

for today's Christian doctor

triple helix



Should Christian doctors strike?

Plus: avoiding burnout, why the NHS needs Christians, legal highs, the changing scene in global health, are we losing our compassion?

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Junior doctors and industrial action



Junior doctors in England have voted overwhelmingly in favour of taking industrial action. More than 76% of 37,700 trainees took part in the ballot. 98% voted in favour of a full walk-out and 99.4% in favour of action short of this. Three dates for action are planned: on 1 December only emergency care will be offered, while there will be full walk-outs on 8 December and 16 December.¹ This action follows months of increasing tension between the British Medical Association (BMA) and Health Secretary Jeremy Hunt over proposed changes to the juniors' contract.

Not surprisingly, the issue of industrial action is one on which not all Christian doctors agree. A blog post by our Head of Student Ministries, John Greenall, which raised five questions for juniors to consider, attracted an unprecedented level of passionate comment.² In this issue of *Triple Helix*, Melody Redman and Matt Lillicrap give contrary views on whether Christian juniors should strike.³ We initially published these on *CMF Blogs*.⁴ I would urge all members to read these pieces carefully and prayerfully.

The juniors' contract – governing the employment of the NHS's 53,000 junior doctors in England – was last updated in the late 1990s. In 2012 the Department of Health (DH) said that there needed to be changes. The BMA began negotiations, but talks broke down in October 2014. In August 2015 the BMA refused to re-enter negotiations and accused the government of a 'heavy-handed' approach. Ministers then said they would impose a new contract on all junior doctors starting in August 2016.⁵

The standoff involves complex issues which are difficult for the public or media to understand. Key questions centre on what junior doctors are paid for working in different settings and at different times of the day, night or week. What level of basic salary? How should overtime rates be 'banded'? The government says it wants to put basic rates of pay up but the BMA says that reductions in overtime payments from 're-banding' will lead to substantial pay cuts for some doctors.

Wider NHS issues such as the long hours culture, patient safety and staff shortages also impact and, as might be expected, the BMA and the DH both claim their stance is vital to protect patients' safety. Both sides are gunning for public and media sympathy. The doctors have accused the health minister of 'megaphone diplomacy' and he has in turn accused the BMA of misleading junior doctors over the facts. Understandably the media is itself divided.

Juniors have received vocal public support from royal college presidents who have warned that the new contract will further weaken morale, deter recruitment and threaten the safety and quality of the care patients receive. Some have threatened taking their services abroad, although with capacity near full in the gentler climes of Australia and New Zealand it is not clear where they might go.

When I was a general surgical registrar in the late 1980s in New Zealand, juniors staged a similar walkout. Low overtime payments (we received a third of our normal rate for each hour worked over 40) provided an incentive for hospital boards to work juniors long and hard. The strike led to a new contract involving better overtime payments. Weekly hours on duty dropped from 70-80 to just over 40 overnight. A shift system replaced the old 'one in four' and hundreds of overseas doctors, some very poorly trained, were brought in to fill the rotas. Team structures were disrupted and some seniors felt aggrieved. The new rates were probably over generous and were cranked back over the next two decades, but there were both good and bad outcomes – not all foreseen. I personally did not participate in the industrial action but believe that the change in overtime rates was the only way of stopping the exploitation, which was largely driven by economic concerns.

As I highlighted in my last editorial,⁶ the NHS is at a crossroads. Financial pressures are powerfully squeezing its ability to deliver. Population growth, ageing and cost increases by 2020 mean that the NHS will require some £30 billion (25%) more than it is getting now just to maintain services at their present level. We are being called to 'make bricks without straw' (Exodus 5:7) in a health service and nation which is gradually falling apart. The major driver of this funding squeeze in real terms is the UK's national debt.

There are no easy answers. In a democracy we all have a responsibility to help shape public policy so that it is just and fair. We need to be engaged in decision-making – 'seeking the good of the city' (Jeremiah 29:7) – whilst remaining morally distinctive – 'shining like stars' (Philippians 2:15); remembering that it is Jesus Christ whom we ultimately serve (Colossians 3:17, 23).

Whatever our conclusions about industrial action are within those parameters, it is essential that we stay calm, gracious, diligent and hardworking in serving our earthly masters, our colleagues and our patients for Christ's sake. And that we undergird all with earnest prayer.

Peter Saunders is CMF Chief Executive.

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A turning point in global health

The role of faith-based healthcare

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

In July, *The Lancet* launched a landmark series of papers on the role of faith groups in the delivery of healthcare worldwide.¹

Three papers explore the breadth and impact of faith-based healthcare, the controversies that exist and both practical and positive examples of positive partnerships.

Evidence for the breadth and depth of religious organisations' engagement with healthcare is sketchy. Almost certainly in Sub-Saharan Africa faith groups play a significant role, but the evidence suggests it may not be quite as big or as effective as some estimate. However, there is evidence that Christian healthcare institutions and programmes are more prevalent in poor rural African communities and that the overall patient satisfaction is high.

Inevitably, controversies around sexual and reproductive health, abortion, sexuality, gender, violence against women, female genital mutilation, immunisation, harm reduction, HIV, stigma, and evangelism have all created tensions for secular bodies working

with faith groups. Engagement with faith practices and spirituality is something of a blind spot for many governments and NGOs. Yet there have been many instances where a constructive engagement has led to effective partnerships.² It is clear that we need greater faith literacy amongst secular bodies and greater health literacy by faith leaders.

We face a potentially significant turning point in global health and development, with the official launch of the Sustainable Development Goals (SDGs) in New York last September. Goal three – ensuring healthy lives and promoting well-being for all at all ages³ – could see a significant increase in access to affordable, appropriate healthcare for the world's poorest people. Governments will need to engage with religious groups (to which nearly 80% of the world's population are adherents) to achieve this.

There will be some hard-core sceptics and secular ideologues who will decry this, but the evidence against their position is mounting.

Christians have engaged with health issues since the first century.⁴ Care for the

sick, vulnerable and dying is an integral expression of our faith.⁵ Churches and church hospitals are often the only local infrastructure in many poor communities. They were there long before the donors turned up. They will be there long, long after these donors have gone off after their next new priority or when the next set of goals are agreed. While the two sides may not always share the same agenda, on the whole they share the same concerns. It is important that we find common ground to work together in many areas, if we can only learn to talk to each other.

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Down's screening

New test creates more problems than it solves

Review by **Rick Thomas**
CMF Public Policy Researcher

The UK National Screening Committee (NSC) is recommending a new test for pregnant women that will detect a higher proportion of fetuses with Down Syndrome.¹ The test is performed around ten weeks, is non-invasive and makes use of cell free DNA from the fetus (cfDNA) circulating in the mother's blood. It is far more accurate than present early pregnancy screening tests for Down's, meaning there would be far fewer false positives and far fewer women going forward for invasive tests to confirm the condition – procedures that may result in the inadvertent miscarriage of a healthy fetus.

So, at first sight, it looks like a good thing. But look closer and a very different picture emerges. First, the numbers. The number of inadvertent miscarriages saved would be far outnumbered by the predicted increase in detection and subsequent abortion of babies with Down's. And if, as seems likely, public demand eventually results in the new test being made available to all pregnant women

(and not just to those already shown to be at risk, as is being proposed) the rates of detection, confirmatory invasive testing, abortion and inadvertent miscarriage will all spiral upwards.

Second, international conventions, guidelines and UK law. The World Health Organisation screening guidelines require that 'there should be a treatment for the condition'.² Prenatal screening for Down's provides no benefit to the fetus – most will be aborted. The Convention on the Rights of Persons with Disabilities (CRPD),³ signed by the UK in 2007, requires health policies to respect the inherent dignity of persons with disability. The UN International Bioethics Committee comments: 'The widespread use of genetic screening and in particular of [the new test] may foster a culture of "perfectionism" or "zero defect" and even renew some "eugenic trends", with the consequence that it could become more and more difficult to accept imperfection and disability as a part of normal human life and a component of the diversity we are

all called on to acknowledge and respect.'⁴

To assume Ground E provision of the UK Abortion Act⁵ should automatically apply to Down Syndrome is to stretch the law to the point of completely misshaping it. Many people with Down's live into their 50s and 60s, finding fulfilment and contributing greatly to family and community life.

The Christian ethic calls the strong to make sacrifices for the weak, recognises and respects the value of every person, regardless of ability or disability, and energises the virtues of patience, perseverance and altruism. Caring for children and adults with special needs fosters compassion in the community and a more sacrificial society – a prize beyond price.

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Marris bill defeated

Vote should settle the matter for a decade

Review by **Peter Saunders**
CMF Chief Executive

The Assisted Dying (No 2) Bill¹ tabled by Labour MP Rob Marris was the eleventh attempt in twelve years to legalise assisted suicide through British Parliaments. But its overwhelming defeat on 11 September 2015 by a margin of 212 votes (330 to 118) should settle this matter for a decade.²

It is striking (and indeed fitting) that this happened the very day after World Suicide Prevention Day.³

Given the margin of defeat there is clearly no chance of a similar bill passing through the Commons in the current parliament and even in the event of a Labour victory in 2020 it is virtually inconceivable that the views of MPs will change enough to make it likely in the next parliament either. Overall 74% of MPs voted against the bill, a proportion almost identical to the 72% who opposed the last bill of its kind in the House of Commons in 1997. So there has been essentially no shift in parliamentary opinion in the last 20 years.

Conservative MPs opposed the bill by

210–27 with 16 cabinet ministers voting against. Labour MPs opposed it by 91–72 and Liberal Democrats and Scottish Nationalists were more or less evenly split. This is hugely significant as it signals that assisted suicide is no longer seen as a simple left/right political issue. Suicide prevention and protection of vulnerable people from exploitation and abuse also resonate strongly with left wing politicians.

Marris's bill would have allowed assisted suicide for mentally competent adults (>18) deemed to have less than six months to live, subject to a series of 'safeguards' including a final decision by a High Court judge.

In a robust Commons debate⁴ in which over 80 spoke, MPs were clearly driven by concerns about the risks it posed to vulnerable people who would have felt under pressure to end their lives so as not to be a burden to family, relatives, caregivers or a society short of resources.

The Care Not Killing Alliance (CNK) published two excellent guides⁵ on the bill which were circulated to neutral and opposed MPs. CMF, both through CNK

and in its own right, participated in a comprehensive campaign from the end of May along with other key groups (especially Not Dead Yet UK, Living and Dying Well, Christian Institute, Christian Concern, LIFE, SPUC, CARE, and No to Assisted Suicide) involving letter writing, media articles, media interviews, MP briefings and culminating in a powerful rally outside Parliament.

The result was a wonderful answer to prayer and a powerful testimony to God's grace, good strategy, excellent collaboration and hard work on the part of many organisations and individuals.

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Atheism, science and liberal values

Why new atheists need to know more of atheism's history

Review by **John Martin**
CMF Head of Communications

We owe a great debt to the philosopher John Gray,¹ a former professor of European Thought at LSE and himself an atheist. Gray wants this generation to learn lessons of history. He confronts us with the disturbing reality that several atheists of the early decades of the twentieth century, notably Julian Huxley and HG Wells as well as Friedrich Nietzsche, publically associated themselves with eugenics and the belief that some races were superior.

In 1931, Huxley wrote that there was 'a certain amount of evidence that the Negro is an earlier product of human evolution than the Mongolian or the European, and as such might be expected to have advanced less, both in body and mind'. This was no isolated statement. It was commonplace among members of the secularist intelligentsia to look forward to an epoch when 'backward' peoples 'would be remade in a western mould or else vanish from the

world' (as Gray puts it). Huxley, says Gray, admitted that the concept of race was 'hardly definable in scientific terms'. He never renounced eugenics but his tone changed. This was not because his science changed but because the application in Germany gradually became known.

Of course, present-day new atheists would recoil if confronted with the charge that they support racial superiority. Gray points out that secular thinkers look to science for a foundation for their values. The new atheists 'have not renounced the conviction that human values must be based in science'. This position is philosophically flawed, buying into what is termed 'the naturalistic fallacy' – deriving 'ought' from 'is'. 'There are no reliable connections – whether in logic or history – between atheism, science and liberal values,' Gray insists.

But this is not just an abstract argument. Where political systems have attempted to assert they have a basis in science, the

results have been disastrous, producing oppressive, authoritarian regimes. As we know all too well, the Soviet Union, driven by this logic, perpetrated a legion of abuses as it imposed its will on citizens.

Atheist movements of today have still not learnt their lesson. As Gray says, 'it's probably just as well that the current generation of atheists seems to know so little of the longer history of atheist movements. When they assert that science can bridge fact and value, they overlook the many incompatible value-systems that have been defended in this way.'

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Monty Barker looks at a common issue for people in the caring professions



AVOIDING BURNOUT

key points

- Understanding burnout is vital for pastors and people in the caring professions who spend their time concentrating on giving out to needy people.
- It helps to be able to say 'no'. Times of difficulty can be catalysts for taking stock and finding new directions.
- We need to have a system of personal support, people who will pray for us and help us sift priorities.

Burnout is a term first used in the 1950s. It encompasses tiredness, exhaustion, emotional drain and often depression in those who have given everything for others. The concept has a special application for those in the health professions and in the pastoral ministry who spend their time concentrating on giving out to those who are needy whether in body, mind or spirit. Yet there is a sense in which the term produces inherent conflict for Christians. If we don't burn out, do we risk simply rusting out? Should we not aim to burn out in the Lord's work?

When we turn to the Bible we are encouraged to take care of ourselves, our families and our fellowship.

Caring for ourselves

Many of us, especially in the caring professions, need to be needed, especially by the most needy. It gives us a purpose in life and may sometimes be a substitute for other relationships and way to control our own insecurity. We need to understand ourselves in this respect. We need to remember that depression is no respecter of persons. We all have our breaking points. When three 'life events' come together, danger and depression threaten. That is especially true of experiences involving loss. These

There is a sense in which 'burnout' produces inherent conflict for Christians. If we don't burn out, do we risk simply rusting out? Should we not aim to burn out in the Lord's work?

may be bereavements in the family or amongst close friends or other losses in our lives such as our job or our health or our home.

Paul instructs the Ephesian elders, 'Keep watch over yourselves' (Acts 20:28) We need an understanding of who we are. We all have our own personal foibles, but God is able to use us despite our weaknesses. When I was at school my history teacher gave me a book entitled *Eminent Victorians* by Lytton Stracey. The book is a critique of some nineteenth century Christians and was written to discredit them. But it had the opposite effect on me. I realised God could use people in a remarkable way in spite of their flaws, and it helped me to look at people as they really are, warts and all, and liberated me from just seeing them all as heroes.

Rosemary and I live in Bristol where George Muller, a German Christian, devoted his life to caring for orphaned children. John Nelson Darby was a fiery Irishman who was the founder of the Exclusive Brethren movement. Both did great things for God but like Paul and Barnabas they fell out with each other. One day Darby came to Muller and held out his hand to make up, but Muller said there were a few things to discuss first before he would shake Darby's hand. This annoyed Darby who walked off. Yet despite their weaknesses and personal animosity God used them both.

We also need to be realistic in our own expectations. Do we have a true vision for the work to which we are called or is it merely a fantasy? Is it a vision given by God that we are able to share and discuss with others – or is it an unrealistic fantasy of our own making, kept locked in our brain and not tested with others?

Elisabeth Elliot wrote *Shadow of the Almighty* which tells the story of her husband Jim, who dedicated himself to missionary work and was killed by the Auca Indians in Ecuador in 1956. It is a triumphal story fulfilling his words as a 22 year old 'He is no fool who gives what he cannot keep to gain what he cannot lose'. Yet later she wrote *No Graven Image*, a novel where she describes the death of a patient from anaphylaxis after treatment by the missionary with penicillin. There is seemingly no benefit to anyone and no answers as to why this happened: 'Why O Lord?'

Yet times of difficulty or ill health can make us pause and take stock and ask 'Where am I going?'

Caring for our families

Paul writing to Timothy, and Peter in his first letter, speak of the care we need to take of our families. Communication is important. 'Consider each other' is biblical advice. We need to learn to *listen* to what the other is saying rather than just *hear* what they are. All relationships include extra baggage. Often when teaching I would do a stick drawing of a man and wife hand in hand, but each with the other hand behind their back carrying a suitcase of stuff from the past, still to be unpacked and shared together. Each of us brings extra bits and pieces to a relationship and these need to be disclosed.

There are added difficulties in being married to a carer, one who is 'called of God'. Children of Christian leaders or missionaries often feel they are living in a goldfish bowl.

The need for a Sabbath was ordained by God in creation; a day of rest restores both the individual and the family. Sunday is not a day of rest for many Christian leaders and often not for doctors. The pattern of rest and working is seen throughout God's creation. The heart beats and rests and beats again. We breathe in and we breathe out. We sleep, we dream, and we wake refreshed. Thus throughout nature there is the pattern of work and rest that we neglect at our peril.

We need to learn to protect ourselves and our

families. That may mean saying 'No' to requests or invitations.

Care for our fellowship

Romans 12 and Hebrews 10 remind us of the importance of being part of the body of Christ and playing our role in our local church. We need friends and confidants and should look for support structures. When Paul Berg was vicar of Christ Church Clifton, he had three elderly women as prayer warriors. John Stott had his Advisory Group of Elders who he called his 'AGE' group with whom he could discuss which invitations to accept from around the world. Jesus had women as financial supporters as well as his close friends at Bethany. We need close friends with whom we can share even if we risk being let down as Jesus was.

Even the greatest Christian leaders will have times of grief and trauma and sometimes may become depressed. In CS Lewis's *A Grief Observed* he describes in very personal terms his grief over the death of his wife. By then he had written many books of inestimable help to those who are going through a time of suffering, none of which were of any help to him.

There are some questions we will never know the answers to in this life. Some of them may aggravate depression and burnout. God is sovereign and he works in mysterious ways. He gave William Tyndale the ability to translate the Bible into English. Tyndale needed money to complete the task. The Bishop of London who objected to his work told people to buy every copy and burn it. Money from the ensuing sales enabled Tyndale to complete the work. Later the King James Version of the Bible drew extensively on Tyndale's translation and within a few years a copy was placed in every parish church in England.

As the years pass our abilities change – and not always positively. Teachers may no longer be able to teach; travellers may no longer be able to travel; carers may be no longer able to care. Our health and other life events will overtake us. We are indeed jars of clay. All of us are subject to psychological and physical afflictions.

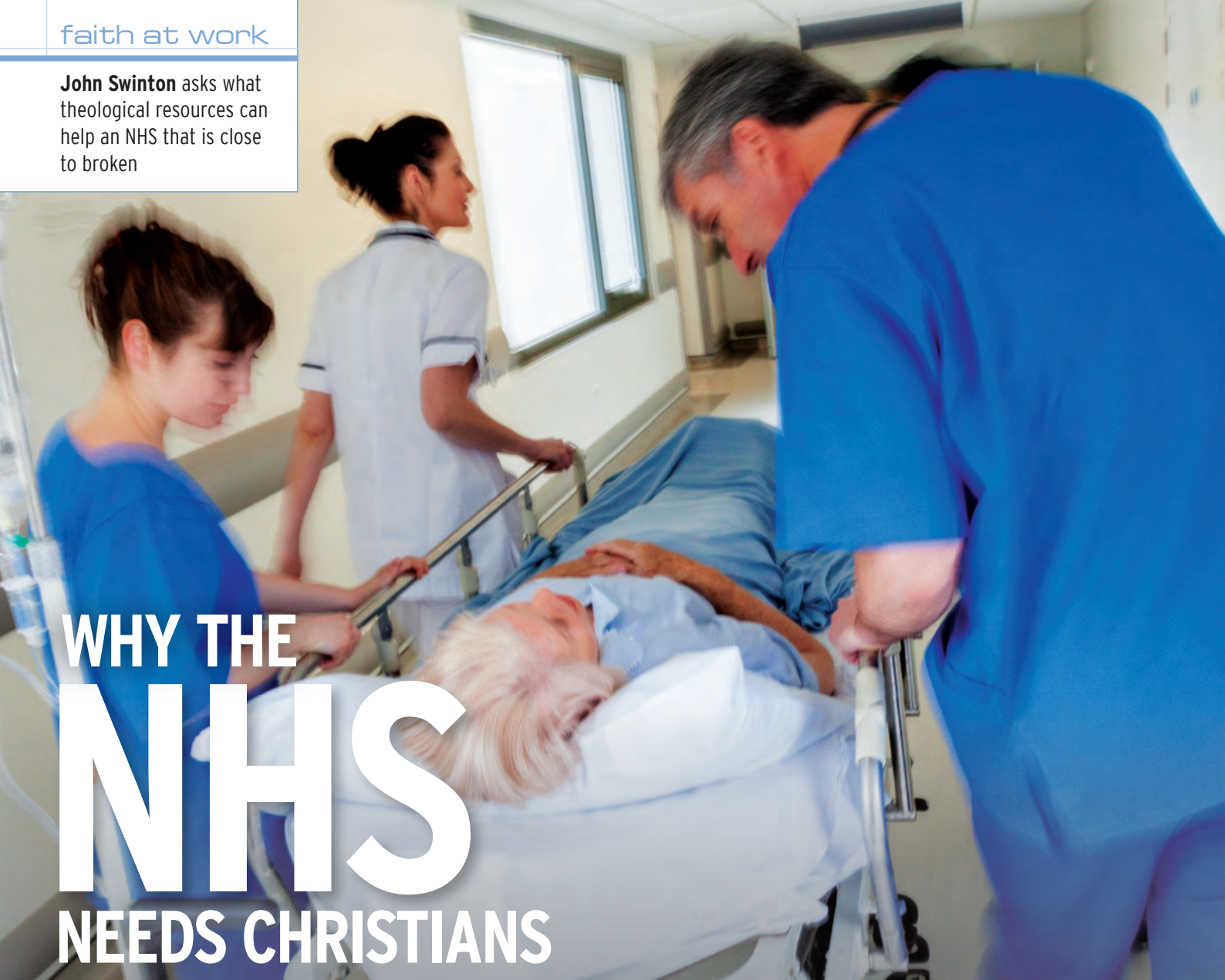
The Bible encourages us to consider – reflect – give thought – remember. As we get older, as Christians we will still want to be useful for the Lord, but that may be in ways that we have not thought of when we were fitter and more active.



The pattern of rest and working is seen throughout God's creation. The heart beats and rests and beats again. We breathe in and we breathe out. We sleep, we dream, and we wake refreshed

This article, based on a talk given at the Oxford Centre for Mission Studies in March 2015, is published to honour Monty Barker who died on 1 July 2015. He was an eminent psychiatrist who had an enormous influence on the medical students he mentored, particularly psychiatry trainees. His impact stretched beyond the UK to France and India. An obituary is published in the current issue of *CMF News*.

John Swinton asks what theological resources can help an NHS that is close to broken



WHY THE NHS NEEDS CHRISTIANS

key points

- The recovery of the Sabbath principle holds the key to how Christians affect the NHS.
- The commodification of health and healthcare is one outcome of secularising trends.
- In the biblical concept of shalom is the key to a proper understanding of what true health is.

How can Christian healthcare workers be salt, light and yeast within a system that seems close to being broken? In this brief theological reflection I want explore three critical questions:

1. What has gone wrong with the healthcare system?
2. What is health and what is it for?
3. What difference can Christian healthcare workers make?

In his book *Sabbath as resistance: Saying no to the culture of now*,¹ Walter Brueggemann reflects on the Exodus story and the slavery of the people of Israel. Brueggemann astutely observes that Pharaoh was driven by profound anxiety. He demanded that the people of Israel work without reward in the toughest of conditions in order that he could overcome his anxiety that there may be another famine and his grain vaults would be empty. Pharaoh turned people into commodities in order to ensure that he would be successful in meeting his goals and targets, maximising the limited resources that were available. There was no rest for the slaves. As Pharaoh became more anxious, so the slave's conditions became worse and worse.

The healthcare system was created for the benefit of human beings; human beings were not created for the benefit of the healthcare system

God's response was profound and surprising. Rather than engaging in the political or military process in an attempt to bring down Pharaoh, God issues a command: 'Remember the Sabbath.' He ordered the people of Israel to respond to their oppression by taking time out to rest with God and for God. Such a response must have looked ridiculous in the face of Pharaoh's violence and anxiety-driven oppression. And yet this small gesture revolutionised the situation, subverting the anxious power of Pharaoh and putting Yahweh in his proper place.

Brueggemann draws a comparison between Pharaoh's anxious presence and contemporary speed-driven work cultures. He points out the ways in which we are all driven by time pressures, league

tables, quotas and a desire to succeed at all costs. My point is not that healthcare workers are treated like slaves. There is, however, a tendency to commodify healthcare and those who deliver and receive such care. It is easy to forget that the healthcare system, like the Sabbath, was created for the benefit of human beings; human beings were not created for the benefit of the healthcare system.²

Into our current NHS system, God speaks these simple words: 'Remember the Sabbath day by keeping it holy.'³ Such remembering does not simply mean that we rest for a single day, without looking at our emails. It means learning to rest in Jesus at all times⁴ and finding ways to create Sabbath moments within our daily healing encounters; moments wherein God can be given God's place. Perhaps the most radical and transformative thing that Christians can do is to create non-anxious Sabbath spaces within our daily work lives where we can slow down and find God in the apparently relentless flow of anxiety and activity that surrounds us. Where are the Sabbath moments in our working lives? If there are none, then we probably haven't heard God's command.

What is health for?

One of the problems for healthcare systems in the West is that it is not clear exactly what health is actually for. In an arguably post-Christian society wherein the only story that matters is the story that we can tell about ourselves in-the-now, the question of what health is for seems obvious. Health is for *my personal happiness*. If there is nothing after this life then health is the only way in which I can find salvation now, in the present. The commodification of health is just another example of secularisation. Health perceived as a commodity is a personal thing: 'it belongs to me because my body belongs to me!' The task of the Health Service is to make *me* better. The target for the Health Service is to get as many people 'well' and out into the community (no longer relying on the professional services) in the cheapest and most effective ways possible. If we can't meet our targets or we can't achieve perfect health, we become anxious; we feel the need to blame someone, whether that's the doctor, the system, the government or the healthcare workers.

Within the Bible, health is not perceived as the absence of something – illness, distress, suffering. Rather it has to do with the *presence of someone: God*. The Hebrew term *Shalom* (shalom), which occurs 250 times in the Old Testament, represents something of how the Bible understands health. The basic meaning of the word shalom is 'peace'. But such peace is much more than the absence of disease or conflict. The root meaning of the word shalom is wholeness, completeness and well-being.⁵ Shalom has several secondary meanings, encompassing health, security, friendship, prosperity, justice, righteousness and salvation, all of which are necessary if wholeness, completeness and well-being are to come about.⁶

To be healthy is primarily to be in right relationship with God. It's not what we have or how we feel that makes us healthy; it's whose we are. It is therefore possible to be dying, psychotic, deeply depressed or in pain in the midst of illness and to be healthy. Health is membership of the people of God and the recognition of one's membership of the whole of God's creation. Healing understood in this way has to do with *reconnection* rather than curing.

Understanding health as shalom makes all the difference. Health is not a commodity; it is a relationship. Faithful medical practice is not aimed primarily at enhancing personal happiness, or even at curing complex diseases (important as both of these things may be). Faithful medical practice finds its primary focus in ensuring that people are given the opportunity to connect and remain connected with the Divine even in the midst of the most difficult storms. This means moving beyond the commodification of health, towards the sanctification of medical practice. Put slightly differently, it means taking day to day practices and imbuing them with new theological and spiritual meaning.

Take for example the act of giving pain medication. At one level pain medication seems quite straightforwardly technical and pharmacological. However, when viewed as an agent of God's shalom, its function shifts from the technical to the spiritual. *Pain is the enemy of shalom*; it is an agent of Pharaoh. Pain separates us from God and from one another. Perceived in this way, offering pain medication is a deep form of spiritual healing, not simply because it takes away the unpleasantness of pain, but because it creates a context for healing reconnection with God.

What difference can Christian healthcare workers make?

The difference that Christian healthcare workers are supposed to make is completely up to God. Christians working within the NHS are called to bear witness to the truth that has been given to them. The thing to notice about the previous reflections is that the things that have been highlighted as Christian callings are not big things. Taking a rest, encouraging others to rest, re-thinking the nature of health and healing and acting accordingly, looking at one's practices in a different light, are not overtly radical. They are however deeply subversive. The task of the Christian healthcare worker is not to try single-handedly to transform the world or the healthcare system (these things are God's job). Rather, the task is to signal the kingdom through small, faithful gestures. Such small things can seem, well, foolish. But, small gestures have great power. Jesus tells us that: 'He who is faithful in a very little thing is faithful also in much'.⁷ Jesus is often found in the small things. The NHS needs Christians because the world needs Jesus.

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The task of the Christian healthcare worker is not to try single-handedly to transform the world or the healthcare system... it is to signal the kingdom through small, faithful gestures

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Richard Vincent wonders if we are losing the intuitive ingredient of healthcare

ARE WE LOSING OUR COMPASSION?

key points

- The key elements of compassion are attentiveness, empathy and action.
- The loss of compassion in healthcare has resulted chiefly from a pre-occupation with the physical sciences, poor role modelling and a mismatch between demand and resources at both personal and institutional levels.
- Strategies for restoring compassion are gaining momentum based on a variety of different worldviews and methodologies.
- A timely opportunity exists for us to promote compassion and spiritual awareness in medical education and practice from a Christian perspective.

Even before the Francis Reports¹² in the UK brought the failure of compassionate care into sharp public focus, observations across the world were growing that compassion as an essential ingredient of care was draining away. In the period since then 17,000 scholarly publications have appeared³ exploring compassion in three main areas: understanding its nature and role in health, determining the causes of its loss, and investigating how it might be restored in both personal practice and in healthcare institutions. This article looks at these themes in the light of our Christian calling to show compassion in all that we do, not least in our service to patients and colleagues.

The shape of compassion

The parable of the Good Samaritan⁴ paints a picture of compassionate care, exemplifying its main components: attentiveness, empathy and action.

1. Attentiveness

Choosing to give someone your undivided attention is the first step of a compassionate approach. In Jesus' parable it seems unlikely that those who passed by were unaware of the injured man, but they chose a strategy that placed the needs of their world higher than his – perhaps because of their workload, their reputation or their status.

2. Empathy

Empathy may best be defined as having an inner sense of what it is like to be in the position of others, particularly in their suffering. This requires both cognitive and emotional intelligence informed by our professional training and experience of illness and its effects – and perhaps also by our personal memories of pain, fear or isolation. Imaginative reflection will help, and need not take

long. But Christians have the additional privilege of prayerful access to God's wisdom⁵ to help us identify and engage with our patients and their immediate concerns – whether they arise from body, mind or spirit.

Jesus identified with the harassed and helpless condition of the people he ministered to, prompting him to weep.^{6,7} Our emotional response to patients and their relatives will vary, but it should never be absent. Empathy establishes a connection with a patient and is quickly appreciated. It also provides important steps toward their recovery.⁸

3. Action

Compassion takes tailored, practical steps to address the suffering of the person in view. This will take time and the energy of *our* body, mind and spirit. We use our knowledge, skills and available resources to their best effect while we continue, at least for a while, alongside our patients in their uncharted journey.

Compassion invites us to address our patients' *human* needs:

- To be properly **H**eard, their words not just being noted down for the record
- To be **U**nderstood in their dis-ease, anxiety and uncertainty even if they present an appearance of calm
- To explore the **M**eaning of their illness – more important to them than our scientific explanation of their diagnostic label and management plan
- To be able, without feeling silly, to **A**sk any question at all expecting a truthful, respectful and accessible answer
- To be **N**urtured, not just treated or referred.

Expressing compassion in a medical context means recognising the patient before us as a person made in God's image, already loved by him far more than ever we could. And compassion's enthusiasm

for restorative action will outweigh the dangers envisaged by those worried that emphasising the importance of an emotional response to suffering might eclipse our necessary skilled scientific response to our patients.^{9,10}

The loss of compassion

If compassion seems an intuitive ingredient of healthcare, why have we been losing it? The side box shows an interesting selection of suggestions from a recent medical discussion in Zimbabwe involving 24 medical students and ten faculty members of Bulawayo's National University Medical School. Many of these will sound familiar.

The focus on materialistic science is strong in both medical education and clinical practice. An interest in mechanisms, measurements and data predominates leading to patients being seen as cases rather than persons, an attitude that may be reinforced by clinical teachers. Demands that constantly outstrip our resources of energy or time have a seriously detrimental effect. This leads to exhaustion or burnout that suppresses our ability to show compassion – even though we know this is a critical component of our practice. Working in systems where we receive a little or no appreciation or are driven toward goals that are neither realistic nor compassionate further dampens our motivation to care. Out of such pressures stress and hopelessness grow readily. These remarks are far from theoretical; nearly half of young doctors in the UK report that their stress levels rose last year,¹¹ and over 40% of doctors are considering early retirement – with 25% thinking of leaving the profession entirely for similar reasons.¹²

The return of compassion

How can compassion – and hope – be regained?

1. Look around

A combination of rising patient expectations and predominantly negative reports about healthcare can subtly drag us down, making compassion harder to maintain. But it is uplifting to note other data that present a more balanced and encouraging profile. For example, in the UK, patient satisfaction with the NHS is nearly as high as it has ever been.¹³ Also in a recent study¹⁴ across eleven first-world countries, including the US, the UK came top in 85 areas of measurement for the quality of its healthcare; and it achieved this at second to the lowest cost.

Note, too, that compassion and the spiritual dimension of our patients are receiving increasing attention with regional and national initiatives¹⁵ to incorporate them into routine clinical practice. The worldview of those involved varies widely, but the 'marketplace' now holds a clear and welcome legitimacy to engage with this activity. Herein lies a wonderful opportunity for us to develop schemes in medical schools and clinical settings that explore, model and teach these topics centred on Christ – the One who is the true source of compassion, spiritual life and hope.

Looking around should also encompass seeking fellow Christians with whom we can enjoy mutual encouragement, share our challenges and blessings, and support one another in prayer. Sadly, service pressures, fragmenting staff rotas and frequent relocations pose serious threats to achieving this in practice. And for those in more settled posts such pressures are often compounded by additional professional demands for teaching, research and administration and by important family commitments. Responsibilities within a local church may also take additional time. But supportive fellowship is an important ingredient of life to pursue wherever possible.

Finally, many in healthcare are compassionate in their service. Looking around to notice even small acts of compassion at work can be encouraging if not inspiring, and giving positive feedback to the carer concerned has been shown to stimulate institutional cultures of compassion.¹⁶

2. Look in

As battle fatigue threatens our reserves of compassion, engineering at least occasional quiet pauses in the whirl of life is essential. Ideally these will allow us to reflect on our main drivers and supports, our fears and our deepest unspoken needs. Bringing these to our ever-listening Father will always prove restorative.

3. Look up

Looking up draws us closer to our saviour, healer and example, Jesus. No one has had greater compassion. He placed himself entirely in our position and made the greatest sacrifice of all for our restoration. He was pressed on every side by the needs of the people he came to serve yet was not overwhelmed because of his continual and deliberate closeness to his Father.

Jesus also gave us amazing promises on which to draw as we struggle with the demands of life. In John 14–15, we are offered his personal presence and power, in obedience to seek from him whatever we need, guidance into truth and generous experiences of peace and joy. By refilling our hearts with compassion from above we can become models of outstanding care as well as agents of hope. The resources we need rest not in us but in the truth that 'We love because he first loved us'.¹⁷ Our role is joyfully to receive God's love and channel it to others – to our patients through empathy with their physical, mental or spiritual suffering and the delivery of expert scientific care; to our clinical and administrative colleagues under pressure; and particularly to all who have yet to find Jesus.

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Reasons for loss of compassion

- Not compassionate to start with ⇨ concern for prestige, top courses
- Trained to be scientists
- Dealing with dead bodies - body ⇨ object
- Persons become 'specimens' in pathology labs
- We become adapted to illness ⇨ hardened ⇨ people become 'interesting cases'
- Clinical role models do not value the emotional world
- Negative attitudes from lecturers, patients and team
- Lack of gratitude and appreciation
- Insufficient resources
- Economic hardship prevents action on needs
- Cannot change the world ⇨ can't change anything of the patient
- Loss of social aspects of life
- Too much demand
- Despair becomes part of you

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In light of the ongoing controversy surrounding the proposed new junior doctors' contract, we asked two of our members to share their views on whether juniors should take part in industrial action.

SHOULD CHRISTIAN DOCTORS STRIKE?

YES

'We need to stand up for the vulnerable'

Melody Redman

Declaration of interest: I am an active member of the BMA Junior Doctors Committee, as well as a CMF member, though I am speaking entirely out of my personal view.

It is 5am on night shift number four. You've slept badly between shifts, and haven't had time for a break yet. Being called to a cardiac arrest may stimulate the needed adrenaline. As for other tasks such as prescriptions, calculations, and handover, you feel the heaviness – the struggle – as you try to approach problems systematically and to make the most appropriate decisions. Junior doctors are already stretched. There is no give left.

As doctors, we already have very demanding jobs with a lot of responsibility. As Christians, we know salvation is through grace and not by works.¹ However, we all know many non-Christian doctors and other healthcare staff who each work admirably hard – well beyond rostered hours, and expecting no compensation.

For many of us, it's an absolute pleasure to actually get paid for a job which (usually!) directly helps people, in a system which upholds biblical principles of treating all as equals.² This equality reaches beyond the patient's past (ie IVDU, alcohol), social status, and personal beliefs. As a Christian,

it is a privilege to work in publicly-funded, publicly-provided healthcare (though we can be good servants in any workplace!). Does that mean it's not okay to strike? Hold that thought...

Safeguards to prevent junior doctors working dangerously long hours: gone. Compensation for unsociable hours: gone. More importantly, as a result, any incentive to stop employers making us work later evenings and more Saturdays: gone (which fits in nicely with the move to increase elective procedures over weekends – medics all know the NHS is already 24/7 for emergency care). This is the contract the government has threatened to impose.

With so much gone, what will be added? More exhaustion from way too many extra hours beyond the rota, as the financial penalty for trusts has been removed. More mistakes. Added to that, more weeknight meetings/fellowship missed, less time spent being parents, being friends, being there for those who need us, and less able to meet with those who support us. From an NHS user's perspective, do you want your mum being met in A&E by a dissatisfied, overworked and undervalued junior doctor? Junior doctors already have a high risk of burnout.³

Those who would suffer the most from this new contract would be those working in the acute

NO

'We need a different message'

Matt Lillicrap

I need to make something clear. Although I was a junior doctor for seven years, a year ago I rescinded my licence to practise and I am now in my third year at Oak Hill Theological College.

So it is with trepidation that I write as one no longer 'on the pitch'. Please don't hear me as an idealist who has lost touch with reality. Rather I am one standing on the sidelines shouting as loud support as I can muster, urging you on to know, love and serve Christ and to call others to him for his glory – not just as my former colleagues but as my current brothers and sisters in Christ.

So what would be the nature of my 'loud support' to junior doctors under the cosh? Answer: keep faithfully serving Jesus, keep loving your patients, and keep giving an answer for the hope that you have even as those around you become more despondent and angry.

But don't strike.

I could give a number of reasons. The imperative to be there to show compassion to your patient. The importance not to cause harm (even indirectly). The importance of understanding communication breakdown – attempting to understand our opponents' reasons for struggling to hear us and our reasons for

not listening to them before we accuse them of not listening (could there be a log in my eye?).

But, Bible college student that I am, indulge me in choosing this: the work and example of Jesus.

Two thousand years ago Peter wrote a letter to a group of Christians under the cosh. Some were suffering for doing good. Others, like the slaves in 1 Peter 2, were suffering *despite* doing good. So Peter speaks to these Christian slaves, not because he approved of their situation but because it was their situation and they needed to know how to live in it. Here's what he said:

'Slaves, in reverent fear of God submit yourselves to your masters, not only to those who are good and considerate, but also to those who are harsh.'¹

Now, you might be thinking, 'hang on, we're not slaves.' Exactly. Imagine their situation for a minute. Not 'persons,' but property. Not workers, but 'tools'. Some had good masters. Some had harsh masters. I can't begin to imagine what that meant. Constantly belittled, treated as vermin, beaten for no reason. And yet Peter calls them to submit nonetheless.

Our reaction to this is complex. We are children of our generation but we try to understand how the Bible teaches us. This means that we rightly recoil at



specialties and A&E; places where we cannot afford to stretch doctors any further, and where we already struggle with recruitment and retention. Nearly 3,000 doctors said they would move abroad, locum, or leave medicine if the proposed contract was imposed.⁴ There is a serious threat that junior doctors will vote with their feet, which would be disastrous for the NHS and for our patients.

Industrial action (IA) is lawful, and employers must be given a minimum of seven days' notice, which allows for appropriate plans to be put in place so that patients are safe.⁵ If the action goes ahead, the BMA will provide guidance and support.⁶ Interestingly, a review of the literature shows that patient mortality may fall during doctors' strikes, perhaps as elective work is cancelled and doctors reassigned.⁷ I would not encourage IA if I didn't believe it could be done safely, and I still hope the government offer meaningful negotiations first.

I never thought I would hear myself encouraging IA as a doctor. We really have reached the last resort, and I strongly believe it has become a necessary step to defend our patients by defending our doctors' working terms and conditions. Who will be next? I genuinely believe this proposed contract, as part of the bigger picture, threatens the future of the NHS. We are called to use our voices to stand

up and defend those who are vulnerable⁸ – those who our NHS already cares for. Having been involved with the BMA, I know that the battle has already been long. Every avenue has been pursued. Along with many other colleagues, I've kept up to date with the issues, written to my MP, written for the newspaper, spoken on the radio and TV, and taken part in protest marching. So, I ask you, can we afford not to?

I encourage others to speak out on other matters too,⁹ and please, let's not undervalue the importance of this matter. Whilst we know we have security in Christ, we can also witness by promoting a healthy NHS,¹⁰ with a healthy workforce – even if that means taking part in IA. The two are not mutually exclusive. I ask you, please think long and hard about what we are fighting for (/against!). Yes, examine your heart and pray. If you choose not to take part, then that is your choice. But whatever your views, please consider the issue fully and be informed.

I believe I can act in good conscience as a Christian and vote 'yes/yes',¹¹ so that we can send a clear message of the need to negotiate – without threat of imposition – for a contract that is safe for patients, fair and safe for doctors, and sustainable for the NHS.

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Melody Redman is an F2 doctor living in York.

the treatment Peter describes, or at the very idea of owning slaves. But those are not the issues Peter is addressing. Rather, he wants to tell those people in that situation what they should do in response. If we recoil at his command to submit to masters, even the harsh ones, we find ourselves on the side of our entitlement-driven culture, recoiling not at human injustice but at God's word. That's dangerous ground.

So we need to understand how Peter can say this, let alone expect these poor slaves to live it. Here's his reason:

'To this you were called, because Christ suffered for you, leaving you an example, that you should follow in his steps.'²

Why should we? 'Because Christ suffered the same way on your behalf and as your example,' Peter answers. These slaves are followers of a different master. A master who enacted the supreme example of unjust suffering, offering no retaliation.³ Why? So that these slaves could be called to follow him. Jesus' unjust suffering on our behalf is the very reason he can call us to imitate him by enduring unjust suffering ourselves. And the real punch is in how he did it:

'He entrusted himself to him who judges justly'⁴

So he doesn't call harshly treated slaves – even unfairly treated employees – to simply endure, but to hope in the final vindication of believers under the cosh. Read through 1 Peter and count the number of times this vindication is in view. He can't point to it enough! It's real, it's the reason Christians can behave in this radical way, and it's the thing Peter consistently calls us to point to – 'the hope' that we have.⁵

My biggest concern is that in all the protesting and social media, there has not been significant difference between the rhetoric of Christian and non-Christian medics. Please don't be silent, but please don't melt into the crowd. At this moment of highly charged emotions the world around you needs, not your joining a strike, but your pointing to the Lord Jesus, your only possible source of hope amidst the pressures of medicine in 2015 and beyond. Your colleagues, your patients, and those looking in from the outside need to see and hear a group of juniors with a different message. One of self-sacrifice and responsibility versus entitlement. Yes, one even of submission. Supremely, one of a crucified saviour who suffered for us, leaving us an example, that by his power we might walk in it.

So from the sidelines I shout: 'Point to him!'

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Matt Lillicrap is a former doctor now training for pastoral ministry.

Derrett Watts explains why 'legal highs' are a serious and growing concern

'LEGAL HIGHS': LAWFUL BUT NOT HELPFUL

key points

- Although 'legal high' usage is relatively low, this group of drugs is causing considerable and growing concern.
- The number of Novel Psychoactive Substances (NPS) identified in Europe each year has increased during the current decade – although most of the substances identified are not widely used.
- Where drugs are not specifically classed as illegal, they may be seen as legal and often then viewed as being safe.

News stories about 'legal highs' are an increasingly common sight in the UK, and more of these substances are coming into circulation all the time. Figures for 2013–2014 show that in England, 'legal highs' were the primary drug for only a small proportion of adults in contact with drug treatment (0.07%). Data for those under the age of 18 shows that 0.63% had legal highs as their primary drug.¹ This, however, does not reflect the higher level of use for those not accessing treatment, as, for example, a Europe-wide poll found 8% of 15–24 year olds in EU member states reported using NPS (10% for the UK).²

Although this group of drugs, more properly known as Novel Psychoactive Substances (NPS), form a minority of those being misused, they are causing considerable and growing concern. In response to this, the Psychoactive Substances Bill was introduced to Parliament in May 2015, aiming to prohibit and disrupt the production, distribution, sale and supply of NPS in the UK. The bill is currently awaiting its second reading in the House of Commons. But what exactly are these drugs, and what risks do they carry with them?

The emergence of NPS

The different terms for these substances (legal highs, herbal highs, party pills, novel psychoactive compounds, designer drugs etc) can all be unhelpful in different ways but the Home Office's expert review panel, whilst recognising some of the difficulties, used the term 'New Psychoactive

Substances', which they defined as 'Psychoactive drugs, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which pose a public health threat comparable to that posed by substances listed in these conventions'.³

Although termed 'new' or 'novel', many of these drugs have been produced in the past, but have only recently started to be misused. This had occurred previously, for example although ecstasy (MDMA) arrived on the drug scene in the UK in the mid-eighties, MDMA had been discovered as far back as 1912.⁴ The difference now is the large numbers of new drugs available and a rapidly changing picture.

The emergence of NPS has introduced a range of new and exotic sounding drugs that people report using, such as Black Mamba, Bliss, Clockwork Orange, Mary Jane and Spice. Indeed the number of NPS identified in Europe each year has increased during the current decade – 41 (2010), 49 (2011) 74 (2012), and 81 (2013)⁵ – although it is felt that most of the substances identified by early warning systems are not widely used.

Key drugs to know about

Within NPS there are three main groups of drugs, Cathinones, Synthetic Cannabinoids and Piperazines:

- **Cathinones:** A naturally occurring stimulant found in the plant Khat. It has been synthetically produced as a number of substances, most notably mephedrone (also known as 'Meow Meow', MCAT) and MDPV (Bath Salts). It may be

Theological reflections

Paul told the Corinthians that while some actions may be lawful, not all are positive or helpful.⁶ So it is with Novel Psychoactive Substances (NPS).

Human beings are made in the image of God and Christians believe our bodies are his temple.⁷ Anything that despoils our bodies therefore dishonours our maker.

As John Wyatt has written, how we treat god-like human beings will create opportunities to express wonder, respect, empathy and to offer protection.⁸

The diagnosis, treatment and aftercare of those who are addicted (or in danger) and people who are in close relation to them, requires a holistic understanding both of addiction and its treatment.

The Editors

viewed as a 'cousin' of the amphetamine drugs (speed and ecstasy), whilst there are similarities with the effects of PCP, Phencyclidine (Monkey Dust). They cause feelings of euphoria and empathy as well as increasing alertness and talkativeness.⁹ They are sold as bath salts, plant food and insecticides, and labelled as not fit for human consumption to avoid some of the regulations on human products.

- **Synthetic Cannabinoids:** Cannabis is derived from the Indian hemp, *Cannabis Sativa*, with the most important ingredient being delta-9-tetrahydrocannabinol (THC). Various different preparations are used with the most common being marijuana (crushed leaves and flower heads), hashish (cannabis resin) and hash oil (concentrated resin extract). All are normally smoked, and vary in their THC content; marijuana (5% THC), hashish (20% THC) and hash oil (60% or more THC).¹⁰ Adverse effects appear to be more likely as the THC content rises, and they are taken for their euphoric and relaxant properties, but may also affect perception and coordination. Synthetic Cannabinoids are chemicals that act like cannabis, with many different products including Black Mamba, K2, Spice and Annihilation.¹¹ They are sprayed onto herbal base material, and may be sold as 'herbal' preparations. They tend to have more potent effects than natural Cannabinoids, with shorter duration of action, quicker time to peak effect and more side effects.¹²
- **Piperazines:** A broad group of drugs which mimic the effects of ecstasy. May be known as Legal X, Nemesis, Smileys, the most common products are BZP, TFMPP, DBZP and mCPP.¹³ Again, they will be taken for their arousing and euphoric effects.

Other drugs to consider in this discussion would be:

- **Salvia:** 'Herbal ecstasy' derived from a Mexican plant with psychoactive chemicals in its leaves that produce hallucinations when chewed or when dried and smoked
- **Ketamine:** A general anaesthetic used on humans and animals

- **Nitrous oxide:** 'Laughing gas', with a number of recent incidents of alleged use by celebrities, (Both Ketamine and Nitrous Oxide may not strictly meet the NPS definition but have seen significant changes in their patterns of recreational use and thus present similar challenges)
- **GHB/GBL:** Developed as an industrial solvent, often sold as 'liquid ecstasy' but with no relation to ecstasy, it is taken for its euphoric and relaxant effects, with heightened sex drive (a 'date rape' drug) and increased sociability. Short acting effects mean frequent doses may be taken.¹⁴

Levels of use

Use of NPS, particularly amongst younger people, has generated increasing concern over the last decade. It is difficult to get a clear picture as to levels of use, given the introduction of new substances, uncertainty from people about what they are taking and changing patterns of consumption. Mephedrone use has fallen from a peak of 1.3% of 16–59 year old in 2010–11 to 0.6% in 2013–14; levels of use tend to be around three times higher in 16–24 year olds. The use of Salvia was first recorded in 2012–13 at 0.3%, but by the following year had risen to 0.5%.¹⁵

However it is important to recognise that there can be much higher levels of use in specific subgroups. A report on drug use in prisons states the use of NPS 'has skyrocketed...over recent years', and describes it as an epidemic. For example, seizures in prisons in England and Wales for the synthetic Cannabinoid 'Spice' having risen from 15 in 2010 to around 737 in 2014.¹⁶ 12.5% of regular night club users reported using Mephedrone in the last year.¹⁷ The UK government's expert panel felt this can be attributed to 'low price, easy availability and enhancement of sexual activities'.¹⁸

What's the problem?

A legitimate question is what harm are NPS causing? As with most drugs, we can look at the harm caused to the user of the drugs (eg physical, psychological or social harm) or to other people (eg victims of drug-related crime). Harm may also be due to intoxication or being in withdrawal. Lack of awareness about NPS may see its effects going unrecognised but data available does indicate some areas of concern. It also should be noted that due to the 'new' nature of these drugs we do not know the consequences of long-term use.

- **Links to deaths:** In England and Wales in 2013, 1,957 deaths were attributed to drug misuse. Deaths related to NPS are not a large contribution to this but rose from nine in 2007 to 60 in 2013. This is largely due to deaths linked to the cathinones drugs rising during the same time period from zero to 26. In 2013, 18 deaths were also attributed to both GHB-GBL and mephedrone.¹⁹
- **Links to A&E attendances/emergency presentations:** A study in Bristol found that 6.9% of all A&E patient attendances were either directly or indirectly linked to illegal drug use.²⁰



A Europe wide poll found 8% of 15-24 year olds in EU member states reported using NPS (10% for the UK)



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Precise figures on how many such presentations involve NPS are not readily available. But some inferences can be drawn from requests for help from poison centres which provide information and advice to health professionals. 'Legal highs' (not otherwise specified) and mephedrone both featured in the top ten drugs for telephone enquiries. The centres also saw the rates of enquiry for a particular drug fall after it was classified as illegal, but this may be accompanied by increased enquiries about similar drugs which have not (yet) been banned.²¹

Specific health risks are outlined in a Royal College of Psychiatrists report:²²

- **GHB:** Dependence and severe withdrawals, confusion and loss of consciousness, delirium, paranoia, aggression, hallucinations, decreased sexual inhibitions.
- **Ketamine:** Bladder and kidney damage, memory impairment, anxiety, panic attacks, depression, paranoia, delusions.
- **Mephedrone:** Heart problems, agitation, psychosis, increased sex drive.
- **Synthetic Cannabinoids:** More potent than natural cannabis, associated with tachycardia, vomiting and psychotic symptoms.

They are often taken in association with other drugs, particularly alcohol, which increases the health risks. Episodes of intoxication will often require supportive care based on the symptoms described above. This may include acute medical care.

- **Links to crime:** Drug-related crime seems most closely linked to heroin and crack cocaine use, and at present there is insufficient evidence to link NPS use to acquisitive crime, but with the development of opioid NPS this could become more of an issue.²³

Must be safe if they're legal?

The root of the challenge of NPS is their legal status. When the sale of these substances is not controlled by laws, they can be sold online or from 'headshops' (shops specialising in the sale of NPS; 250 are estimated to exist in the UK).²⁴ When any of these drugs are made illegal, people may switch to buying them from drug dealers, as with other illicit substances.

The Misuse of Drugs Act 1971 aimed to prevent the non-medical use of certain drugs, putting them into classes A, B and C, with varying sanctions for the different classes. Where drugs are not specifically included in these lists they may be viewed as not illegal, and hence legal, and often then viewed in some way as being safe, despite the Advisory Council on the Misuse of Drugs (ACMD) in 2011 stating that '*Just because a substance is termed "legal" this does not make it safe, nor may it be legal*'.²⁵ This seems to be in line with Paul's advice in 1 Corinthians 10:23, where he indicates that some actions, although not breaking the law, may hinder Christian living.

This has led to other legislation seeking to close loopholes but the producers of the drugs change the

synthetic compounds and people using the drugs adjust what they are taking. An example of this was seen with GHB which was classified as a class C drug in 2003, after which some users switched to taking GBL (which has a faster onset of action than GHB). GBL itself became a class C drug six years later. With new drugs being produced each year, the UN reports: 'the international drug control system is floundering, for the first time, under the speed and creativity of the phenomenon known as new psychoactive substances'.²⁶

As stated above, the UK government is now seeking to introduce legislation specifically to address this area, the Psychoactive Substances Bill.

Responding to the challenge

NPS appear to present a number of challenges, some of which can be addressed by politicians, some by health and other professionals, and some by individuals, including church-goers. It is clear these drugs, despite the 'legal' part of their name, can have serious consequences and should be viewed in a similar way to other drugs. For the Christian they may hinder their ability to live as God intended.

For health professionals, the Royal College of Psychiatrists report, referred to earlier, proposes six areas of action.²⁷

- **Widen the front door:** Addressing the previously narrow focus of drug services
- **Support the front line:** Help staff to become more knowledgeable about the issues and management of NPS. As health professionals become informed, they should be able to recognise the drug use and offer appropriate help. As with other drugs, single sessions of motivational interviewing can be helpful, but if there is a poor response or accompanying mental health problems are found then referral to specialist services should follow.²⁸
- **Connect the front line:** Enhance links between drug specialist services and the non-specialist services where people are presenting; eg A&E, acute physical and mental health services, primary care and sexual health clinics.
- **Watch all horizons for harm:** Ensure people are up to date with changing patterns of use
- **Promote research** into NPS and club drugs
- **Empower users through education:** for drug users and the general public

Some of these – such as 'widening the front door' and being contemporary – seem good principles for churches to adopt, (both generally and specifically in relation to NPS), as we seek to follow the Lord's mandate: 'To proclaim good news to the poor. He has sent me to bind up the brokenhearted, to proclaim freedom for the captives and release from darkness for the prisoners'.²⁹ We need to be aware of the emergence of these substances so that as we come across people who use them, whether in our clinics or our churches, they feel understood and open to help.

Derrett Watts is consultant psychiatrist and clinical director, substance misuse, North Staffordshire

A panel of CMF members discuss trends in twenty-first century medical mission



THE CHANGING SCENE IN GLOBAL HEALTH

key points

- The emergence of a truly global Christianity requires a shift in how we understand and talk about medical mission and the role of westerners in it.
- There are a huge variety of roles and contexts where there are opportunities for service, long and short-term.
- The traditional mission hospital is only one of many avenues open to today's Christian doctor with a vocation to work cross culturally. We probably need to mint new terminology to reflect this.
- It's possible to argue the case that Christian doctors who positively choose to work in tough UK contexts deserve to be thought of as 'missionaries'.

In the last century Christianity became a truly global faith, as Todd Johnson has pointed out: 'At the dawn of the twentieth century the statistical centre of global Christianity was near Madrid, Spain. In fact, at that time, over 80% of all Christians were European or North American. By 2010 the statistical centre had shifted well south of Timbuktu in Mali. This 100-year shift is the most dramatic in Christian history.'¹

The doctor with a call to cross cultural mission may no longer be European. Europeans will not necessarily lead medical teams. These medical teams will be composed mainly of nationals, working in situations that often don't look much like the traditional mission hospital.

To tease out more about the changing scene, *Triple Helix* put a series of questions to six CMF members. One has just begun to dip her toes into cross cultural mission. Others are early to mid-career. For the rest, involvement with cross-cultural mission has been a big part of a lifetime's work.

What big headline changes in medical mission have you observed during the span of your experience?

Andrew Tomkins (AT): The main headline change in 'medical mission' is that there are now many more ways for Christians to work in global health than *just* working in church-based hospitals or community health programmes. With a greater range of opportunities for Christian doctors now available for working in national government,

international agencies, NGOs and research and teaching organisations, the term 'medical mission' is not always appropriate. Some people, including myself, suggest a title of 'Christians in global health' rather like 'Christians in science' or 'Christians in sport'. Thus, 'medical mission' is just one of the many opportunities for Christians in global health.

Richard Vincent (RV): There is an expectation of shorter durations of service – sometimes much shorter. Plus an increasing readiness to work collaboratively with the local population; greater skills of listening to the local population are expected; a slowly broadening view of the global nature of health challenges.

Ted Lankester (TL): Fewer 'classic' self-described medical missionaries but many healthcare Christians are going abroad with a kingdom ministry to work in a variety of situations including humanitarian aid or teaching.

Huw Morgan (HM): A shift from hospitals initially run by ex-pat missionaries, now handed over to and run by national doctors and staff, with ex-pats being ordinary staff members or working in a consultative, advisory capacity. There is an increased emphasis on community healthcare and primary care clinics, in recognition of the fact that these have a much greater impact on morbidity and mortality than hospitals. However this is not a straightforward transition and there are many problems, not least funding. Then there is the emergence of teaching hospitals or university



The old model of a doctor going from the UK to a developing country for 10-20 years is increasingly uncommon. Many people go for 1-5 years, perhaps more than once in a career

medical schools in developing countries – many of these need ex-pat missionaries to be faculty members when they start.

Emma Pedlar (EP): Compared to what someone like Helen Roseveare was doing some years back in the Congo, I would say the internet and technology have made a huge impact. I was working at the CURE hospital in Malawi where patients' stories were recorded and sent to prayer and financial supporters all over the world. Now mission doctors can be asking questions over the internet and getting quick replies, using technology to connect patients with specialist hospitals to perform complex operations or serving communities by providing centres of excellence and training the next generation.

Catriona Waitt (CW): There is a shift away from the long-term 'career' missionary towards short-term, focused projects. This can include very short-term work: for example week-long training or intensive 'stored up' operating lists of complex cases through to more medium-term work, like setting up a project or staff training staff. Often it's working oneself out of a role as national Christians emerge to take on leadership. But there is still a role for long-termers.

How big an impact has the emergence of local (national) Christian doctors had on the way medical mission is understood and practised?

AT: There are many more national Christian doctors now working in church-based (mission) hospitals and community health programmes and more with a specialist training. Thus the need for generalists from the UK is less and the need for training in specialties is greater.

RV: The impression that 'the west is best' hasn't faded by that much, I think. It often takes conscious effort by missionary health workers to resist being put on a pedestal.

TL: Global north missionary doctors and nurses and AHPs should ideally have an added value which they can bring rather than being a post holder – that can be wisdom, training skills, reconciliation skills as well as the purely medical.

EP: I think it's fantastic that 'missions' have become more indigenous. I suppose western medicine can be seen less as a white man's science if local doctors are practising it as well, and communities may respond better to one of their own sharing the gospel.

CW: In Sub-Saharan Africa there remains a shortage of skills, so a great benefit missionaries can bring is to train and equip national doctors. Furthermore, the Christian churches may be young and in need of focussed, systematic Bible teaching alongside the practical tasks.

Is a pattern emerging where doctors with a missionary vocation move in and out of a country, returning 'home' sometimes for considerable periods?

AT: 'Missionary vocation' is a term that's being

most commonly used to describe the motivation for Christian doctors as they work in 'medical mission'. There does not unfortunately appear to be widely used or accepted term to describe others who work as 'Christians in global health,' with an equal conviction that God wishes them to work in a particular type of work place. I'm not aware of a suitable term to describe Christian motivation of doctors who feel God's guidance and power in their professional lives in the UK. Perhaps 'Christian motivation in medical practice' is a starter – but there is plenty of room for more imaginative terminology. There are definitely new patterns emerging whereby doctors move from centre to centre, perhaps for clinical experience or teaching activity or research. Again a key issue is the need for professional validation to ensure that ongoing training and updating occurs.

TL: Yes, but from the US and some other countries the long term pattern remains. As far as the UK is concerned, the non-resident medical missionary is becoming a feature, for example with Medical Services International. They make a relationship with members of a hospital, medical school or health facility and work out a timetable with agreed topics over a three to five year period or longer.

HM: The old model of a doctor going from the UK to a developing country for ten to 20 years is increasingly uncommon. Many people go for one to five years, perhaps more than once in a career. Many ex-pat missionaries now work in national government hospitals and universities rather than mission hospitals, teaching and doing research. Direct links made possible by the internet have meant that recurrent short term visits to support, advise and teach are occurring without reference to 'mission agencies' which in the past controlled the flow of doctors to overseas Christian hospitals. PRIME's work is an example of this. International networking, perhaps at present mostly brokered by UK agencies (like PRIME) is increasingly enabling 'South to South' transfer of skills. For example, a surgeon in an Indian mission hospital taught a rural surgery course in Nigeria; a Christian Kenyan University teacher ran seminars on medical education on Uganda. Medical missionaries are increasingly not westerners but Christians from developing countries with a passion for extending the kingdom beyond their own borders.

What are the major trends affecting mission hospitals and how do you see their future?

What has been the impact of networks of primary clinics on how they work?

AT: Mission hospitals face different opportunities and challenges, according to where they are based. In some situations, mostly African countries, national governments pay a substantial proportion of the wages of staff and the costs of running services. Thus, they are able to continue to provide outstanding service, with a reputation of being a Christian mission hospital, while being supported

financially from a secular source. They can do extremely well. The paper on the scale of Christian-based healthcare which came out in *The Lancet* in July 2015² gives further information on this. Mission hospitals in rural areas and not supported by government face more of a challenge. Many of them are not able to be supported so well by private income from surgery. In India, in particular, some face considerable difficulties if they are not supported by national government. As to the impact of primary healthcare clinics, a key issue has been the focus for international funding on malaria, TB and HIV. Much of this funding has focused on community-based activities and there has been little money available for hospital care. A lot of Christian development agencies put much less emphasis on healthcare these days, emphasising holistic community participation and activity rather than provision of services. Thus 'medical mission' is less supported in the UK than it was.

RV: This varies enormously from place to place. There are very good reasons to focus on community services. That is where the health action is most effective, especially in prevention, education, working with church communities and giving support. These are less glamorous, less exciting, but the key to reducing illness. Governments generally think in terms of increasing the power, facilities, and size of hospitals and many give scant attention to community services. A Christian distinctive is to invert this priority.

TL: Mission hospitals will remain valuable (often under different names) providing they retain their God-given mandate to care for the most vulnerable. This does not, however, exclude others including private patients, providing they are well governed and managed. The means of reconciliation is built into their DNA so interpersonal problems don't fester. They support and connect with primary healthcare rather than despise it or fail to understand it. They need to work in cooperation with government, ideally having such an excellent or irreplaceable reputation that the government contracts out services to them or adopts/mandates them to become or serve as district or sub district general hospitals.

HM: I am personally encouraged to see more recognition that medical care is part of demonstrating the kingdom of God and has legitimacy in and of itself; that it need not merely be seen as a 'vehicle for evangelism', although good care by Christians inevitably has its own evangelistic impact. Doctors and healthcare workers need to be clear what their calling is (ie to care for the sick and all that that entails), and not act as evangelists-church planters, tasks where this can be done much better done by national Christians.

What new models of medical mission and medical missionaries have you observed?

How could these change perceptions about how we talk about medical mission?

AT: The 'new models' available for Christian

doctors in global health are multiple. They include: research, teaching, specialist care, policy development, provision of services for those who are neglected or despised. I think it's important to emphasise that there is a continuing vital role doctors to work in church based hospitals, both in the short and long-term. However, Christian doctors, particularly those in the early years of their career, need to be made much more aware of the many ways that there are of serving God within a great range of global health opportunities. Focusing on medical mission alone is too limiting.

RV: Idiosyncratically, I would abandon the terms 'mission' and 'missionary'. So, 'Next year, God willing, my wife and I will be working at X, [a Christian-faith-based -government] hospital-clinic in rural Zambia; we expect to stay there for at least three years and look forward to God's leading after that.' Serving abroad should undoubtedly garner considerable respect, prayer, and financial support where appropriate. For folks to leave their own culture for another can certainly be a major sacrifice. But maybe serving God in a very down-town practice in a 'western' city, or any place where frank opposition is experienced by a colleague on account of their faith, will have similar demands while not conventionally attracting the term 'missionary'.

TL: All healthcare missionaries must understand global health and be in tune with the sustainable development goals and universal health coverage. This is all about shifting healthcare to the community, home and neighbourhood and building on a primary healthcare model. Networks are critical to bring together all the health players within an area or bring together all those involved in similar themes, eg mental health, NCDs, palliative care, disability. Finally let's remember that the great commission and other verses in the Bible less often quoted imply that members of every congregation in every country town village or slum in every country have a mandate to preach and to heal. That means we will increasingly see those from eg the Chinese or Mongolian church being medical missionaries to Madagascar. It will lead to glorious and inglorious chaos making interconnection, communication and networks all the more essential. We must not forget miracles.

There are times in the evolution of many churches local and national where God chooses to do an Acts 29. We must be able to recognise and welcome it. Equally we must stand against all initiatives based on the prosperity gospel, and on the mistaken belief there is a dualism between the spiritual and the physical. There is an attitude that says taking ARVs is a sign you don't trust in God so you chuck them down the latrine and pray for a miracle. That's platonic dualism, not biblical Christianity.



Direct links via the internet mean that recurrent short term visits are occurring without reference to 'mission agencies'

Contributors

Andrew Tomkins is Emeritus Professor of International Child Health, UCL.

Richard Vincent is Emeritus Professor of Cardiology, KCL.

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Huw Morgan is a retired GP, medical educator and missionary working with PRIME Partnerships. He is Chair of the CMF International Committee.

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Catriona Waitt is a specialist registrar based in Liverpool.

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Healing God's way
From natural to supernatural
Angela Walker

- CreateSpace, 2014, £11 Pb 189pp, ISBN 9871502325662
- Reviewed by **Peter Pattison**, retired missionary and GP

Angela Walker is a CMF member who trained in Liverpool and specialised in paediatrics. She has spent most of the last ten years in Uganda and neighbouring countries.

This is a dangerous book; dangerous because it will stir a hunger for God and challenge half-hearted discipleship or compromises with sin. The first and last chapters are particularly good on this. It challenged me.

Angela has been on a learning curve of discovering the spiritual roots to many common diseases. She has been practising what Paul Brand and others termed pneumo-psychosomatic medicine. She would concur with some of our American colleagues who have suggested that failure to take a spiritual history could be construed as negligent practice.

However, this is also a dangerous book because, having come face to face with all forms of demonic activity, Angela gives the impression (maybe unintentionally) that *all* diseases have spiritual roots, that experiences in Africa can and should be replicated in Western Europe (where the spectrum of pathology, spiritual as well as physical is overlapping but different).

Most seriously of all, she gives the impression (probably inaccurately) that her discovery of spiritual roots to disease has, for her, rendered her training in medicine and paediatrics irrelevant. This impression is enhanced by the oft-repeated phrase, 'I believe that...'

Read it with a warm heart and a discerning mind. Expect to be challenged and be prepared to respond to the Holy Spirit.



Crazy busy
A mercifully short book about a really big problem
Kevin DeYoung

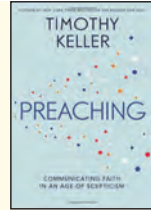
- IVP, 2013, £8.99 Pb 119pp, ISBN 9781783590230
- Reviewed by **Chris Lavy**, consultant orthopaedic surgeon

Hands up those who are secretly a bit proud when people say 'you are one of the busiest people I know'. Many Christian doctors run a busy NHS practice with a role in management, plus some private work, and a smattering of national committees, plus a commitment to mission, a church group, and I've not even started on family life yet.

Kevin DeYoung is a dynamic American pastor who describes many of our lives when he says his average day is a cross between a perpetual summer camp and a three ring circus. This book is

short, readable and funny but serious. I read it on a train journey because my PA told me I had to change my life.

DeYoung is my kind of writer. He warns us of three serious spiritual dangers of an over-busy life. It can ruin our joy, it can rob our hearts, and it can cover up the rot in our souls. He then gives us seven common and practical areas of busyness which we can review and consciously change. Finally, from the Mary and Martha story in Luke 10 he shows us one thing that is necessary, which trumps all busyness; a close relationship with Christ.



Preaching
Communicating faith in an age of scepticism
Timothy Keller

- Hodder & Stoughton, 2015, £16.99 Hb 310pp, ISBN 9781444702170
- Available as an ebook.
- Reviewed by **John Martin**, CMF Head of Communications

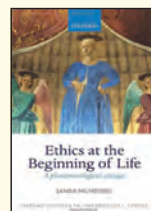
Tim Keller continues to amaze with his prolific output. In his words this is 'a manifesto, not a manual'. Plenty of books detail preparing expository sermons; this is an *apologia* for a certain kind of preaching to engage minds and hearts shaped by the culture of our times.

The author pre-supposes the infallibility of the biblical text; expository preaching is its handmaiden. He insists, however, there is more to it than mere exegesis. Part of it is taking biblical context seriously, not just where words appear in the text, but where the text fits within the Bible as a whole. Thus expository preaching always points to Christ and his saving work; the hearer should always be left

without doubt as to what is the meaning and efficacy of the gospel. The preacher must know how to speak into the prevailing culture and be able to bring the resources of the gospel to its questions and needs.

We tend to skip footnotes and appendices. Nearly a third of this volume is devoted to them. It is here that Keller offers some of his most useful resources for the budding preacher, not least his account of how he himself prepares.

It's worth buying the book for chapter five alone where Keller addresses the theme of how to preach to people whose worldview is shaped by relativistic and hedonistic late-modern culture.



Ethics at the beginning of life
A phenomenological critique
James Mumford

- OUP, 2013, £67 (Pb £25) Hb 212pp, ISBN 9780199673964
- Reviewed by **Trevor Stammers**, Programme Director in Bioethics and Medical Law, St Mary's University, London

This book is not a light read, but for those with a good grounding in moral philosophy and theology, it proves as rewarding as it is challenging. Phenomenology has traditionally been used by feminist writers largely to support abortion. But this work is remarkable in being the only one (to my knowledge) to use the phenomenology of pregnancy or what Mumford dubs 'the human emergence of the newone', to argue a moral case against abortion.

It is erudite and, though a dictionary may be needed alongside, it is also lucidly and

engagingly written with plentiful illustrations drawn from works as diverse as Shakespeare's plays and Shriver's *We Need to Talk about Kevin*.

Mumford takes Scripture seriously and cogently but is equally familiar with Nietzsche. He notes that, in the end, the latter also concluded that it is the Christian doctrine of the *imago Dei* which 'granted man (and *Mensch* as each individual man) absolute value, as opposed to his smallness and accidental occurrence in the flux of becoming and passing away'. Exactly so – and this book demonstrates clearly why.



Healed at last *Separating biblical truth from myth* Scott Blackwell

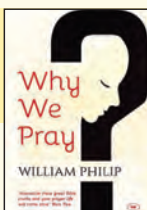
- Matthias Media, 2014, £8.99 Pb 199pp, ISBN 9781922206565
- Reviewed by **Peter May**, retired GP

This thoughtful, theological reflection on healing is written in the light of personal illness and pastoral experience. Christ-centred, caring and well written, his motivation to write came from being told he should seek healing for his short leg, by a man who was visually impaired but could not see the irony!

The book gets better as it progresses but I have two misgivings. Firstly, he rather scolds miracle healers, which will make it difficult for them to read – which is a shame.

Secondly, and more importantly, he gives too much credence to Jack Deere’s evidence (1993) supporting contemporary miracles. Healing presents great difficulties for lay

people, who cannot distinguish between incurable, remitting, psychosomatic and hysterical illnesses. Everything seems to be miraculously cured at healing crusades, but that is not so. Sir John Houghton’s consultation, involving over 30 charismatic healers, theologians and doctors, met four times between 1991–94. Not a single case of Christ-like miraculous healing could be verified (See Lucas E, ed. *Christian healing – What can we believe?*). Yet such miracles would make headlines. If a fixed curvature of the spine like mine was immediately healed (Luke 13:13), I would be four inches taller! Prayers may be mercifully answered, but Christ-like miracles must be very rare if we cannot properly document one.



Why we pray William Philip

- IVP, 2015, £7.99 Pb 112pp, 9781433542862
- Reviewed by **Tom Roberts**, CMF Communications Coordinator

Praying can be hard, and teaching on prayer can often leave us feeling discouraged and guilty that we don’t pray more. The author of this short book feels the same, but thinks he has identified the problem. The real reason we don’t pray is that we forget *why* we pray, turning prayer into yet another burden on top of everything else in our busy lives.

But Philip holds that ‘we learn most about prayer simply by learning about God’. The more we understand about the God we pray to, the more we will be drawn to prayer, because ‘the real truth about God is never discouraging...the Lord himself

is never depressing’. Philip then takes the reader through four key truths about why we pray: because God is a speaking God, because we are sons of God, because we have a sovereign God and because we have the Spirit of God.

The short, well-structured chapters, lively style and good illustrations make this an easy read. Questions at the end of each chapter help the reader to reflect and apply. This book is a wonderful reminder of the astonishing privilege we have to freely come to our heavenly Father in prayer, knowing that, ‘through our union with Jesus, he can’t not hear us’.



Half the sky *How to change the world* Nicholas D Kristof and Sheryl WuDunn

- Virago, 2010, £12 Pb 352pp, ISBN 9781844086825
- Reviewed by **Rhona Knight**, GP in Leicester

Fierce, pragmatic, full of inspiring stories of courage and determination, *Half the Sky* is essential reading for every one of us – whichever our gender, wherever we are. There are not many books that I recommend everyone should read, but since I read this book, I have echoed the book cover accolade and told many people about it, used it in sermons, and tweeted about it.

The book of real-life narratives is written by a couple who have encountered first-hand the unnecessary suffering of women globally, particularly in cultures where women are devalued and denied education; are subjected to rape and violence; are trafficked into prostitution. It also tells of

extraordinary women, who, when given the opportunity, have overcome unbelievable obstacles and made an immense difference.

The title *Half the Sky*, is based on the words of Mao: ‘Women hold up half the sky’. From an oppressive culture of foot-binding, the position of women in China has improved immensely. Chinese cities are ‘one of the best places to grow up as female’ (p229). Change is possible. The book evidences how education and employment for women are key factors in preventing child marriage, forced prostitution and trafficking. It demonstrates how grassroots, culturally appropriate interventions change lives and shows how you and I can become involved. Truly transformational.



Protestant social thought in Latin America Dr H Fernando Bullon

- Regnum Books, 2015, £16 Pb 261pp, ISBN 9781908355553
- Reviewed by **E John C Parker**, retired GP

The application of the Christian Faith to Economic and Social development in South America has generated much interest, some of which has been labelled ‘liberation theology’.

The author is of an evangelical persuasion but the book is a fair and balanced account, set in the Latin American context, of both evangelical and ecumenical thought going back to the latter part of the nineteenth century. He then describes how protestant missions and churches have demonstrated a strong social conscience, usually with a well thought out theoretical framework, and how this has been worked out on the ground. Medicine features highly in this,

but also education, agriculture and ethics as well as substance abuse. It attempts to answer the question ‘what is the church good for and does it make a difference?’ Worthwhile questions indeed.

Dr Bullon is based at the evangelical University of the Americas in Costa Rica and is regarded as the premier protestant thinker and theologian of socio-economic development theory and the role of the church in Latin America today. He has written a rich and extensively researched study which would benefit anybody wishing to think seriously about mission strategy in South America. It also provides a very extensive bibliography on the subject.

Quality of death index 2015

In the aftermath of Rob Marris's Assisted Dying Bill, one upshot is increased calls for better palliative care. That is heartening. Eutyclus notes the UK is ranked best among 80 countries for its care of dying people, but nothing is beyond improvement. The UK owes its standing, not least, to the hospice movement (pioneered here by Christians and widely imitated). One oft-repeated scenario is that legalised euthanasia would spell the death of the hospice movement. *The Economist Intelligence Unit*, 6 October 2015 bit.ly/1Gurckq

Access for mental health sufferers

People with mental ill health die younger and have poor physical health compared to the general population, says the Nuffield Trust. People with serious mental illnesses, such as psychosis or bipolar disorder, die on average ten to 17 years earlier than the general population. Nuffield notes with approval efforts towards 'parity of esteem' between mental and physical health, but calls for better understanding of how people with mental health issues access health services. One in six UK adults has a mental health condition with one in 100 suffering 'severe' mental illness. *Nuffield Trust*, 14 October 2015 bit.ly/1GepcLj

Holy smoke

Not everyone is keen on incense, even if its use in the Tabernacle and Jerusalem Temple affords it some biblical warrant. Eutyclus couldn't help noticing how church legal eagles went up in arms when draft measures to outlaw so-called 'legal highs' (see pages 14-16 for more info) went public. Legislation appeared to rule out use of incense in churches and temples, leaving purveyors on the wrong side of the law. Eventually it's emerged that this was yet another of those phony media storms in the proverbial. *Daily Telegraph*, 16 September 2015 bit.ly/1Lm1Pfm

WHO and Ebola fallout

The Ebola crisis was a 'defining moment' for WHO according to an interim report of a panel inquiring into its handling of the crisis. Ebola 'not only exposed organizational failings' but also 'short-comings in International Health Regulations'. Ebola began to spread in December 2013 but it took until August 2014 for the WHO to sound the global alarm. The report recommends abandonment of planned zero budget increases (over 75% of WHO's Programme budget comes from voluntary funds). It endorses plans for a stronger global emergency workforce and a contingency fund to enable rapid response. *WHO*, July 2015 bit.ly/1JS5IQe

WHO wins plaudits too

Ebola may have exposed the frailties of the WHO, but the agency has its success stories too. The fight against Malaria is one example. A study claims 700 million cases were prevented since WHO implemented concerted efforts against Malaria from 2000. A report published in the journal *Nature* claims a 50% fall in cases across the African continent. The key strategy sounds simple: installation of bed nets. WHO's director general Margaret Chan said: 'Global malaria control is one of the great public health success stories of the past 15 years.' *BBC News*, 17 September 2015 bbc.in/1LyD5Am

15 million get HIV treatments

The goal of getting HIV treatments to 15 million people by the end of 2015 was met nine months ahead of schedule, the UN Aids agency claims. The UN first set goals to combat HIV in 2000. At that time 700,000 people were receiving antiretroviral drugs. The report says since 2001 the global response to HIV has averted 30 million new infections and nearly eight millions Aids-related deaths. Over this period HIV infections have fallen from an annual 2.6 to 1.8 million. UN Aids hopes the HIV epidemic can be ended by 2030. *UN Aids*, July 2015 bit.ly/1UXBJR8

Sodden oldies

GPs are less attuned than they might be to 'unsafe' levels of alcohol intake by over 65s. New research says one in five older people drink too much. London is the biggest problem region and heavier drinkers tend to be relatively affluent males. For older people drinking too much contributes to confusion and falls, in addition to the normal health issues caused by alcohol abuse. Among the top 5% of biggest drinkers, men were consuming more than 49 units a week - more than a bottle of whisky. *BBC Health*, 25 August 2015 bbc.in/1U1JJsO

E-cigarettes: evidence, not opinion, please

Public Health England has issued a report claiming e-cigarettes are 95 per cent less harmful than conventional tobacco. 'Fie' say experts from the London School of Hygiene and Tropical Medicine and the University of Liverpool. *The Lancet* published an editorial by Professors Martin McKee and Simon Capewell, insisting there was no reliable that evidence showing e-cigarettes are safe. Moreover, claims that they do not provide a 'gateway' to tobacco smoking don't stand up. The PHE report, they say, is flawed, based on inconclusive evidence, and tainted by vested interests. *The Lancet*, 26 September 2015 bit.ly/1MDAc6h

Only one life

Obadiah Slope thought he'd delivered the ultimate curse, telling the Proudies, 'I hope you live forever' (Barchester). Not everyone sees it that way and many go to amazing lengths to extend life or even make a comeback after death. A two year-old Thai girl, Matheryn Naovaratpong, victim of brain cancer, has become the youngest person to be cryogenically preserved. Her parents keep her bedroom in readiness for her cure and return. Christians have a certain hope for this life and the next that's not dependent on science fiction (1 Corinthians 15). *BBC News*, 15 October 2015 bbc.in/1N5r62A

Strengthening FGM safeguarding

In our Summer 2014 issue we drew attention to how 125 million girls and women suffer having experienced Female Genital Mutilation (FGM). We pointed out, moreover, that it happens in the UK as well. Now under regulations issued by the Department of Health, professionals are obliged to report new-found cases - ideally by the end of the next working day. While this is an important step, globally much still needs to be done with FGM practised in at least 29 countries, affecting up to three million girls and women worldwide annually. *Department of Health*, 30 October 2015 bit.ly/1MBuzHx



WHAT MAKES A GOOD STORY?

She was 93 years old and alone in the bay. Dying from oesophageal cancer. Cachexic and pale. She held my hand and said 'Doctor, don't waste your time with me. Help some people you can cure. I'm not worth it. I'm better off dead.'

I told this story on a BBC Radio Five Live phone-in ahead of the Assisted Dying Bill debate on 11 September. The host wanted to know my experiences on the wards. He wasn't interested in the statistics. But he was moved by my story from when I was an F1 on a geriatric ward.

At the same time the world was seeing images of a little boy washed up on a Turkish beach. We knew that 3,620 migrants had died in the eight months to this point,¹ trying to reach Europe, amongst whom would have been numerous three-year-olds. And yet the politicians' stance became more entrenched. The world seemed hardened. And then a story. An image of three-year-old Aylan Kurdi, drowned and lifeless in a policeman's arms. And everything changed. Because stories are powerful. And yet they are not limited to our postmodern world and media.

When God actioned his divine cosmic rescue plan, he didn't present us with facts and figures. He presented us with a person, Jesus Christ. His story, the greatest ever told, had reached its climax. In the Gospel accounts of his ministry, Jesus answered 61 questions. And he answered many with a story (eg Luke 10:29–37) with 46 parables recorded in total.

Aristotle stated that the best storytellers need a combination of three elements to be most persuasive: *logos* (words, statistics, data), *pathos* (the passion of the speaker connecting with the emotions of the listener) and *ethos* (the credibility of the speaker connecting with the emotions of the listener). As doctors, because of our work and the people we meet, we are often blessed with all three ingredients. We

have stories. And as Christians we are connected to the greatest story.

But are we telling these stories? We might do great work in our hospital or surgery, and this is part of our act of worship to God. But I believe we are charged with having the courage to be a body of Christian doctors who speak up prophetically; in situations of injustice, whether issues of commission or omission, to report our experiences with honesty. In the case of the Assisted Dying Bill, warning for example of the vulnerable majority who will feel increased pressure to take the quick way out to avoid 'burdening' their family (or even the F1 doctor!).

We don't need to be experts to do this. We just need to speak of what we have seen. Supporters of 'assisted dying' release individual, tragic, powerful stories in an attempt to change the law. So why don't we tell the innumerable stories where the opposite is true and death with real dignity is the reality? This would help powerfully refute the arguments head on and dispel the fear that many feel about events at the end of their lives.

But we also need to be bold to speak out our faith evangelistically. We are all called to share God's story even if it costs us our reputation or career. In Acts 4:29–30 Peter prays for God to work powerfully through the disciples' deeds. But he first prays for the disciples to speak his word with boldness, even when their lives were at risk. Have we moved from this New Testament position?

Let's boldly present God's story not just in deed but in word – prophetically and evangelistically.

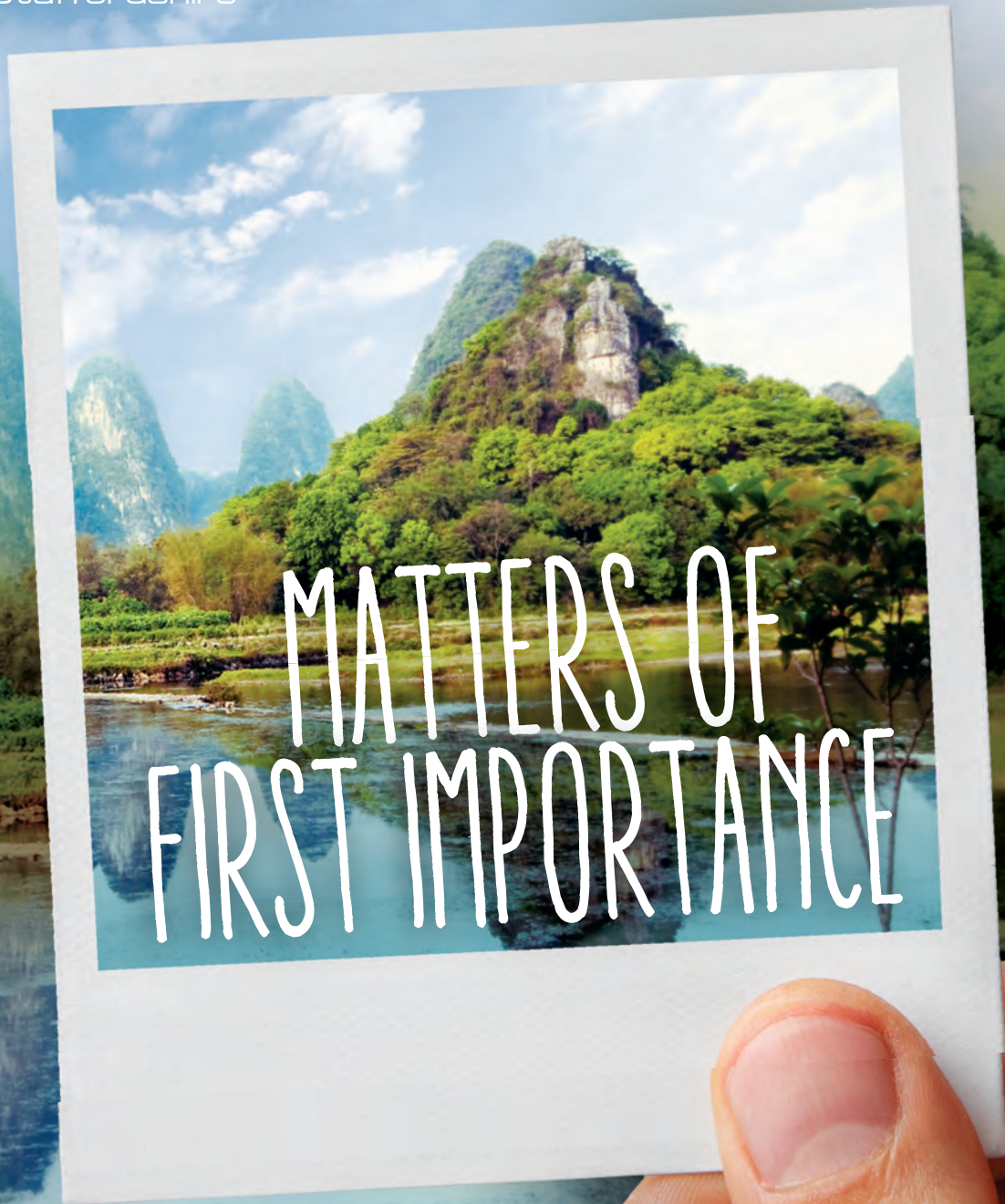
John Greenall is CMF Head of Student Ministries

references

1. missingmigrants.jom.int

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