, for there are times when no words are good or holy enough to minister to someone's pain.

Rev Dr James Simpson, a former moderator of the Church of Scotland, tells a story of being asked to inform the parents of a boy killed in a road accident. The father understandably broke down, and as the father leaned forward, his head in his hands, Dr Simpson put his hand on his sobbing head and kept it there for some time. His sobs gradually grew quieter. Employing touch, he was able to communicate that his heart bled for him.

Touching has always been an essential part of healing. Lewis Thomas, the American physician and author who died in 1993, rated touch as the oldest and most effective act of healing. '*What did doctors [of old] do*,' he asks, '*when called out at night to visit the sick for whom they had nothing to offer for palliation, much less care?*'

He replies: '*One thing they did, early in history, was plainly magic. ...Dancing around the bedside, making smoke, chanting incomprehensibilities and touching the patient everywhere. This touching was the real professional secret – never acknowledged as the central essential skill.*'[10]

He goes on to say: '*Some people don't like being handled by others, but not, or almost never, sick people. Part of the dismay in being very sick is the lack of close human contact.*'

Reviewing Thomas' book, Nobel prize-winner Sir Peter Medawar explains, '*In the course of time, touching, like everything else in medicine, became more specialised and refined and turned into palpation – feeling for the tip of the spleen, or the edge of the liver – or into a thumping of the chest in order to ascertain whether the sound was dull or resonant. The gift possessed by these doctors who began the laying-on-of-hands was probably the gift of affection.*'[11]

However, technology has tended to increase the distance between clinician and patient. A doctor or nurse may now remain in their office while the patient is in another building. Telemedicine is here to stay, but it may well cause the patient to feel that the clinician is more interested in the disease than in themself as a person.

Sir William Osler, whose greatest legacy was taking students to the bedside to talk to the patients, famously said, '*The good physician treats the disease, the great physician treats the patient who has the disease.*'[12]

Henri Nouwen, a Dutch Catholic priest, professor, writer, and theologian recalls an orphanage in Peru where the children's greatest need and desire was no mere material gift: '*These boys and girls only wanted one thing: to be touched, hugged, stroked, and caressed.*'[13]

Princess Diana touched people with HIV. Florence Nightingale and Mother Teresa touched the dying, and, like Jesus with the leper, were unconcerned by the possible risk to themselves.

Yet today, it is not just COVID that we are worried about when we touch a person. The recent publicity about sexual misconduct of people in powerful positions gives further concern about the use of touch. Touching any patient without clear permission can make them ill at ease and mistrustful and risk justified accusation. On the other hand, I know colleagues who have had false accusations made against them, leaving them devastated and facing lengthy court cases before they were exonerated. It is a tightrope all of us must walk very carefully.

Yet effective personal ministry always includes risk, and if the New Testament is anything to go by, Christian ministry, as well as medicine, will always involve touch. Indeed it is difficult to conceive of any effective Christian ministry that does not involve touch. As Father Timothy Radcliffe, former master of the Dominican Order, wrote in *The Times* some years ago:

'*You can see and not be seen, or hear and not be heard, smell and not be smelt, but you cannot touch without being touched. ...Our society is so worried, rightly, about the risk of sexual abuse, that we have become nervous about touch. ...But we must recover this most human and Christian way of being the Body of Christ. We shall be deeply deprived and seem to undo the Incarnation if we keep our distance all the time when God has drawn near.*'[14]

So, let us pray that the ability to hug and touch is not lost. As members of the medical and nursing professions, and the Christian community, in whatever sphere and the appropriate setting, may we remember the importance of touch.

David Cranston *is an Associate Professor of Surgery at the University of Oxford*

Technology has tended to increase the distance between clinician and patient. A doctor or nurse may now remain in their office while the patient is in another building

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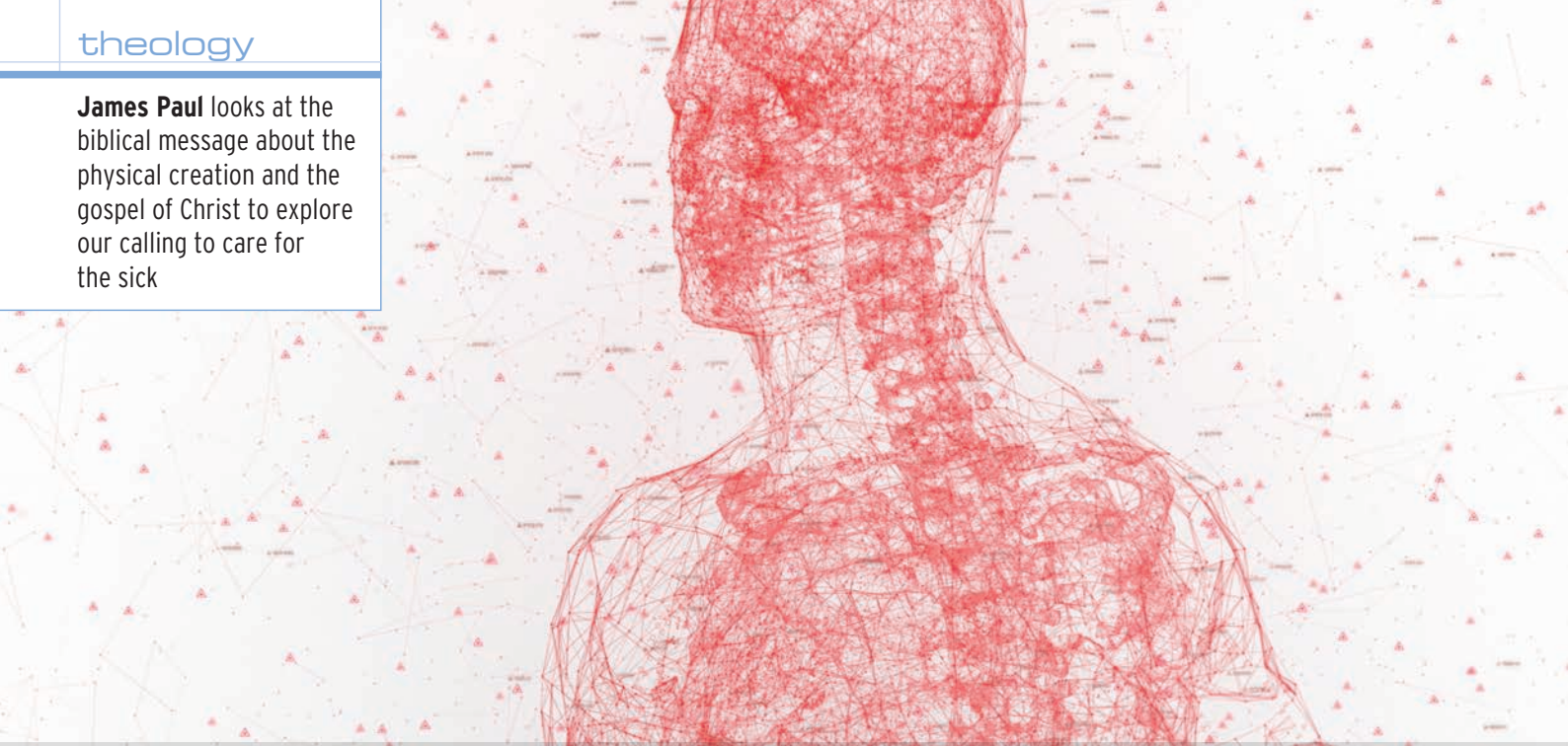
James Paul looks at the biblical message about the physical creation and the gospel of Christ to explore our calling to care for the sick



A HEAVENLY REASON TO CARE FOR BODIES

key points

- What is the relevance of physical medicine when our ultimate hope is in Christ and a heavenly existence after death? The author deconstructs the common misconceptions about heaven and the kingdom of God and how the Scriptures show us an embodied, physical existence for God's people in the age to come.
- As a result, the physical and the spiritual are not as separate or distinct in the biblical understanding of humanity as they are in popular, Western culture.
- The role of medicine and healthcare as part of God's redeeming work in creation is explored – while not diminishing the importance of repentance and faith.

'Why be a doctor? Why should I bother to heal and cure bodies if everyone is going to die in the end? Why don't I become an evangelist?'

I was leading a discussion group for medics when one of them asked this question. At first hearing, her line of reasoning seemed logical. If the most important concern of our lives on earth is the eternal destination of our souls, then why do health professionals spend their time healing bodies that will only get ill again and eventually die? Why spend countless years studying and practising our professions if our bodies are destined to become nothing but dust? Surely, if we take our faith seriously, then we should all be evangelists and spend our energies saving souls for heaven. Would this student be right to give up medicine and become an evangelist? Well, it depends on your view of 'heaven'.

A common way we think of heaven is as a place where God and Jesus live and where the non-material part of us, our soul or spirit, goes when we die. Many Christians believe that at the end of time, when Jesus returns, he will destroy this sin-infected material creation and take the souls of the righteous to be with him in heaven. In this understanding of the afterlife, the mission of the Christian on earth is to save as many souls as possible for a future of heavenly bliss. The main question that the gospel answers is, 'how do I get to heaven when I die?' But if we look at the Bible, we see that the idea of heaven as an escape route is a reduction of the gospel that owes more to a dualistic worldview than it does to the Christian Scriptures.

It is a common feature of many religions to propose a dualism between heaven and earth as part of a larger opposition between a perfect, higher spiritual realm and a fallen, lower material world. In this worldview, if we want to pursue the spiritual quest, we must ignore the pleasures and pains of our bodily existence and focus on the inner spiritual ascent of the soul. The apostles had to counter such dualistic teachings spread by Gnostic religious sects that were infiltrating the first Christian congregations.[1] But it was in the third and fourth centuries after the death of Jesus that dualistic beliefs began to have a more pervasive influence on some parts of the early church. These came through a group of Greek

philosophers known as the Neoplatonists who taught that humans were comprised of a pure immortal soul trapped within a sinful material body.[2]

As Neoplatonic philosophers began to engage with Christian theologians, this dualism between spirit and matter began to permeate parts of the early church so that heaven and earth, spirit and matter, soul and body became in opposition to one another. This dualistic thinking has affected the church in various ways ever since. One example is the enduring negative attitude to bodily sexuality that some churches have. But in the Bible, there is no such dualism between spirit and matter.

The Christian story begins in Genesis with the goodness of the created physical world[3] and ends in Revelation with the redemption of the created physical world.[4] God didn't create humans as souls trapped in bodies but as integrated physical-spiritual beings.[5] He gave us bodies because he wanted us to be a part of his physical creation. Our bodies are not barriers to spirituality, as the Neoplatonists taught, but an essential part of our spirituality since they are integral to us fulfilling the mission God gave us on earth.[6] The brokenness we experience in the world is not because the material creation is inherently evil but because human hearts have turned away from God. Yet God has not given up on his world or on humanity.

God's work of grace in human history is not to destroy the earth but to bring heaven and earth together in one glorious, renewed reality.[7] Until that day, the whole creation is groaning as it waits to be '*liberated from its bondage to decay*'. (Romans 8:21-22) We too groan with creation as we suffer sickness, disease and death that marks this fallen world. But God's answer is not an escape into an otherworldly heaven but to work towards the restoration of the creation by bringing the kingdom of heaven to earth. This work of re-creation includes our physical bodies, something that is clearly demonstrated by the healing miracles that Jesus performed in his earthly ministry.

When Jesus began to preach, his message wasn't, 'escape with me into a spiritual heaven' but, '*Repent, for the kingdom of heaven is near*'. (Matthew 4:17) His message was about the kingdom of heaven coming to be near us, here on earth. And the first signs of this kingdom were healing miracles. Social outcasts with leprosy were restored to health,[8] a man so violent that he had to be constrained by chains was returned to his right mind,[9] a dead girl was brought back to life,[10] and a man born blind could see for the first time.[11] These were miracles that required complete re-creation of a broken and fallen world. Only the re-creative power of heaven could re-wire a visual cortex that had never received neural input so that it could see again. However, it took Jesus' resurrection to really convince the disciples that Jesus had come to bring the restoring power of heaven to this material world.

When the disciples first encountered the risen Christ, they assumed he was a ghost, a disembodied spirit.[12] But Jesus encouraged them to touch him and even ate some fried fish to prove that he still had a body.[13] When he ascended into heaven, he did not leave his body behind on the hillside but took it with him.[14] And when Jesus comes to earth again, it will not be to take our souls to heaven but to reunite the souls of the dead with their re-created bodies.[15] This is why the earliest Christian confessions of faith affirmed their belief in '*the resurrection of the body*'.[16]

So, when as health professionals we care for bodies, we are not wasting our time. Rather, we are participating in the work of restoring God's creation. It is not the case that to be a doctor or a nurse is a secular occupation and the 'really spiritual calling' is to be an evangelist. Of course, telling people the gospel is vitally important because they need to know about the forgiveness and new life that God offers through Jesus Christ. But to care for bodies is to participate in the hope of recreation just as much as evangelising. When we care for bodies, we proclaim the uniquely Christian hope that God is bringing his kingdom of heaven to heal and restore the earth. The gospel is a lot bigger than just saving souls for heaven because God's will is to '*bring everything in heaven and on earth under Christ*' (Ephesians 1:10). God's work in and through Jesus and his church is to save not just individual souls but to save whole human beings – including their bodies – entire cultures, and all earthly history, for the glorious joy of his new creation.

***Dr James Paul**, director of the English branch of L'Abri Fellowship and a former palliative care doctor in London.*

*This article is based on James' brand-new book, **What on earth is heaven?** (IVP Books), in which he explores what the Bible has to say about questions such as 'what is heaven?', 'where is heaven?', 'why can't science find heaven?', 'what happens to us after we die?', and 'what does heaven have to do with our lives now on earth?'*

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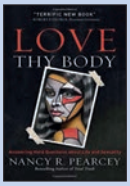

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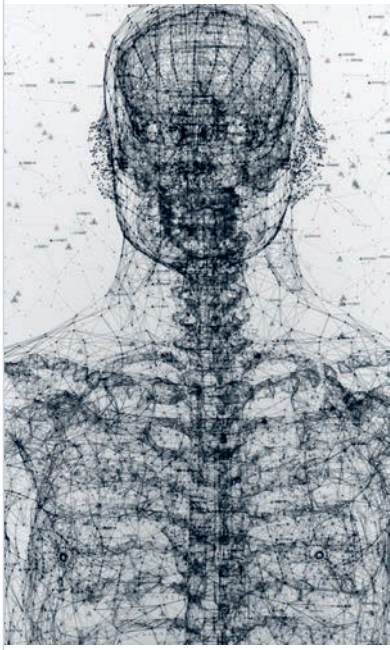

Our bodies are not barriers to spirituality... but an essential part of our spirituality since they are integral to us fulfilling the mission God gave us on earth

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2. For an informative discussion of the Neoplatonic influence on early Christianity, see Richard Tarnas, *The Passion of the Western Mind*. London: Vintage, 1996, pp 106-143.
3. Genesis 1:31
4. Revelation 21:1-5
5. Genesis 2:7
6. Genesis 1:28
7. In Revelation 21:1, the Greek word for new in 'new heaven and a new earth' is '*kainos*', which describes something that has been renewed or made new again, rather than something brand new.
8. Luke 5:12-16
9. Luke 8:26-39
10. Mark 5:35-43
11. John 9:1-12
12. Luke 24:37
13. Luke 24:36-43
14. Acts 1:9-11
15. 1 Corinthians 15:12-19
16. This statement is found in the Apostles' Creed, one of the earliest statements of Christian belief.

Martin Bricknell reflects on Christianity in conflict medicine and what it teaches us about managing the current pandemic

RELIGION, MORALITY, ETHICS AND WAR

key points

- The pressures on healthcare systems around the world have raised resource and care prioritisation issues similar to those found in the practice of healthcare in conflict situations, from which there is much we can learn.
- Those working in military healthcare have to balance 'dual loyalties' to their healthcare profession, its values and ethics, and to the military and its requirements. This is seen most acutely during times of military conflict.
- For Christians in this situation the ethics, values and loyalties we have to Christ and his Kingdom add a further level of complexity to these 'dual loyalties'.

The COVID-19 crisis has challenged our healthcare system's very fabric and placed enormous burdens on healthcare workers. There have been comparisons between this crisis and healthcare practice in the Armed Forces.[1] As a recently retired military doctor, I believe my reflection on the personal beliefs that have grounded me throughout my career might provide some insights into resilience in crisis medicine.

Military healthcare professionals' practice is grounded in the concept of dual loyalty: loyalty to our healthcare profession and loyalty to the military profession.[2] This 'dual loyalty' has profound implications for the clash of purpose between the professions; the first to save life and the second to wage violence on behalf of our nation, which might involve taking life. At an intellectual level, this clash is resolved through the principles of *'jus ad bellum'* – the legal authority to go to war; *'jus in bello'* – the measures under international humanitarian law to reduce the suffering caused by war; and 'the humanitarian principles' – humanity, impartiality, neutrality and operational independence – which protect humanitarian organisations from harm.[3] Military health services operate at the intersection of these principles. Governments organise military medical services to reduce the harm from war on their military personnel (and other entitled populations such as prisoners). The Geneva Conventions protect medical facilities and personnel, as well as non-combatants. Thus, military medical services exist to mitigate the consequences of warfare, not be party to it. Beyond this, all military health personnel must reconcile this clash personally. Their mere existence within the military medical services could be construed as tacit acceptance of the armed forces' potential role in taking life. I was able to balance this based on my Christian faith that recognises the clash between God and the devil,[4] and that it may be necessary to fight to prevent the imposition of evil (eg World War II against the Nazis). However, I believe that a government's use of violence must be accountable, which lies at the heart of our democratic system.

Dual loyalty extends to healthcare practice within the armed forces, too. There is a fundamental tension between patient-centred practice focussed

on the needs of the individual and a utilitarian perspective that might see health services as a means to achieve maximum productivity of humans within a state system. This is most stark in the application of triage in crises.[5] In an emergency, the usual practice is to treat the most severely sick or injured first based on clinical need. However, if there are insufficient health resources to meet the demand (a mass casualty incident – MASCAL), then prioritisation is based on the 'ability to benefit from treatment' and the interests of the many over those of the individual.[6] Arguably, the NHS approached this situation during the peak of COVID admissions, and it has been implicit in the decision to prioritise treatment for COVID over treatments for certain other life-limiting conditions. Fortunately, I never had to use MASCAL decision-making during my military career. However, I did have to argue for more medical resources on several occasions to prevent this from occurring. To me, it is essential that any system of triage is underpinned by the provision of compassionate care to all patients, even if physical treatments are limited. The CMF File on care and compassion provides an excellent summary of the Christian foundations for this aspect of healthcare.[7]

The most common dual loyalty tensions occur in the occupational health aspects of military healthcare practice rather than emergency medicine. This commonly occurs around confidentiality and the desire of military leaders to understand the health of their personnel.[8] The military requires a high level of physical and psychological fitness due to the combat environment's challenging nature. This varies according to the specific role, with different standards for a pilot, a submariner, and an infantry soldier. Information on the medical fitness for duty of everyone in the armed forces is required to understand how many personnel are not fully fit. Whilst individuals may allow medical information to be shared with their managers, medical staff can also express the impact of a medical condition on functional performance without revealing the condition itself.

Dual loyalties are also a factor in questions of uncoerced consent, such as for receipt of vaccinations or antimalarials, or for involvement in medical research. These aspects of dual loyalty have analogies with other medical specialities such as public health and travel health. They have become particularly important as we adjust employment for healthcare workers who are especially vulnerable to COVID-19. I have found the ethical guidance provided by the health regulatory bodies and the medical Royal Colleges and faculties to be extremely helpful in supporting my decision-making in these technical aspects of clinical and organisational practice. Whilst not explicitly based on religious values, many of the underlying principles in Western medical ethics arise from a Judeo-Christian theology of care through compassion-based grace. This is explored in the paper by Cavanaugh[9] and the *CMF File* on Christian views on ethics.[10]

Whichever branch of medicine and the healthcare professions we choose to join, we cannot avoid the possibility of having to make difficult decisions that could have profound implications for our patients. These occur much more frequently and immediately in crises, like the COVID pandemic or war. Such decisions can have a long-term impact on our mental health, especially if the process or outcome goes against our internal values. This can damage our psychological, social and spiritual health, causing 'moral injury'. This term has arisen from the academic literature covering the psychological impacts on soldiers of war and is distinct from post-traumatic stress disorder (PTSD). Whilst both can occur due to the same events, the distinction is important. 'Moral injury' encompasses the much greater complexity associated with conscience-based decisions and actions, whilst PTSD has a narrower psychiatric definition relating to symptoms resulting from exposure to life-threatening incidents.[11] As I have become more senior in my military career, and since transitioning to academic practice, I have spent more time reflecting on the foundations of clinical and organisational decision-making. I found the WHO definition of health as a state of complete physical, mental and social well-being increasingly valuable, but it still misses the spiritual component that truly encompasses the emotional and moral foundations of our identity. Notably, the Armed Forces continue to have chaplains and other faith leaders as an integral part of the welfare services that support military personnel. This spiritual dimension of our health is most at threat when we respond to crises, both personal and societal. The Christian faith provides reassurance during difficult times that the gift of Jesus guarantees us life beyond the present day to eternity.[12]

One of my biggest projects in 2020 has been to develop a tool for teaching military medical ethics to healthcare professionals in the armed forces. This has led me to reflect on my decision-making foundations during my military career, and to a more explicit acknowledgement of my Christian faith's importance as the essence of my spiritual health and resilience during difficult times. As we think about how to support our colleagues during these challenging times, we must explicitly acknowledge the importance of spiritual understanding and values as a significant contributor to our resilience to moral injury.

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This spiritual dimension of our health is most at threat when we respond to crises, both personal and societal

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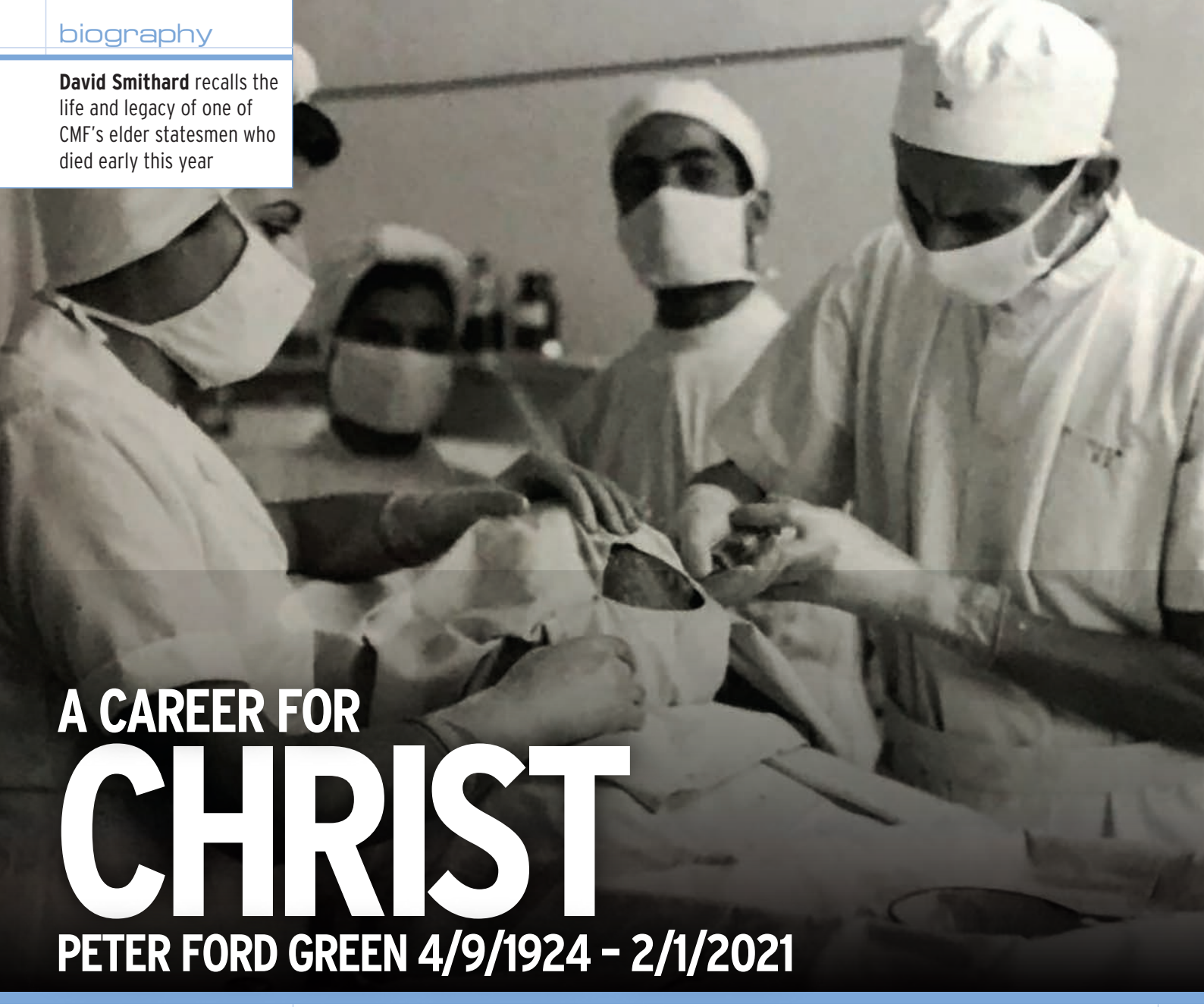
David Smithard recalls the life and legacy of one of CMF's elder statesmen who died early this year



A CAREER FOR CHRIST

PETER FORD GREEN 4/9/1924 – 2/1/2021

key points

- Within the lifetime of one of our founders, the nature of both medicine and mission has changed beyond recognition.
- Being open to God's leading can take us to people, places and situations where God can use us, however unexpected and unusual the circumstances.
- Even in old age and retirement, being open to God's leading can bear fruit for his kingdom.

This article is taken from an interview that Peter gave to me in February 2020 and a Christmas letter that Peter composed in December 2020. Both highlight Peter's devotion to God throughout his life.

During his career, Peter worked as a missionary doctor, farmer, accountant and teacher, alongside his wife Hope, a nurse who opened and ran several missionary nursing schools in Africa and the Middle East. He continued to witness to those around him until the time of his death.

Peter trained and worked at a time when CT scans and ultrasounds had yet to be invented; the number of antibiotics available could be counted on one hand; and X-rays and blood tests were requested sparingly to aid diagnosis and not as the primary means of diagnosis.

Peter was a medical student in Edinburgh when he attended the Inter-Varsity Fellowship (IVF) meeting in 1943. Here he met Douglas Johnson and 'crossed friendly swords' with Arthur Rendle Short over subscriptions to the IVF. Peter graduated in 1948. In 1949, after one year of postgraduate training Peter went to Nazareth. He left the UK as a member of the Medical Graduate Fellowship of IVF and returned in 1951 as a member of the newly formed CMF, with Douglas Johnson as the Secretary and Martyn Lloyd-Jones the Chairman.

Peter spent a year undertaking General Practice training, getting married to Hope and becoming a father. In 1953 Peter and family went to the Gaza Strip and Hebron and then on to Kenya in 1957. He and Hope were sponsored by the Church Missionary Society (CMS) in Palestine, and American Missions and the Church of Scotland in Kenya. There they served for the next 20 years.

A tale from the mission field

Peter's long experience in the mission field left him with many stories to tell, too many to include here. But here is just one example of God's guidance and mercy whilst Peter and Hope were based in Kenya.

'Hope and I held regular clinics at Baragoi and Wamba (respectively 70 miles north and 80 miles south-east from Maralal Hospital, where we were based at the time). At the end of one trip to Baragoi, as we were packing up to return home, something

said to me "Call into Wamba on your way back and see if everything is alright". So, I said to Hope, "I think we will drop in on Wamba as we go back to make sure it's alright". Hope was not keen, wanting to get home whilst it was still light.

'As we were travelling, I still had the nagging feeling that I should call in at Wamba. As we arrived at the turning, it was so burning in me I said to Hope, "I'm sorry dear, I've got to go into Wamba, I don't know what's wrong, but something keeps telling me 'Go into Wamba'. I promise you, I will go in, and if it is all well, I will come out. I won't even take my hat off".

'When we arrived at Wamba, it was very quiet. On the ward was a crowd of people around a bed, and my Dresser was on his knees. Looking up, he said, "Doctor, where have you come from? This man has just walked in, and I don't know what to do". The patient had been gored by a rhinoceros, resulting in a hole in the side of his chest. You could actually see the heart beating inside. I thought, "Oh my goodness, what do I do here?"

'I sent one of the team to ask Hope to bring in all the equipment that we had for an operation. She took control of the nursing care at once. The bed was low, and I was operating virtually on my knees. I was eventually able to close the wound and put in a sealed drain, and run two bottles of plasma expander slowly in through a drip. I wiped the sweat off my brow. Enquiring if there were any other problems, I was told that he had come in holding his stomach. Removing the cloth covering his abdomen, I found his gut hanging out, coils of it open like a zip fastener. I thought, "This man's not going to live".

'As you can imagine, I was praying from start to finish, "Lord, show me what to do". So we cleaned him up as much as we could and sutured him together. We set up a drip to replace as much fluid as possible, and I left with instructions to keep close monitoring of his vital signs.

'The next morning, the Dresser radio-called me and said,"He's much better this morning, Doctor".

"What do you mean... much better?" I replied incredulously.

"Well, his pulse is 120, but his blood pressure is up to 100 over 70."

"Is he conscious?"

"Oh yes, he's conscious; he's wanting breakfast!"

'That was Monday morning. On Friday, I got another call asking if they could take the stitches out, "as he wants to go home". I thought to myself, "'Take out those stitches? I can imagine the whole thing going Pop!" So I got him transferred to us in Maralal. I kept him in until the following Tuesday, and when I couldn't put it off any longer, I took him to theatre and gingerly took out the sutures. They didn't go "Pop", and I was able to discharge him the next day. And he walked home!

'Looking back on it, one of the things that has amazed me was not that God guided me to Wamba that night, but that, as far as I could make out, God sent me there before the accident had even happened. It took me at least an hour to get from Samburu Lodge to Wamba, and the man had only just walked in when I got there. He couldn't have walked hanging onto his bowels for an hour, especially with a chest like that!

'I believe I was put there for that man. He survived because God called me to go to that place at that time. The Lord had given me the things in my hands to do what was needed. If I told that story to a Royal College of Surgeons meeting, they wouldn't believe me!'

Mission in retirement

Returning from Kenya, Peter became the part-time General Secretary of the Medical Missionary Association (MMA) while working as a Consultant in A&E at the Royal Free. Peter travelled around to careers fairs at hospitals and universities, talking about the need for doctors to serve internationally. Peter and Hope, with MMA and CMF, ran courses for student doctors going out to mission hospitals on electives to prepare them for life in a strange land.

They also helped run what was then known as the Missionary Refresher Course, the precursor to the Developing Health Course

One of the schemes the MMA developed was the 'OYSTER' scheme [One Year's Service to Encourage Recruitment] which provided grants to young Christian doctors to experience life working in a Mission Hospital, and later the 'Baby OYSTER' scheme which was for a shorter period suitable for student 'electives'.

In 2000, Peter and Hope retired from the MMA to their beloved cottage in Sussex, but they both remained active supporters of CMF mission work and the developing nurses and midwives' ministry.

Hope died in September 2018, and at the end of 2019, Peter fell at home, breaking his hip. He moved into a residential home to be near his family. Prior to this, Peter had run and been involved in various church and Bible study groups. So it was unsurprising that at Easter 2020, with a retired Anglican Reader who was also resident, he commenced producing a weekly devotional booklet. When COVID-19 restrictions were relaxed in August 2020, Peter, with his fellow resident, was asked to hold a weekly church service with up to 25 residents and staff attending. Even in retirement, Peter found new mission fields!

Just after Christmas 2020, Peter became unwell with COVID-19 and went to be with his Lord on 2 January 2021.

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

I believe I was put there for that man. He survived because God called me to go to that place at that time

Colina Archie-Pearce and **Twinelle Baidoo** relate their path to becoming and working as Physician Associates

PHYSICIAN ASSOCIATES

key points

- Physician Associates are, relatively new grade of health professional in the UK, and play an increasingly important role in the NHS.
- Two Christian Physician Associates relate their experiences of being called to serve Christ in this profession, and how fellowship with other Christians through CMF has been important for them spiritually and professionally.
- We look at how Physician Associates can get connected to other Christian health-carers through CMF.

Physician Associates (PAs) were introduced in the UK in 2003. The UK Association of Physician Associates (UKAPA) was established, acting as a professional body for physician associates in 2005, becoming the Faculty of Physician Associates at the Royal College of Physicians (RCP) in 2015. The Competence and Curriculum Framework (developed by the Department of Health, Royal College of General Practitioners and RCP) for PAs was released in 2006 and updated in 2018. In 2011 a voluntary register was adopted, and the Faculty was launched in 2015 by the UKAPA and the RCP.

PAs are medically trained, generalist healthcare professionals (from science, social care, or medical backgrounds), who work alongside doctors providing medical care as an integral part of the multidisciplinary team. PAs can work with a degree of autonomy with appropriate support.[1]

PAs can undertake many of the tasks undertaken by trainee doctors (FY1 (Junior House Officer) to IMT2 and ST1 (Junior Registrar)) except ordering ionising radiation investigations (eg X-ray and CT scans). This is expected to change when PAs come under the remit and regulation of the GMC.[2]

How I became a PA: Colina Archie-Pearce

My story is unique from start to finish, but one that is to the glory of God. I had not planned to be a PA; in fact, I was initially completely opposed to the idea.

From a child, I had always said 'I will become a doctor', such that I studied Science and Maths at A-Level and was a member of the Bexley Grammar School Medicine Society. The God who knows the end from the beginning has a funny way of reminding us that he has not only ordered our steps,[3] but the future is all in the past tense to a God who sits outside of time.[4]

Scripture is clear that the Lord speaks to us in various ways, including dreams and visions.[5] I experienced this strange phenomenon during the transitioning period of my final year of Biomedical Sciences in 2015. I was reaching the point where I had to decide what to do after completing my degree. I was attending a conference, when I had a vision in which I saw myself walking down a hospital corridor with a stethoscope around my neck. I took this as a clear sign from God to apply for medicine; I completed the UCAT (University Clinical Aptitude Test),[6] and sent my applications off with the confidence that this was God's direction for me.

I was wrong. I received four rejections and was devastated.

A few months later, I discovered that PAs dressed like medical doctors and everything finally made sense; this is where God was leading me. I applied for the programme at the University of Sheffield, a scholarship and travel expenses were paid and to the Glory of God, I received an offer.

The third year of Biomedical Science was probably the hardest period of my life. It was in this period I finally understood the character of God. He is a loving, yet relentless Father who, if he promises something, is faithful to complete it.[7] During my third year of University, I had to endure a few

hardships not limited to, but including, my parents' divorce, depression and subsequently struggling in my degree. This meant I was unable to commence the PA course at the University of Sheffield. Subsequently, I was offered a non-scholarship place at the University of Birmingham, which required a deposit of £500 the following week.

The vision and direction I had from God now all seemed to be a product of my imagination. The funny thing is, God, the Alpha and Omega, may show us the future ahead of time,[8] but may not reveal the details of the journey to get there! I remember telling God how much I trusted him and his plans for me. I knew what he had promised me, and I believed that if it were truly the Lord who had detailed this career path, it would happen.

I will never forget the following Friday afternoon (a few days before Birmingham University required their deposit). I received a call from the University of Sheffield asking if I would like to study there. Someone had dropped out. Thrilled, I accepted and immediately realised that I was now moving back to Sheffield in a few weeks but had nowhere to live.

During the final year of my Biomedical Science degree, I had worked as a residential mentor, which entitled me to free accommodation. However, the applications for the upcoming school year had closed months earlier.

In faith, I called the residential mentoring team, explaining my situation and was wondering if, there were any vacancies for a residential mentor. They told me that someone had quite literally dropped out that day and so they had an unexpected vacancy that they could offer me.

Like a dream, I completed PA studies at Sheffield University. The month after passing my national qualifying exams in 2018, I commenced at the Queen Elizabeth Hospital, and I have not looked back. I understand why God directed me to become a PA, and I am still learning how to express the nature of Christ in how I relate to my colleagues and patients.

Looking back on everything, I would never trade my experience, though difficult, because it allowed me to see different sides to God from what I thought I knew; I learned the sustenance of God and the depths of his grace and mercy.

Life as a Physician Associate: Twinelle Baidoo

As a child, I was fascinated by Bible stories of Jesus helping and healing people. Jesus taught us through his Word that joy was to be found in serving, not in self-centredness.[9] Jesus further emphasised that we should be stewards to our neighbours and this world. Throughout my life, I was challenged by the healing accounts in the Scriptures about how I could best serve others, particularly the vulnerable. I could have done this in many ways, including working for the justice system and social services.

Aged five, my brother was diagnosed with leukaemia and had a significantly poor prognosis. This was a distressing time for us all; we learnt to rely completely on God when medicine did not have all the answers (Psalm 23:1-6). After this encounter, I developed an interest in life sciences and how diseases were treated. I also had a newfound admiration for healthcare professionals and their dedication towards families like mine.

As a result, I applied to study medicine in sixth-form. However, I received multiple rejections. This was challenging to deal with after being convinced that becoming a clinician was my calling. Yet even in rejection, I had to recognise that *'he guides me along right paths, bringing honour to his name'*.[10] I decided to undertake a degree in biomedical sciences, committed to obtaining a significant amount of work experience in healthcare to support an application for graduate medicine, convinced that this would make me a stronger candidate. I was not successful in my application. Then the MSc PA Studies course was advertised to me, complete with a full scholarship.

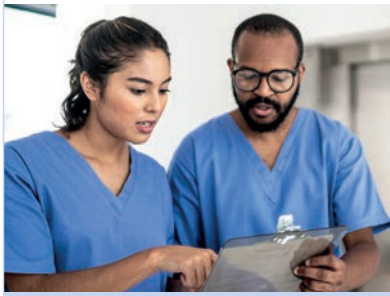
Following extensive research, I decided to embark on the MSc PA Studies course. Although this journey would not be the same as being accepted into medical school or becoming a doctor, it allowed me to obtain knowledge and skills that could improve lives and serve vulnerable people, which remained in line with my career goals.

It was an immensely steep learning curve picking up the principles of medicine and clinical reasoning within two years. Starting clinical placements in the first few days of the course without prior clinical knowledge or reasoning skills and having to undertake objectively structured clinical examinations (OSCEs) in the first few months of the course are examples of how tough the course was. The growth and expectations over just two years were overwhelming yet equally rewarding.

I started my first job as an acute medicine and geriatrics PA approximately one year ago. Helping to optimise people's health has certainly been as rewarding as I had anticipated. Many colleagues do not understand a PA's role, either expecting too much or too little of us, which can be stressful. Despite working in a clinical team, there can be a feeling of isolation. There can be a lack of the identifiable peer-to-peer support and community that other professionals have. While doctors are responsible for the clinical and educational supervision of PAs, there can be a feeling of disconnect due to differences in our academic and career trajectories.[11]

My future as a PA remains somewhat unclear, but God knows the beginning and end and his plans concerning my life.[12] Wherever my journey leads, I want to ensure that I am always of service and impacting lives around the world. The Christian Medical Fellowship was a reminder from God that he would always provide me with community, irrespective of where I find myself.

Colina Archie-Pearce *and* ***Twinelle Baidoo*** *both work as Physician Associates at the Queen Elizabeth Hospital, Woolwich*



Can Physician Associates be part of CMF?

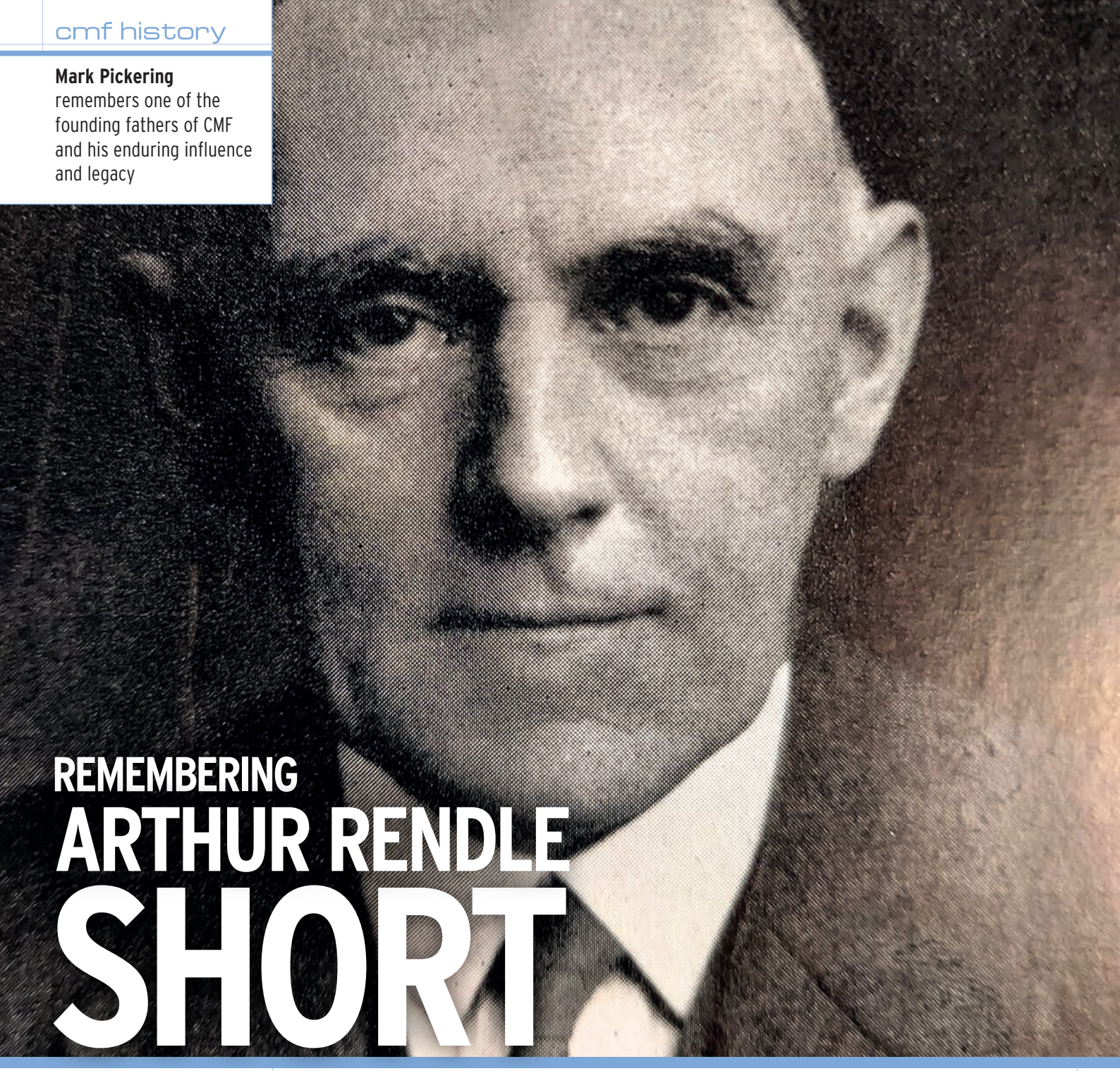
Yes! Currently, PAs can join CMF as Associate Members, both as students and as graduates. If you join as a student, it is a good idea to link up with any existing CMF (Medical/Nursing/Midwifery) student groups nearby – there is likely to be one at most universities where PAs train. Where no such group exists, as a member of CMF, we can link you with a local CMF member to act as a point of contact with the local CMF Catalyst Team.

Wherever my journey leads, I want to ensure that I am always of service and impacting lives around the world

references (accessed 15/2/21)

1. Who are physician associates? *The Faculty of Physician Associates at the Royal College of Physicians*. 2021. *bit.ly/2ZgNG3B*
2. *Ibid*.
3. Psalm 37:23
4. Isaiah 57:15
5. Eg Daniel 1:17; Job 33: 14- 15; Acts 2:17
6. See *ucat.ac.uk*
7. Hebrews 10:23
8. Isaiah 42:8- 9
9. Philippians 2:4
10. Psalm 23:1-6
11. Brown MEL, Laughey W, Tiffin PA, et al. Forging a new identity: a qualitative study exploring the experiences of UK-based physician associate students. *BMJ Open* 2020;10:e033450. doi: *10.1136/bmjopen-2019-033450*
12. Revelation 22:13

Mark Pickering
remembers one of the founding fathers of CMF and his enduring influence and legacy



REMEMBERING ARTHUR RENDLE SHORT

key points

- Arthur Rendle Short died only four years after the founding of CMF but played a crucial role in its formation and early years.
- A passion for Christ, surgery and an apparently thwarted call into mission led him to a life of service to fellow doctors and medical students, to the very day of his death.
- Like many of his generation, the experiences of the First World War shaped both his surgical skills and his faith in unexpected ways.

Those who are regulars at the CMF National Conference will remember the *Rendle Short Lecture* (RSL) that has been a feature of Saturday afternoons there for many years. In fact, Prof John Wyatt's RSL in 2019 was the 60th such lecture. The change in format of CMF National Conferences for 2020 and 2021 due to COVID has disrupted this long tradition, and it seemed an opportune time to end that particular lecture series on a high note, the final lecture being given by our current President in the diamond jubilee year of the lecture.

The RSL has traditionally been introduced and chaired by the sitting President of CMF. For as long as I can remember, the introduction has included a summary of who Professor Arthur Rendle Short was and why he has been so commemorated in our traditions. However, since he died in 1953, even our oldest surviving members mostly have only passing memories of him.

> He was raised in an atmosphere of deep Christian faith that was worked out in practical service

For that reason, I decided to research and write a little about his life and example. What might this great Christian doctor, who lived and worked through both World Wars and was a leading light in the early years of CMF, have to teach us today?

In finding out about him, I have relied on two small books, *The Faith of a Surgeon – belief and experience in the life of Arthur Rendle Short*,[1] and *The Christian Medical Fellowship – its background and history*.[2]

Early life and influences

Arthur Rendle Short was born in Bristol and spent almost his whole life there. He was known to many as Rendle, his mother's maiden name, deriving from Cornwall.

He was raised in an atmosphere of deep Christian faith that was worked out in practical service. His family were members of the Open Brethren, churches that strove to live out a faith like that of the early church and did not have ordained ministers. One consequence of this is that Rendle developed a passion for lay preaching in his teenage years, which he continued regularly until his death. He read widely and had an incredible knack for communicating great learning in a simple, direct, and memorable style.

His family were intimately connected with the famous George Muller, also part of the Brethren, who established orphanages in Bristol and became renowned worldwide for his distinctive approach of never asking directly for money. The Muller orphanages are an incredible story of God's amazing provision and of George Muller's faith; Rendle's grandfather was a teacher in the orphanage.

These two influences loomed large in Rendle's life. Of eleven Christian books he wrote, the first was a description of the Open Brethren, and the last was a condensed version of George Muller's personal diary.

Medical training and marriage

Rendle did his medical training first in Bristol and then in London at University College Hospital. As a testament to his broad interests, he found time to notch up a first-class degree in geology during his training, chiefly because of his interest in contemporary debates in science and religion, such as evolution. However, he also found time for lighter subjects, such as packaging up live cockroaches to send to a group of nurses in response to their previous practical joke on him!

However, he worked hard at his medical studies. He was highly successful, gaining so many scholarships that it led the medical school to adjust the regulations to prevent one student from winning more than their fair share. He spent time as a junior doctor back in Bristol and then again in London, receiving a Diploma in Tropical Medicine and his Fellowship of the Royal College of Surgeons, both in 1908. This was clearly a momentous year for him, as he also married his cousin, Helen Case, a nurse.

It seems incredible to us today that junior surgical posts in those days were unpaid, and that a surgical registrar had to find income from other means, such as teaching students. However, Rendle was talented and dedicated and eventually secured full surgeon's status in 1913.

Devotion to medical mission

Throughout their lives, Rendle and Helen were committed to supporting medical mission. Even before their marriage, they offered to go to what is now Taiwan. However, despite their evident deep faith, they were shocked to be eventually turned down as their views on infant baptism differed from those of the denomination concerned! Further efforts to go as Brethren missionaries did not materialise, mainly because the denomination decided that Rendle's rare surgical skills could not be fully utilised in the kind of simple pioneer mission stations that they could offer.

The couple ploughed their efforts into supporting mission from the UK. Rendle was a regular speaker at the Missionary Study Class Movement conference, urging many young men and women to consider serving overseas. Often, he would pay the equipment costs of a missionary doctor about to leave, and on one occasion, he took time to summarise his notes from the tropical medicine course for a young doctor who did not have time to take the full course before leaving.

Support for students and the beginnings of CMF

Rendle was remembered by generations of Bristol medical students as a devoted and talented teacher, full of memorable stories to help cement his points. This interest in students spilt over into his Christian life. He was a keen supporter of the early Christian Union movements after the First World War, including the Bristol Inter-Faculty Christian Union. This became part of the Inter-Varsity Fellowship, now the Universities and Colleges Christian Fellowship (UCCF), with which CMF continues to work closely. For over 40 years, he and Helen hosted student prayer meetings in their home, and he was a regular and popular speaker at many student meetings.

CMF eventually formed in 1949 as an amalgamation of the medical graduates' section of IVF, and a forerunner organisation, the Medical Prayer Union, which was formed in 1874 but was waning by the time of the Second World War. Rendle was a popular speaker at meetings of all three organisations and was the main speaker at CMF's first-ever Northern Conference at Windermere in the early 1950s, which ran for over 60 years.

Surgical pioneer

The field of surgery was advancing rapidly during Rendle's early career. He took a keen interest in applying the new knowledge in physiology to the existing knowledge of anatomy and surgical technique, writing a textbook on physiology for surgeons in 1911.

He spent his final full day of life, in September 1953, preaching in church, writing letters, and advising a young man on his future career and Christian service

Throughout all this busy, eventful, and successful career, he continued to preach in local churches in the Bristol area and at Christian medical events

He gave the Hunterian Lecture at the Royal College of Surgeons in early 1914 on surgical shock. Little did he know just how vital this interest would become later that year, as he and many colleagues battled to save casualties from the fighting, both in military hospitals in the UK and field hospitals in the battlefields of France. In these extreme situations, he was involved in some of the early developments of blood transfusion.

God's Word and his works

Throughout all this busy, eventful, and successful career, he continued to preach in local churches in the Bristol area and at Christian medical events. His in-depth knowledge of science combined with a deep love for and reflection on Scripture, having learnt to read both Hebrew and Greek.

This meant that he could apply rare insights to some of the challenging areas where science and theology intersected. He was a sought-after speaker on issues such as Christianity and Evolution, and published books on topics such as *Modern Discovery and the Bible*, *Archaeology Gives Evidence* and *The Bible and Modern Medicine*.

Faithful to the end

Despite his hefty workload and the many calls on his time and talents, Rendle seems to have had a very close-knit family life, ably supported by Helen. Their three children all went into medicine or nursing. Their daughter Coralie, who became a Professor of Gynaecology in Uganda and Ethiopia, recalled long walks and cycle rides, during which she would pepper him with questions.

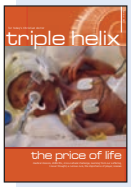
He did not let up right until the end. He spent his final full day of life, in September 1953, preaching in church, writing letters, and advising a young man on his future career and Christian service, before the pain of a fatal myocardial infarction came on.

Earlier that year, his son John had proposed to the CMF General Committee '*that the Fellowship should institute an annual CMF Lecture to feature a major topic of concern to the profession and to be given by one of the more research-minded members*'.[3] As CMF was in its infancy, it took some time for this suggestion to be realised. Finally, in 1959, the first Rendle Short Lecture was given by Mr W Melville Capper, who had continued Rendle Short's legacy in Bristol, on the subject of 'Some Great Christian Doctors' – a very apt title, given the influence of the man after whom the lectures were named.

Mark Pickering *is a prison GP and the CEO of Christian Medical Fellowship.*

Rendle Short lectures 2010-2019

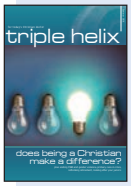
2010 Triple Helix 48
Foundations for practice - how should Christians teach medicine?
Richard Vincent



2011 Triple Helix 51
Medical mission - changing the world together
Ted Lankester

2012 Triple Helix 54
Compassion: an antidote to NHS debt and distress
Tim Lyttle

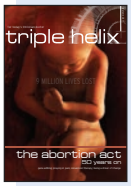
2013 Triple Helix 57
Being a servant leader in the NHS
Nick Land



2014 Triple Helix 60
Does being a Christian make a difference?
Vinod Shah

2015 Triple Helix 63
After the sexual revolution
Glyn Harrison

2016 Triple Helix 66
Tackling global health inequalities
Andrew Tomkins



2017 Triple Helix 70
The ethics of gene editing
Trevor Stammers

2018 Triple Helix 72
Lessons from the refugee crisis
Bert Nanninga

2019 cmf.li/RendleShort_19
The impact of Artificial Intelligence in healthcare [audio only]
John Wyatt

references (accessed 10/2/21)

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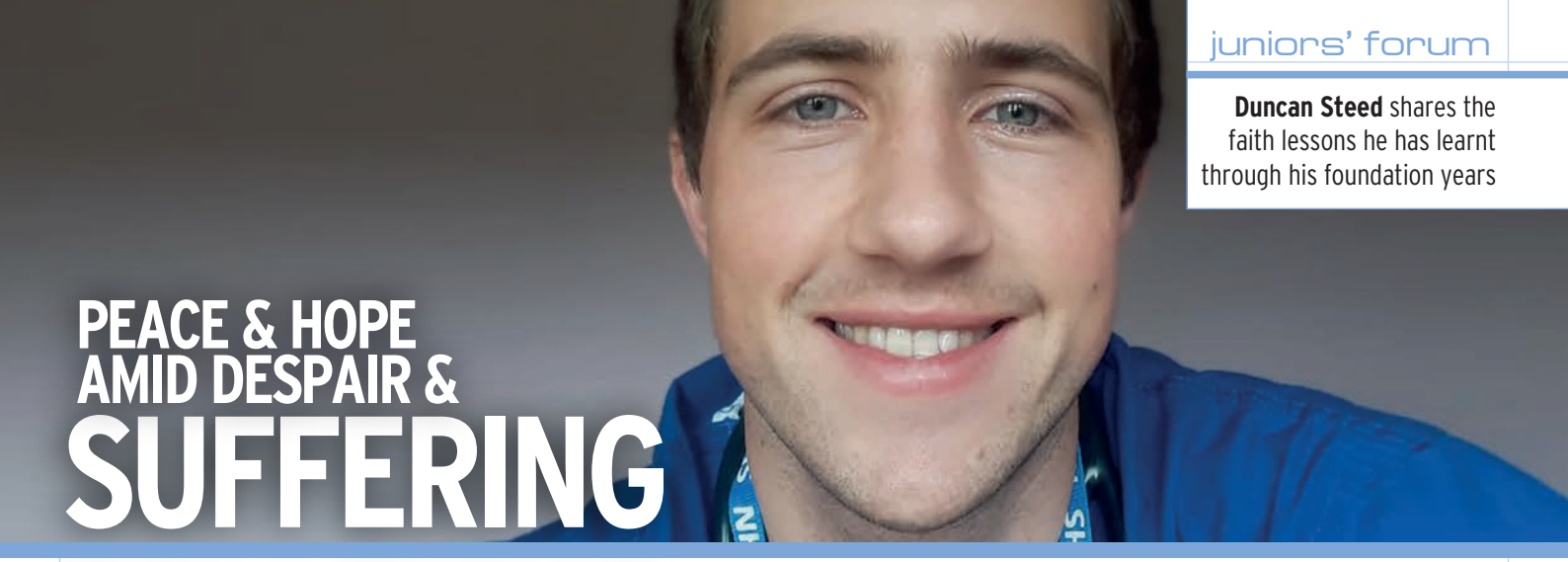
2. Johnson D. *The Christian Medical Fellowship - its background and history*. London: CMF, 1987
3. *Ibid*: 39

Duncan Steed shares the faith lessons he has learnt through his foundation years



PEACE & HOPE AMID DESPAIR & SUFFERING

Triple Helix: ***Where do you live?***
Duncan Steed: Currently between Portsmouth and Northern Ireland.

THx: ***What's your job?***
DS: I've just finished my two foundation years at Queen Alexandra Hospital in Portsmouth. I am also a medical officer in the Royal Navy and am about to start my three years of general duties, beginning with Officer training at naval college.

THx: ***How are you involved in CMF and what does that look like?***
DS: I help to lead the Wessex Junior Doctors' group. Before the pandemic, we were meeting monthly in a local consultant's home. Wonderfully, we were able to continue our meetings online during the lockdown. Recent topics included conscientious objection, humility, and palliative care, as well as the impact of Coronavirus on the developing world.

THx: ***What's the best thing about CMF for you?***
DS: I consider CMF to be a real provision of God's grace to me personally. It's the place where you get to know your Christian peers locally and build friendships and community together. It's where you meet inspiring, faithful servants of Christ who impart their wisdom and share their experience of careers devoted to serving him and their patients, and who are honest about the challenges of all this whilst remaining faithful to him. It is where I have been confronted with the big medical ethical issues of our time and heard wisdom and biblical exposition in response.

The annual CMF conferences have featured all of the above and more. I have had the joy of hearing Tim Chester and John Lennox, amongst others, preach God's Word, our greatest help in our stand for Jesus and the greatest power for being impactful for him in all that we do and say.

THx: ***What encourages you day-to-day?***
DS: A regular source of encouragement is seeing the faithful and bold witness of some dear Christian colleagues in Portsmouth. A registrar who bravely professes Christ and chats to all colleagues (consultant or junior). A research nurse who intercedes for the hospital every day in the ground-floor chapel. Seeing others live for him in the midst of an incredibly busy and hectic environment is a wonderful and timely reminder of who I am really serving, helping me keep my priorities in perspective.

THx: ***What difference does your faith make to you as a doctor?***
DS: Chiefly, following Christ gives me peace and hope amid often overwhelming despair and suffering. An early memory of starting on colorectal as an F1 was just how devastating, and terminal many patients' diagnoses were. The COVID-19 pandemic caused me to experience a similar level of despondency. To which our supremely compassionate Lord speaks these wonderful, hope-inspiring, despair-banishing words:

'In this world you will have trouble. But take heart! I have overcome the world.'(John 16:33b)

Oh, how we ought to take heart. Christ has overcome! To know and trust in the overcoming power of Jesus Christ gives me the strength to live amid such sorrow. To know he has overcome the grave and defeated death gives me hope. This strength and hope are not of my own creation, but a gift God has given us, his people, in order to live faithfully and boldly for him and to declare his gospel message of salvation in our words, our conduct, our compassion and our many daily sacrifices at work.

THx: ***How have you grown spiritually since starting medicine?***
DS: Medicine has given me such a stark and profound realisation of just what Christ has done for me. When our Lord declares he came not for the healthy but the sick, it becomes clear just how perilous and hopeless my own spiritual condition was before his intervention on the cross. Being a doctor has helped me to understand the depths of my own brokenness in sin whilst aiding my understanding and delighting in the glories of Calvary and how wonderful our rescuing Jesus really is. Our Great Physician, stricken to make me whole. This has fueled my desire to serve in church and help others to encounter Jesus in his Word. God, by his grace, has shown me the joy and mutual encouragement to be enjoyed by his people meeting together as his family.

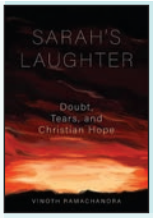
THx: ***What top tip would you give to other Christian junior doctors?***
DS: Church. Church. Church. Please, I pray, make church a priority. I have seen far too many friends fail to do so and suffer spiritually as a result. You will not be able to attend every Sunday morning and mid-week small-group meeting. But keep your Sundays free wherever possible. Plan your zero-days and annual leave on the assumption that you're going to some sort of church meeting. Please don't make it an optional extra, make it the bedrock of your life wherever you happen to be. I can't even begin to explain how sustaining and glorious church has been to me these past two years. As a regular reference point of grace when you've had the most demanding week ever; as a routine time of plugging into the Word of life and worshipping the living God with others; as a means of being prayed for when you are struggling with patient deaths on the ward and when you are utterly exhausted and fatigued. And so importantly, as an opportunity to serve your Christian brothers and sisters. We have such a unique and God-given opportunity and gifting to serve and lead in local churches. I implore you to be faithful and be prepared to make sacrifices, be that of time or finances in order to serve God and advance his local church.

2084
Artificial Intelligence and the Future of Humanity
John Lennox

- Zondervan Reflective, 2020, £10.99, 208pp, ISBN: 9780310109563
- Reviewed by **Jennie Pollock**, CMF Associate Head of Public Policy

In 2017, the London Science Museum held an exhibition of robots. It featured some of the earliest automata and followed their progress through to the robots in development today. What struck me was how much effort was being channelled into making robots that could do things humans can do. They can sort and analyse data far more quickly and efficiently than humans already, but it turns out it is incredibly hard to develop hands that can pick up a selection of different objects, or eyes that can judge distance, or legs that can take a step. There is a lot more engineering in the human body than I had ever considered.

But the question I was left with was, why were they bothering? As John Lennox points out in his new book *2084: Artificial Intelligence and the Future of Humanity*, '*the aircraft industry involves making machines that fly... [but not] in exactly the same way as birds do*.' It was striking that these scientists were not simply trying to make machines to solve our problems, rather to make beings in our own image, but which would supersede us. The project of robotics, and particularly of the striving towards Artificial General Intelligence (AGI), Lennox argues, is an attempt at self-deification. Like Adam and Eve, we are not content to be God's creations, made in his image, but rather want to be gods ourselves. This little book covers a lot of ground and is an accessible introduction to many of the vast ideas and dilemmas surrounding AI and AGI. The final apocalyptic chapters are perhaps the more worrying since it has been clear throughout the Lennox is not a Luddite; he appreciates what technology has to offer but has significant concerns around its trajectory. Perhaps one outcome of this book will be to encourage scientists with what Lennox calls '*transcendent ethical convictions*' to take a seat at the table when it comes to wrestling through the ethics of what we should do, as what we can do races on apace.



Sarah's Laughter:
Doubt, tears, and Christian Hope
Vinoth Ramachandra

- Langham Global Library, 2020, £9.44, 137pp, ISBN: 9781783688579
- Reviewed by **Trevor Stammers**, former Reader in Bioethics at St Mary's University and Director of the Centre for Bioethics and Emerging Technologies.

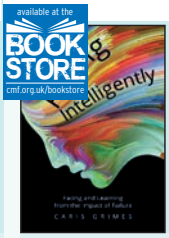
For those whose faith in God is tested by evil, pain, and grief, this book is for you. From his opening analysis of the civil war in his beloved home nation of Sri Lanka, Ramachandra, in the five chapters of this sobering yet ultimately hopeful book, covers a vast terrain of pain, including his own. He mentions the death of his wife, Karin, only once early on, yet this inevitably influences the text, and the book is dedicated to her.

Scripture also permeates the pages with extensive quotations throughout, especially, as one might expect from the many passages of lament. Ramachandra bewails 'lamentless churches' which don't permit such pain to be expressed.

The many unanswered questions in the book of Job are also explored. The author's central point is that Job's anguish is not so much about the fact of suffering but rather the religious attempts to explain it away. Ramachandra sees in God's speeches that conclude Job the gratuitousness of divine love, sovereignty, wisdom, patience, justice, and engagement as sources of hope.

The Tears of God chapter explores the suffering of God over and with his people. Classical theism's doctrine of God's impassibility receives a challenge here as Ramachandra suggests its origins lie more in the pagan Plato and Aristotle than in Scripture.

The final chapter looks towards our future hope as God's people, seeing this hope as both a struggle and a sign of our vulnerability this side of heaven. Yet, it is also a prophetic way of life, pointing others to the Christ who sustains us. He reminds us '*The church, that section of humanity which has glimpsed the dawn in Easter Sunday while sharing the agony of Easter Saturday in fellowship with the rest of humanity, seeks to witness to that dawn*'.



Failing Intelligently
Facing and Learning from the Impact of Failure
Caris Grimes

- Sarah Grace Publishing, 2019, £10.99, 179pp, ISBN: 9781912863051
- Reviewed by **Patricia Wilkinson**, a GP in East Lancashire

As doctors and other health care professionals, we are expected to know everything and get everything right, making all the correct decisions and never failing at anything! However, we know and admit, if we are being honest, that this isn't always the case. Although such honesty may not come easily to us. We try to avoid failure or minimise the damage rather than accepting it.

In this book, Caris Grimes looks at failure and how we can manage to deal with it. She starts by looking at the (seemingly) most significant failure of all; that of Jesus on the cross. Then through other characters in the Bible, who have failed for various reasons, she looks at how we may be able to cope with what may appear to be or actually is failure in whatever field; work, home, relationships or church. There are several real-life examples drawn from the author's experience, and each chapter ends with questions to reflect upon.

This is a practical book with tips and ideas about how we can cope when things go wrong, whether it is our fault or out of our control. I particularly like the idea that we need time and space to process failure rather than moving quickly on to the next thing.

I would recommend this book to anyone who has ever failed or is likely to fail, in whatever way.

Disability and the Gospel: *How God Uses Our Brokenness to Display His Grace*

Michael S. Beates

- Crossway, 2012, £9.99, 192pp, ISBN: 9781433530456
- Reviewed by **Ruth Eardley**, a GP in Market Harborough

For the Christian response to disability, I invariably turn to Joni Eareckson Tada. However, Michael Beates (who has served for twenty years on the International Board of Directors at 'Joni and Friends') has written here an excellent exploration of the theology of brokenness. The father of Jessica (now 38), who was born with a rare chromosomal abnormality and lives with profound, multiple disabilities, Dr Beates carefully takes the reader on a survey of disability through time.

Starting with the voice of God through the prophets and the law, he shows how physical and spiritual brokenness is a biblical motif. Beates is self-deprecating: '*I am not by any stretch of the imagination an expert*', and his openness is disarming. Yet here is someone who knows what they're talking about and can answer tough questions with convincing scriptural applications.

The author's convictions are Reformed, and some may query his assertion that God ordains and causes disability, preferring to say that he allows it. Years of raising Jessica have, by his own admission, '*softened his edges*'. He is gracious when speaking of differing viewpoints; for example, those who say that even calling someone 'disabled' is reinforcing an oppressive stereotype. He points out that the ear was designed for hearing and that it is an obvious disability to live without that sense '*no matter how courageous and proud the accomplishments of the Deaf culture*'. (p110)

It is a slim volume, so mental health is not addressed, and there is a distinctly American perspective. However, the challenge to welcome and assimilate the 'broken' and to recognise our own brokenness applies to churches worldwide. As Joni Eareckson Tada says in her foreword, '*God's power always shows up best in brokenness. And you don't have to break your neck to believe it.*'

Promises in the Dark *Walking with Those in Need Without Losing Heart*

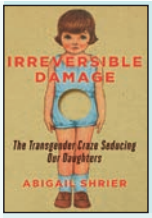
Eric McLaughlin

- New Growth Press, 2019, £12.17, 176pp, ISBN: 9781645070290
- Reviewed by **Steve Sturman**, CMF Associate Head of Doctors' Ministries and a semi-retired Neurology Consultant in the West Midlands,

Eric McLaughlin is a missionary physician in Burundi. In this remarkable book, he takes us on his journey from A&E residency in the USA to dealing with the almost impossible demands of his mission hospital career, as he faced a series of under-resourced and heart-breaking healthcare situations.

This extremely honest book tackles enormously deep questions and challenges, from the problem of suffering in the face of God's love, to being haunted by the thought that more could have been done and bearing the moral injury, and of seeing the preciousness of the mundane. It is as if he has encountered so much moral distress and difficulty that he has been able to write a catalogue of almost every challenge one might face in healthcare. The intensity and the poignancy of each situation is amplified by the spiritual and resource-poor context in which they are experienced.

The truly remarkable thing about this book is that he not only frames these dilemmas with powerful, personal narratives, but he then expertly applies the Word of God to each one. The reader can almost hear God speaking to McLaughlin and explaining, reassuring and giving perspective that helps him cope. Anyone dealing with healthcare's moral dilemmas, particularly in the present pandemic, will find this book of God's promises, explained through narrative, encouraging, informative, and even foundational in their service for Christ. I strongly recommend it.



Irreversible Damage: *The Transgender Craze Seducing Our Daughters*

Abigail Shrier

- Swift Press, 2020, £12.68, 288pp, ISBN: 9781800750340
- Reviewed by **John Greenall**, CMF Associate CEO, and a paediatrician

In our current climate, it takes courage to write a book critiquing the transgender movement. But that is what *Wall Street Journal* journalist Abigail Shrier has done. I confess that I was sceptical when approaching the book, given the title, as strong opinions in this realm often lead to echo chambers of accusation, 'cancellation', and insult-throwing. Yet Schrier writes in a disarming and compassionate way which meant that I emerged with greater understanding and empathy for those involved and more conversant with the arguments in both directions. However, as a parent and a paediatrician, I also emerged feeling disturbed that something is very wrong indeed.

Before 2012 '*there was no scientific literature on girls aged eleven to twenty-one ever having developed gender dysphoria at all*'. But this has all changed. As well as a 4,000 per cent increase in referrals over the last decade, last year, 77 per cent of referrals between ages twelve to 16 to the UK's Gender Identity Development Service were for females, reversing the trend of the previous ten years.

Meticulously researched, we hear from several of 'the girls' involved, as well as their parents, schoolteachers, the social media influencers, 'the shrinks' and those who have detransitioned. We are painted a humanising picture of people with real hopes and dreams, but simultaneously a disturbing theme of 'cult-like' internet subcultures preying on vulnerable girls.

Shrier concludes that we are witnessing a social contagion, a hysteria akin to multiple personality disorder and anorexia.

Whilst Shrier reports from America, it's happening here in the UK too. How will history judge our professions? Will we live up to our calling and training in the face of political ideology, or will we capitulate and leave our legacy as those who abandoned our girls in their time of need?

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Why exercise can't make you thin

While studying the physical activity patterns of the Hadza people of northern Tanzania, Herman Pontzer discovered that despite walking, running and heavy farm work, the average Hadza burns no more calories in a day than the average American. In fact, a slew of research now shows that our bodies adapt our calorie expenditure in a narrow range. It's what we eat and how much of it that is the problem. But don't bin the running shoes or cancel your gym membership – exercise remains vital to well-being, but not much to weight-loss. *Daily Telegraph*, 21 February 2021, *bit.ly/2ZBY2eD*

Exercise can be a pain – in the knee

Many middle-aged runners get regularly told we'll destroy our knees in old age unless we stop our 5k-a-day vice. New research suggests that while using weight training to strengthen limb joints may not work to improve joint pain [*New York Times*, 19 February 2021, *nyti.ms/2NuMG9x*], other research suggests that even those with existing injuries will see them improve if they take up running – even marathons! Time to dust of the trainers... *BMJ* 16 October 2019, *dx.doi.org/10.1136/bmjsem-2019-000586*

Precision medicine comes one step closer

The Cancer Dependency Map (DepMap) project has begun a comprehensive mapping of around 500 individual cancers. The aim to is identity drug sensitivities and explore the use of CRISPR-CAS9 in cutting out genes responsible for the unregulated growth of cancer cells. The advent of effective mRNA vaccines against SARS-CoV-2 also promises individualised vaccines against specific cancers in the long-run. Exciting stuff, but will those in middle and low-income countries see any benefit, even in the long-term? *The Economist*, 13 February 2021, *econ.st/3qVheA5*

Power naps save lives

Winston Churchill swore by them, Boris Johnson regularly takes one as part of his routine, and Michelle Obama was a great advocate. A 10-20 minute 'power nap' in the early afternoon seems to boost productivity, reduce coronary heart disease and improve your sleep at night. Provided, of course, that your work routine allows time for this! *The Times*, 20 January 2021, *bit.ly/3uoV9M7*

How do face masks protect us from coronavirus?

Until recently, the generally agreed consensus has been that triple layer facemasks keep us from inhaling viral particles in aerosols. It turns out that it has more to do with snot! Apparently, the increased humidity in the upper respiratory tract caused by wearing a face mask keeps the mucus fluid (especially in cold weather), increasing its protective properties against airborne virus particles. So, a runny nose is a good thing, at least when it comes to COVID-19! *The Economist*, 6 March 2021, *econ.st/3ec7hdP*

Zoom fatigue? Try Botox...

Yes, you heard it here. Many men are finding the stress of lockdown is making them look older and more haggard on the ubiquitous video conferencing calls that have replaced our previous work and social life encounters. So worried are we, apparently, that there has been a 70 per cent increase in men seeking video consultations for plastic surgery in the last year – everything from dermal filler for 'jawline definition', chin enhancement and Botox to eliminate wrinkles. I personally prefer to use a Zoom cat filter – it is cheaper, less painful and gives everyone a quick laugh! *The Times*, 5 March 2021, *bit.ly/38djbQJ*

Telemedicine benefits the environment

According to research by Newcastle Hospitals NHS Trust, switching to virtual outpatient appointments over telephone or Zoom has reduced the carbon emissions from their patients travelling to hospital by 160 tonnes. Northumbria Healthcare NHS Trust estimates its patients travelled two million fewer miles in the last year. Proving that remote appointments have time and environmental benefits without detracting from patient care in most instances has led NHS England to announce that it plans to reduce in-person outpatient appointments by 30 million next year. While there is no denying the benefits of telemedicine, one wonders how much the reduced interpersonal contact will have on patient care and recovery in the long-term? *BBC News Online*, 6 March 2021, *bbc.in/3rn0aTN*

'Skin hunger' and mental health

It is said that Aristotle regarded touch as the basest, most animal sense. Notwithstanding the fact skin constitutes 20 per cent of our body by mass and is the largest single organ, with in the region of 50 nerve endings per square centimetre, the skin is also our largest sense organ. As David Cranston's article in this edition points out, loss of touch or 'skin hunger' may be one of the most significant sensory deprivations of the COVID-19 pandemic. It is also being recognised as one of the major contributors to the current rise in mental health problems. We may find British reserve needs to go out the window when the day comes that we can once again '*greet each other with a holy kiss*' (Romans 16:16). *The Guardian*, 28 February 2021, *bityl.co/5s6N*

Simple skin swab to test for Parkinson's disease

Talking of skin, recent research has shown that a simple skin swab can pick up tell-tale compounds in sebum that indicate the early onset of Parkinson's disease. Early studies show this test is 80 per cent accurate, and if further trials are successful, it could speed diagnosis and early detection of the disease for tens of thousands each year. This discovery started with a retired nurse noticing a change in her husband's scent years before his diagnosis. She could spot the same odour in 100 per cent of cases in blinded tests. *BBC News*, 11 March 2021, *bityl.co/5wWz*

Esme MacKrill explores how we keep our spiritual eyes and ears open to respond to injustice

DEVELOPING COMPASSION PERMANENCE

'For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.' Matthew 25:35-36

There are many inequalities in our world. The news is full of images of people facing the consequences of natural disasters, oppression, or disease. Through participation in the new 'Health and Justice Track'[1] run by CMF and Integritas Healthcare,[2] I have been challenged to develop my 'compassion permanence'.[3] This means not forgetting the world's injustices when we stop seeing them in the news or (more dangerously) becoming so accustomed to them that we accept them as normal. It would be all too easy to despair. So, rather than letting such stories overwhelm or numb us to the point of inaction, we must instead learn to turn to God to guide us on what action to take.

In the parable of the sheep and goats,[4] Jesus sets us apart as children of God through our compassionate responses to our fellow humans. Our service of others reflects our love for Christ. And just as Jesus demonstrated how to show compassion and love to those considered the least in society, we also have a responsibility to care and advocate for the vulnerable.

When we place our hope in Jesus Christ, we anchor ourselves to the truth that God is enough and can change circumstances, conditions, and structures. God's kingdom is not yet fully here, but we are placed in this broken world to participate in bringing life under his rule and reign.[5] In the story of the good Samaritan,[6] we are shown how to respond to seeing someone broken, poor and desperate for help. The Samaritan did not hesitate to risk his own safety or money to meet the needs of the person in front of him. Nor did he see the cultural or religious difference between them.

We should not miss any opportunity to imitate the 'Great Samaritan' that is Jesus Christ in acknowledgement of his sacrifice to meet our own spiritual poverty, debt, and brokenness.

Whether it is a short or long-term mission trip, charitable fundraising, or signing petitions and raising awareness on social media, there are many ways to be involved in advocating and acting for the vulnerable. When you ask God what opportunities there are, you will find he will do extraordinary things through you.

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references (accessed 12/2/21)

1. See *cmf.li/HandJTrack20* for more details.
2. Integritas Healthcare is a Christian faith-based non-profit organisation with a heart for detainees, delivering international healthcare, expertise, advocacy, research, and training. See *integritas-healthcare.squarespace.com*
3. Haugen G. *Good News About Injustice*. London: IVP. 2004
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5. Keller T. *Generous Justice: How God's Grace Makes Us Just*. London: Hodder & Stoughton. 2012
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