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for today's Christian doctor

triple helix

Christian doctors in leadership

Also: Ebola update, Growing to your full potential, The demographic time bomb, Philosophy and medicine, Gaining patients' trust

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How should Christian doctors vote?

Making an informed decision

On 7 May the UK goes to the polls for the general election. Whoever assumes power will have a profound influence in shaping public policy in matters which affect us, our families, churches, patients and colleagues.

Some claim that politics and religion should not mix – but God is intimately involved in politics. He is sovereign over the rise and fall of nations.[1] He establishes governing authorities, and holds them ultimately accountable.[2] As Christians, we should both pray for our political leaders[3] and be subject to them.[4] But God has also given us a part to play in who actually exercises civil authority.

Each of us, before God and in good conscience, must make our own decisions about voting; but we have a duty before God to ensure that we exercise our votes wisely, thoughtfully and in an informed way. For some, the key question will be about who they would prefer as prime minister for the next five years. For others it will be a matter of which specific issues they care about most and how the various parties and candidates stand on these. Whether we choose to vote for, or against, a particular party or candidate, or on a specific issue, there are lots of resources to help us reach our decision.

The Economist/IPSOS Mori Issues Index ranks political issues in order of importance as seen by the British public. In September 2014 race relations/immigration was top with 39% followed by the economy (30%) and the NHS (25%).[5] The next seven were defence (23%), unemployment (21%), education (16%), housing (15%), crime (14%), poverty (13%) and inflation (11%).

The BBC's Manifesto Watch helpfully outlines where the seven main parties stand on each of these ten top issues.[6] With the economy and the NHS ranking second and third respectively, it is also worth remembering how the two are closely interrelated. Most CMF members are employed by the NHS and almost all of us, along with our patients, rely on it for our healthcare.

In June 2014 the NHS was declared the best healthcare system in the world by an international panel of experts. They rated its care superior to countries which spend far more on health.[7] The Commonwealth Fund, a highly respected Washington-based foundation, examined an array of evidence about performance in eleven countries, including detailed data from patients, doctors and the World Health Organisation. In their study, the UK came first out of the eleven countries in eight of the eleven measures of care. It got top place on measures including providing effective care, safe care, co-ordinated care and patient-centred care. The fund also rated the NHS best for giving access to care and efficient use of resources.

The 30-page report *Mirror, Mirror on the Wall* concluded, 'The United Kingdom ranks first overall, scoring highest on quality, access and efficiency'.[8] But financial pressures are squeezing the ability of the NHS to deliver. The Nuffield Trust has shown that because of population growth, ageing and cost increases, by 2020–21 the NHS will require some £30bn (25%) more than it is getting now just to maintain services at their present level.[9] But while real average NHS spending has increased by at least 3% per year since 1951, this has fallen to 0.75% per year since 2010.[10]

The major driver of this fall has been the UK's national debt, which is now at its highest peace-time level. When the coalition government took office in 2010 our total government debt was £811bn.[11] By December 2014 it had reached £1,483.3 billion (80.9% of GDP), a rise of over 80%, with much more to come. This rise is the result of accumulating annual deficits. Although the gap between annual government income and expenditure is gradually falling the total debt is paradoxically rising.

This national debt matters. It must be serviced with regular interest payments, diverting money from front-line public services. Even at rock-bottom interest rates, the government will spend almost half as much on debt interest in 2014/2015 as it will spend on the NHS (£52bn[12] cf £113bn[13]). As the national debt escalates, courtesy of £100bn-plus annual deficits, and as interest rates inevitably rise, we may yet end up spending more on government debt service than on health. This situation clearly cannot continue and a key question must be what kind of government is best placed to put our balance of payments in order. Debt is a moral issue with serious consequences for families, communities and countries.

We also face other moral threats in the health service, not least the legalisation of assisted suicide. On this and other conscience issues we will want to know where our own MP stands. Recent parliamentary votes on same-sex marriage, sex-selective abortion and three parent embryos, for example, have been deeply disturbing. The Public Whip website[14] tells you exactly how your own MP has voted on a range of crucial issues and The Christian Institute[15] and CARE[16] have also compiled valuable online databases on past voting records.

Let's make use of all this valuable information in making an informed vote that really counts this May. But let's also pray for the future of our country, and our health service.

***Peter Saunders** is CMF Chief Executive.*

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news reviews

Assisted suicide

Continuing threats

Review by **Peter Saunders**
CMF Chief Executive

Lord Falconer's Assisted Dying Bill[1] sought to legalise assisted suicide (but not euthanasia) for mentally competent adults (aged over 18) with less than six months to live, subject to 'safeguards' under a two doctors' signature model similar to the Abortion Act 1967.

The bill had an unopposed second reading in the House of Lords on 18 July 2014[2] and Committee stage debates took place on 7 November 2014 and 16 January 2015. Over 175 amendments were tabled and three votes held. Lord Pannick's amendment (to delegate the final decision in any specific case to the courts) was 'accepted' and attempts to change the bill's wording throughout from 'assisted dying' to 'assisted suicide' and to require two doctors to carry out examinations were defeated by 179–106 and 119–61 respectively.

The bill has now fallen with the approach of the general election on 7 May and will not enter the House of Commons in this parliament. However it is expected to be reintroduced, possibly in the Commons, later this year. Its progress then will depend very much on the post-election composition of parliament. It is clear that the mood of the House of Lords is now sympathetic to Falconer but the lower house is another matter altogether. Both Prime Minister David Cameron and Liberal Democrat Leader Nick Clegg remain opposed to it although Labour leader Ed Miliband is neutral.

There are excellent reviews of the debate and analyses of the deficiencies of the bill on the Care Not Killing website.[3]

Patrick Harvie's Assisted Suicide (Scotland) Bill,[4] however, remains very much alive in the Scottish Parliament. The MSP took over the bill following the death of Margo Macdonald MSP in April 2014. It proposes an 'Oregon type system' with trained 'licensed facilitators' but with a wide scope for mentally competent adults (>16) with a 'terminal or life-shortening illness' or a 'progressive and terminal or life-shortening condition' who have concluded that the 'quality of their life is unacceptable'.

The bill has even more holes than Falconer's, including relativistic definitions, poor reporting provisions, minimal penalties, a 'savings' clause protecting doctors acting in 'good faith', no specification of 'means' of suicide and the absence of a conscience clause.

Oral evidence sessions took place in January and February this year and a first stage debate considering the general principles of the bill must take place in the Scottish Parliament before 8 May. Scottish First Minister and SNP leader Nicola Sturgeon has already signalled that she will not support the bill[5] and over 10,000 Scottish people have signed a petition against it.[6]

The voices of Scottish Christian doctors will be crucial in the lead up to this first stage debate, where we hope the bill will be soundly defeated. We need to speak out for those voiceless vulnerable people who will be exploited and abused by this ill-conceived draft legislation.[7]

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The spectre of excess males

China offers a warning of the dangers of gendercide

Review by **Philippa Taylor**
CMF Head of Public Policy

Just as the UK debated the need for a new law to prevent abortion based on gender, the Chinese Government announced its latest population statistics.[1] The report contains the admission that gender imbalance among newborns in China is 'the most serious and prolonged' in the world.[2] At the end of 2014, there were nearly 34 million fewer women than men in China. This massive imbalance is a result of three decades of the one-child policy, the practice of sex-selective abortions and the traditional belief that only men can continue the family bloodline.

Every year, about 13 million registered abortions are carried out in China. That equates to 35,000 abortions per day. A further one million babies are abandoned every year, mostly healthy girls. On average, 116 boys are born for every 100 girls (the natural sex ratio is 105:100). This figure masks the fact that six provinces have sex ratios of over 130:100 in the 1–4 age group.[3] It is predicted that by 2030 25% of Chinese men in their late 30s will never have married.

The presence of 'excess males' is also one of the main driving forces behind human trafficking and sexual slavery, not only in China but in surrounding nations as well. A US Department of State report states that women are trafficked into China from neighbouring countries for prostitution and forced labour, while Chinese women are trafficked from rural areas to urban centres.[4]

The problems don't stop there. China is the only nation in the world where more women commit suicide than men, and has the highest female suicide rate of any country in the world. According to a US Department of State human rights report, the number of female suicides in China has risen to a staggering 590 per day.[5] But statistics can hide the fact that behind each number are millions of individual women. We only hear a few of those stories because they are hidden and suppressed by China's regime.

The UK is complicit in these issues. Western governments fund (through our taxes) the United Nations Population Fund and the International Planned Parenthood Federation. Both have worked hand in hand with the coercive Chinese population control machine for decades. There is no apparent will from our government to close down such funding, let alone pressurise the Chinese Government to stop gender abortions. If we refuse to make clear that it is illegal here, on what moral grounds can we insist it is wrong in China?

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Freedom of conscience

New nursing code raises questions

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

At the end of March, the Nursing and Midwifery Council's (NMC) revised version of *The Code: Professional standards of practice and behaviour for nurses and midwives* came into effect.[1] Most of the changes are good – CMF was able to be very positive about much of the draft Code that went out to public consultation in June 2014.[2] But an interesting addition is the inclusion of a clause on conscientious objection:

'[You must] inform and explain to colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care'. A footnote adds: '"Conscientious objection" to participating in a particular procedure can only be invoked in limited circumstances.'

The recognition of freedom of conscience within the *Code* for the first time is a welcome development. However, the caveat in the footnote raises some concerns. Arranging for a colleague to take over seems initially uncontentious, but in practice this means tacit involvement in the procedure by making a referral – nullifying any real notion of conscientious objection.

There seems to be an underlying misunderstanding about what freedom of conscience actually is and is not. It is not just about saying 'I have *decided* that I believe X, and therefore I will no longer do Y'. Freedom of conscience is rather about a clear set of deeply held convictions (faith-based, worldview-based or otherwise) congruent with the values and ethics primary to medicine and nursing, which value human life, human personhood, and individual human dignity.

A doctor or nurse who takes a stand on these issues needs to make it clear that their priority is care for their patient. They are taking a stand that may put them at odds with colleagues and superiors because they hold sincere beliefs about the value of their patients' lives. They genuinely believe that the fetus in the womb or the dying patient is worthy of the same respect and care as any other young person or adult.

So, in laying down new guidelines on exercising freedom of conscience, the NMC needs to recognise these strictures. Any attempt to demand that all professionals should leave their conscience at the clinic door or get out of the profession should be strenuously resisted. Instead, we need guidance that will make reasonable accommodation for freedom of conscience, genuinely helping nurses and midwives act with the greatest professional and personal integrity, whilst neither violating their deepest beliefs nor threatening the wellbeing of the lives in their care.

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Three-parent embryos

Unnecessary, unsafe and unethical

Review by **Peter Saunders**
CMF Chief Executive

Britain has become the first country in the world to offer controversial 'three-parent' fertility treatments to families who want to avoid passing on mitochondrial diseases to their children. The House of Commons approved the measure by 382–128 and the House of Lords by 280–48 on 3 and 24 February respectively.

There are about 50 known mitochondrial diseases (MCDs). They vary in severity, but most presently have no cure and little other than supportive treatment.[1][2] It is therefore understandable that scientists and affected families want research to go ahead. But there are good reasons for caution.

First, this is not about finding a cure. It is about preventing people with MCD being born. These technologies will do nothing for the thousands of people already suffering from mitochondrial disease or those born with it in future. There are also already alternative legal solutions available for affected couples, including adoption and IVF with egg donation.

Second, safety is far from established. Each technique involves experimental reproductive cloning techniques (cell nuclear transfer) and germline genetic engineering, both highly controversial and potentially dangerous.[3] Any changes or unpredicted genetic problems (mutations) will be passed to future generations.

Third, there are huge ethical issues. The research requires large numbers of human eggs, the 'harvesting' of which is risky and invasive. How many debt-laden students or desperate infertile women will be exploited by being offered money or free IVF treatment in return for their eggs? How many thousands of human embryos will be destroyed? If it ever works, what issues of identity confusion will arise in children with effectively three biological parents?

This debate has not been handled responsibly. The research scientists involved have huge financial, ideological and research-based vested interests. Getting the regulatory changes and research grants to continue and extend their work is dependent on them being able to sell their case to funders, the public and decision-makers. Hence their desire for attention-grabbing media headlines and heart rending (but extreme and unusual) human interest stories. The language of 'changing batteries', 'mitochondrial donation' and 'DNA donation' used to persuade parliamentarians has been both simplistic and misleading.[4]

Two leading lawyers in the Lords debate (Lord Brennan and Baroness Scotland) have suggested that the new procedures are incompatible with European law, making it likely that judicial reviews may delay further the implementation of the new regulations in October. The responsible use of technology, good applied science, is part of good stewardship, but these techniques are unnecessary, unsafe and unethical.[5] This is, in short, bad science.

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Vicky Lavy shares stories from the front line

HOPE IN DARK PLACES

key points

- Ebola has claimed almost 10,000 lives in West Africa but the epidemic is at last abating
- Rebuilding health systems will require international assistance for many years to come
- National health workers continue to praise, thank and serve God in the midst of great suffering

The Ebola epidemic is now just over one year old; it was officially declared by WHO on 23 March 2014.[1] Since then almost 10,000 lives have been lost and thousands of orphans remain. The UK has been at the forefront of responding to the outbreak in Sierra Leone; hundreds of NHS volunteers went to help, coordinated by the UK International Emergency Medical Register. Among them were CMF members Rosie Brock and Andrew McArdle, who worked in Mateneh Ebola treatment centre (ETC) outside Makeni, Sierra Leone's fourth largest city.

Rosie: The strangest Christmas

'Christmas Day 2014 was the strangest one I have ever experienced. I worked the early shift at the ETC. Six days after the centre opened, our ward for confirmed cases was busy and the mood was sombre. 23-day-old twins had been brought in by their grandmother on 22 December. During the night shift, I'd held the dying baby boy and for the first time came face to face with the cruel reality of viral haemorrhagic fever. It works through whole families by the links of care – tending to the sick, paying respect to the dead, breastfeeding your children.

'On Christmas morning the first patient we'd admitted died, a 13-year-old girl called Aminata who had regarded our offers of hydration and antimalarials with terror. She was brought in by doctors and nurses dressed top to toe in yellow suits with menacing hoods, goggles and masks, so I could identify with her anxiety. But there were other reasons for her fear; the village elders had warned her that the white doctors would try to poison her. They said Ebola was not real; it was all a fabrication made up by Westerners who wanted to steal her organs. We shouldn't be too critical of the ignorance and paranoia – after all, the record of colonial influence and current officialdom in West Africa is hardly one of transparency and altruism. Reluctance to seek help, mistrust of health promotion messages, and fear of an unknown enemy are rife and real obstacles to the on-going Ebola response.

'We certified Aminata's death and the next team continued the round of the wards – bringing painkillers, antiemetics, antidiarrhoeals, sedatives, IV fluids, antibiotics and antimalarials to treat co-infection and vitamins offered in the hope of "boosting the immune system". The weakest patients needed help even to lift their heads to drink or get out of bed to use the toilet. After a short shift, we returned to the compound to share a late lunch. Oddly, this Christmas I felt I had more to celebrate than usual. I was reminded that it's in the darkness that Christmas shines most brightly. I've never been gladder that there is a saviour, that there will be justice one day, and that redemption and restoration are possible for all nations. So we did have some pretty good celebrations – we baked mince pies, sang carols at the ETC; our hotel kitchen staff tried extremely hard to produce a Christmas dinner, which definitely contained recognisable roast potatoes and chicken legs. And to top it all off I got a personal Christmas card from Jeremy Hunt! Our pre-deployment training talked endlessly about developing "resilience" both as individuals and as a team. We all dealt differently with the stress and sadness of the epidemic – there was easy recourse to banter, alcohol, music and DVDs. All have their

place but I was thankful that as well as these gifts, as Christians we have a better comfort by far.'

Andrew: Taking up the baton

Andrew McArdle *went out to Mateneh in the next deployment of volunteers, joining Rosie's team in early January.*

'Ours was a time of relative calm, with declining numbers of Ebola cases nationwide. We admitted only seven patients with Ebola, all but one of whom survived. However, we looked after many sick patients who tested negative for Ebola but had to stay with us for three days awaiting a confirmatory blood test. This was a challenge as our ability to diagnose and manage non-Ebola illnesses was limited. We did our best to look after patients with malaria, pneumonia, unknown illnesses and even sometimes strokes. On several occasions fit young adults walked in, became prostrate over the next day and died.

'For both Rosie and I, working in a cross-cultural team was sometimes frustrating, hectic and stressful but full of joy and fun. Despite ostensibly being a country in crisis, we experienced warmth, hope and hospitality, and saw a nation largely getting on with life despite privation. The Sierra Leonian clinical staff were an continual inspiration to us. They have borne the brunt of the clinical responsibilities and risk throughout the epidemic; they have not come and gone like the majority of internationals but have had less international attention. They carry the added burden of seeing this disease harm their family, friends and country.

'In what is a broadly secular British humanitarian response, the Sierra Leonians discern the spiritual battle of the epidemic too. Their determination to try to offer compassionate, safe care in the face of overwhelming obstacles flows from their worldview; when offered encouragement to stay safe they invariably reply: "By God im power" and both Muslims and Christians publicly look to God at the start of each shift with songs and prayers.'

Sam: Building a plane while flying

Sam Dunnet *went to Sierra Leone at the beginning of November to work as staff health manager for the 1,000 people working with Save the Children.* [2]

'I arrived to find complete chaos. With such a high turnover of staff, I struggled to find someone who knew more about the situation than I did. Someone described the Ebola response program as "trying to build a plane while flying". My job, it seemed, was to provide parachutes for the builders. I had a stressful first week with an unexpected encounter with a critically ill Ebola patient in a public place and then an international staff member who became unwell with vomiting and fever – both possible signs of Ebola. By the end of that night (with little sleep) I had connected with all the key advisory contacts and become well versed in the protocols on managing a suspected Ebola case. It was definitely a baptism of fire.

'Ebola is a strange enemy because it is invisible but with many effects on daily life.

'All the schools were closed since August so we saw children aimlessly wandering the streets or working. School lessons were being aired on the radio but teenage pregnancies were soaring and all the teachers were unemployed. As cases started to rise in Freetown in December, shop opening hours were restricted, all restaurants and bars were closed and you could be arrested for hanging out on the town beach. Many roadworks were abandoned in mid-construction when the Chinese companies evacuated, which led to chaos on the roads. Hospital services were very limited – the only private hospital essentially closed to anything but chronic disease management. All the laboratories shut down because so many lab staff had died and those remaining were understandably too afraid to continue work.

'I found the sadness and scale of the situation almost overwhelming at times, especially during December when cases reached 100 new infections per day, almost all in Freetown. House-to-house searches were finding dead bodies in the parts of town that I drove through regularly. There was a sense that the epidemic was closing in around us and I often found myself on the floor before God, praying over the city. I went to a church in Freetown and it was wonderful to join with local believers who simply poured out their hearts to God and yet also found that the joy of the Lord was their strength.'

Conclusion: The work is just beginning

It seems that the end of the epidemic is at last in sight, although a sudden spike in cases in February [3] showed that it's not over yet. Sierra Leone has suffered unimaginably through decades of war, poverty and disease. Ebola has shattered its fragile health service and taken the lives of over 300 health workers. [4] But as the infection rate falls, the work of rebuilding is just beginning: restoring and strengthening health systems, training new health professionals and supporting orphans and devastated families. The Sierra Leonian people will bear the brunt of the work, but appropriate international support will be vital for many years to come. Is there a part that you are called to play?

The following organisations are part of this support, and would welcome your help:

- **StreetChild**: Supporting vulnerable families and promoting children's return to school. *bit.ly/1AQIOg1*
- **SOS Children's Villages**: Caring for children orphaned by Ebola. *bit.ly/1A9cpAf*
- **The Welbodi Partnership**: Supporting Sierra Leone's paediatric hospital and training paediatricians. *bit.ly/1NAMfR0*
- **King's Health Partners**: Supporting Connaught Hospital in Freetown since 2012 and working on health system strengthening. *bit.ly/1Fr8bKx*

Vicky Lavy *is CMF Head of International Ministries.*

Photos: Rosie Brock

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Howard Friend on making the most of senior years

MALAWI REVISITED

We are now well into our year back in Malawi, where we had previously spent almost half our professional lives. I am working as a volunteer, part time, in an AIDS hospital. My wife Helen is giving physio a break and enjoying gardening. We're both having a ball. Isn't that what gap years are all about? We even have a blog so we can feed the children selected information.

On getting near the age of retirement – I was reading one of Francis Drake's prayers about being too comfortable:

Disturb us Lord, when we are too well pleased with ourselves,
When our dreams have come true
Because we have dreamed too little,
When we arrived safely
Because we sailed too close to the shore

The opportunity arose when our last child graduated and, to be frank, the last parent died. Plus, I think it only fair to say, we baby-boomers had free medical education, made money on our houses and have a good pension to boot. I think therefore we both felt an imperative to put something back in, not as a result of guilt, but out of an understanding of grace – the generous love that God has shown us.

Those of you who, like me, are challenged by RS Thomas's poetry will perhaps know these lines from his 'The Bright Field':

Life is not hurrying on to a receding future,
Or hankering after an imagined past.
It is the turning aside like Moses
To the miracle of the lit bush

I think living for God in the moment is something that is even more important as one ages. I certainly learnt that lesson from my patients in the hospice where I worked in the last seven years of my NHS career. How many times did I hear this story from a grieving spouse: 'We had so much planned for our retirement you know, and then this happened'.

So I took early-ish retirement. I fitted in an appraisal, volunteered for an early revalidation (something of an anticlimax I discovered) and off we went. We shipped our Land Rover to Cape Town and bought a roof top tent and all the gear. It took two months getting to Malawi – travelling by the scenic route. That gave us time for each other. We did the usual hike around the great game parks. However one of the best bits was sharing our Bible readings together each morning, something we didn't have time for with a busy GP and four children. By the way if you want to test a marriage, try living in a tent and relying on your spouse's map reading for a prolonged period of time. I am glad to report that the ground tent I packed – just in case – was never unpacked! When we finally got to Malawi we were given an enthusiastic welcome by our old friends. I think our Malawian colleagues in particular appreciated that we have given some of what they called our golden years to their country. Old age is respected here, unlike in the UK.

I am working in the paying GP part of an AIDS hospital, which has been a very challenging change from my hospice job. It has been wonderful, however, once I got the hang of the ARVS, to see patients come back to life – something none of us could have dreamed of in the early days of AIDS here.

I decided not to get involved in palliative care, which is in its infancy here, because I wanted to finish my career 'making people better'. That has been a good decision. Only when I stopped did I realise how hospice work can narrow your view of life – if you'll excuse the expression. I intend to get more involved in the palliative care scene in due course. But I realised early on that, with medicines for opportunistic infections available now, 'dying' AIDS patients can be resurrected. Even if one wants to be a palliative care doctor for AIDS patients, you have to be capable of intervention too.

We are both very involved with the student CMDF, being now called 'seniors'. How did that happen so quickly? It is really exciting to see the next generation of medics coming on. Structures in third world countries almost always disappoint. People, not so often. I have been able to transfer my Reader ministry to St Peter's here in Lilongwe, which is keeping me on my toes, and hopefully, the congregation on theirs.

I hope my experience should encourage others of you who have a lifetime of medical experience to consider a time in third world medicine because – if you are capable of adapting to local conditions – both you and the patients will benefit.

Of course I realise that many of you will have responsibilities; family and church-wise, which detain you. However there are a variety of opportunities for shorter stints in countries like Malawi. And so, if you are feeling comfortable and having problems thinking about how to spend your Lump Sum, beware: another country might need you!

Howard Friend *wrote from Partners in Hope Hospital, Lilongwe, Malawi.*

David Stevens considers leadership principles

BECOMING THE LEADER YOU NEED TO BE

Professional competency is an act of worship to God and a duty to our patients. Godliness is an important goal as we let Christ mould our hearts and minds to his will for our lives. But we need to pursue a third priority as we endeavour to model our lives after the Great Physician: being an effective leader. Effective leaders have the ability to influence others.

Christian doctors need to influence people to consider the claims of Christ. We need to influence patients to abandon destructive behaviours and take their medicine. We need to influence our professional team to perform to the highest standards. Real leaders bring real change in individual lives, groups, organisations and cultures. This is because leaders are never content with the status quo. I often tell my staff, 'There is a better way to do everything, and we're out to find it!'

Nurture, not nature

Some people seem to be natural leaders, but leadership is most often the result of nurture, not nature. If you daily devote yourself to improving your leadership, you can develop the skills you need to make a difference. Observe role models, find a mentor, read leadership books, listen to a podcast while you jog or take a leadership training course. You will learn how to deal better with less-than-ideal situations and circumstances, as well as how to choose your words wisely. You will learn how to thrive, not just survive, through seasons of change. You will learn to stick it out no matter how difficult the situation.

Integrity

Focus on certain characteristics and abilities as you develop your leadership ability. The foundational one is integrity – having an uncompromising adherence to biblical principles in your relationship to God and people in areas such as personal honesty and a sound moral character. Always remember to safeguard your integrity. People won't follow someone they don't respect.

Increasingly, influencers in our culture create their public persona. Remember, image-driven leadership won't last. People will ultimately see behind your facade. For a Christian, no dichotomy should exist between your professional and private life. Stand up for what is right, demonstrating the courage of your convictions. Courageous leadership is contagious. No one follows the fearful, but they are drawn to the daring.

Vision, communication and values

Be a visionary. One of my favourite stories is about Steve Jobs when he was trying to recruit a top executive from Coca-Cola early in the Apple saga. This executive was reluctant to join a start-up, so Jobs cast his vision by asking a question, 'Do you want to make fizzy water for the rest of your life or do you want to change the world?' Compelled by Jobs' vision, the executive joined Apple's team.

Leaders require good communication skills. You need to articulate your vision so well that it becomes a magnetic force attracting others to join your cause. Remember, though, most people are more emotional than rational. Connect to their hearts rather than their heads. Pull don't push. If you push people too hard, you will run right over them, but they will thrive if you get out in front and pull them with your example, charisma and vision.

Communicating your values is more important than your vision. One delineates where you want to go, the other defines what those following you will be like when you get to your destination. That is why it is important to take time to form your core values, so there will be no chance you'll rationalise or compromise your stance in a moment of weakness or stress. First verbalise your leadership values to those you lead and then validate them by living them out.

Motivating others

Motivate those who follow you on the journey. People will really work for what they really want. Find what motivates them to excel. Interestingly, money doesn't motivate people long term. You can never pay people what they think they are really worth, but they will pour themselves out for a cause they believe in. Recognise their efforts by giving them as much credit as possible for their successes. As you do this, you are saying, 'What you are doing is important; what you are giving to the endeavour is making a difference and I value you.'

Add to that a sense of 'belonging' by creating a sense of family among your followers. That sense comes through shared experiences and people knowing that you genuinely care about them as a person, not just for what they do to help you further your cause. Christians have another motivation because we have a stewardship responsibility to help those following us become all that God designed them to be.

Facing worry and criticism

Don't worry. A worried leader is a whirlpool dragging everyone into a vortex. Fight worry by seeking God's guidance, following his principles, doing your best and leaving the results in his hands. The leaders Christ mentored didn't have it easy and you won't either. Don't let criticism disable you. The more you succeed, the more criticism you can expect. At the same time, always remember to explore a criticism before you ignore it.

Effective leadership is essential. With study and application, you can become the leader God designed you to be.

David Stevens *is CEO of Christian Medical & Dental Associations, USA.*

Sam Leinster on why Christians should get involved in health service leadership

LEADERSHIP AS CHRISTIAN SERVICE

key points

- Entering leadership or management is a legitimate form of Christian service.
- When considering leadership, it is important to examine your gifts and seek opportunities to use them.
- Leadership should not be pursued for self-aggrandisement or to improve your CV, but should be Christ-like.
- Christian leaders should provide outstanding examples of supporting team members.

As professionals, we want to see patients receiving the highest possible standard of healthcare. In the current environment of rapidly developing knowledge and technology that means, as a minimum, maintaining and improving our skills to ensure the management we offer is the most effective and up to date. In addition, as Christians, we should be offering an extra dimension of care arising from our own experience of God's love to us in Christ. However, this ideal is challenged on a daily basis as we face the pressures of working in the complex bureaucracy that is the modern National Health Service. Sometimes it seems that maintaining the system has become an end in itself. This perception is strengthened by targets which seem to relate more to what can be easily measured than to what really impacts on clinical outcome.

A common response to perceived shortcomings in our workplaces is *grumbling*. We complain about the problems that we face and (often) recall fondly how much better things were in the past (they weren't; I was there). A more constructive approach is to draw the attention of management to specific problems with solutions or suggestions for improvement. A third option, which I believe each one of us should prayerfully consider, is to become involved with management and leadership within the organisation where we work whether this be serving on committees in the CCG or NHS Trust, acting as Clinical Lead for a particular service or even becoming Medical Director within the organisation.

> Leadership is not for self-aggrandisement or to improve your CV... our example is Jesus

There are, of course, parallel leadership roles that may better suit our gifts or temperament, for example roles within the Royal Colleges or academic roles within medical schools. The important question is 'Where is God calling me to serve?'

Should Christians be involved?

Most health professionals are reluctant to become

involved in management. After all, most of us entered our profession with the idea of caring for patients. One challenge is the time commitment of being involved in management. Inevitably, the more we become involved in management the less time we will be able to devote to clinical practice. It may also mean that we have to cut back on church-related activities, which can result in a negative impact on how we are perceived by our fellow Christians. Sadly, even as Christians we have bought into the modern separation of sacred and secular, so that we see what we do at church as our 'work for God' and what we do in the clinic as (at best) our 'work for humanity' or (at worst) our 'work for the NHS'.

The Bible is clear that God is sovereign over all areas of human activity. God created humans to manage and control the earth. Despite the Fall, God still chooses to work through humans and the authorities that exist are appointed by him. The Bible is explicit on this subject: remember both Peter [1] and Paul [2] recognised the legitimacy of the Roman authorities even though they were distinctly anti-Christian. Those involved in leadership at any level are doing God's work whether they recognise it or not. This also means that involvement in leadership and management is a legitimate form of Christian service. In support of this, we have the example of Joseph [3] and Daniel, [4] both of whom served at the highest level in pagan governments having been very clearly called to this role by God.

Is God calling you to leadership?

The first stage in answering this question, I suggest, is to examine your gifts. As a general principle, it is a good idea to explore your gifts with someone who knows you well. Not everyone is called or equipped to take a formal leadership or management role, but Paul recognises a gift of leadership. [5] If you have such a gift then it could be that the NHS is the context in which you should exercise it. Secondly, look out for opportunities to use your gift. Whatever your role in the health service there are likely to be opportunities to contribute to management tasks. These tasks are not always popular with our colleagues. Prayerfully consider whether you should volunteer. A willing volunteer will be welcomed with open arms. Again, talk it over with a trusted friend. Start small, get experience and who knows where it will eventually lead. I am always encouraged by the enthusiasm and insight of the student representatives I meet on various committees. I am even more encouraged when I meet them at later stages in their career and find them still engaged in leadership activities.

How should leaders behave?

It is important to remember that the reason for becoming involved in leadership is not for self-aggrandisement or to improve your CV. Paul reminds us that we are to do nothing out of selfish ambition or vain conceit; that we are to value others above ourselves; and to look to the interests of others. [6] Our example in this is to be Jesus himself.

In practical terms, an important part of our task will be to keep the focus on the care of patients as the reason for the existence of the health service. This will not exempt us from difficult fiscal decisions in times of constrained resources but should encourage us to look for creative solutions. In my own practice, introducing a 'one stop clinic' for patients with suspected breast cancer improved the service to the patients and saved the Trust money by reducing the number of outpatient appointments needed before a diagnosis and decision on management was reached. Maintaining the status quo is not necessarily a Christian virtue; providing caring service is. The second great commandment is still 'You shall love your neighbour as yourself'.

The love of neighbour extends to our colleagues of all grades and roles. If a cup of cold water given in Jesus' name will receive a reward, what is the outcome of a cup of coffee and a friendly word for a junior colleague who is at breaking point? The medical profession has not been good at supporting members of the profession who become stressed for whatever reason whether it is the emotional trauma of ill patients, the effects of overwork or the impact of personal life events. Providing support to members of the team is a fundamental part of being a good leader. Christians should provide outstanding examples of how this can be done. Am I the sort of person to whom somebody in need of help would naturally turn?

How should leaders challenge injustice?

An uncomfortable part of leadership is challenging poor performance or bad behaviour. Again this is an area where the medical profession has often failed. The Kennedy Report provided evidence of systematic failure in this regard in reference to cardiac surgery in Bristol. [7] Depressingly, similar issues were found 20 years later by the Francis Report into the Mid Staffs Trust. [8] This may be due to a fear of confrontation or to a misplaced sense of loyalty, but the patients involved have experienced a particularly unacceptable form of injustice. God is deeply concerned that justice should prevail [9] and as his people we should not be afraid to speak out against anything that will lead to injustice for our patients or our colleagues. Speaking the truth in love may be difficult and there is a danger of becoming strident, but Jesus promised that when we needed to speak to the rulers and authorities we would be given the words to say. [10]

So, is involvement with leadership worth the hassle? Certainly. So then, if God is calling you to it – what choice do you have?

Sam Leinster *is the President of CMF and Emeritus Professor of Medical Education at the University of East Anglia.*

Those involved in leadership at any level are doing God's work whether they recognise it or not

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9. Amos 5:24
10. Matthew 10:19

Nick Land offers advice for leaders facing hard times

LEADERSHIP IN HARD TIMES

key points

- The NHS is under pressure: tightening resources, increased regulation in a context of demographic change.
- More than ever, Christian doctors have opportunities to make a difference. Our faith offers examples and principles that can be applied to great effect.
- Making a difference will include practising age-old Christian values like truthfulness, hospitality and being peacemakers.

This is a difficult time to be a health professional. There are substantial clinical and resource challenges and change seems to be the one constant in our health services. This article examines three questions: What makes these hard times? Why, as Christians, should we seek to influence decision makers? How do we influence decision makers in a way that is compatible with biblical values?

Hard times: what's happening?

There are several issues which make the present time particularly hard. We face *tightening resources*. All our services have to find around 4% savings each year, at a time when there is increased demand both from demographic changes and increased consumer expectations. This means that there is enormous pressure to change radically the way in which we deliver services. Another pressure is *increased regulation*. Governance failures such as those shown in Mid Staffs have resulted in significant increases in regulatory pressures. My own organisation is currently expecting 140 CQC Inspectors for one of the new-style inspections. While external regulation and inspection clearly have value, there is a risk that regulatory pressures move 'time for care' into time spent making copious defensive records. *Changes in society* have also made things harder. Increased access to information and a digital generation's expectation of immediacy has increased pressures on health services. Consumerism has increased people's expectations whilst intensive media and social media criticisms potentially undermine morale.

Why influence decision makers?

First, because *governance is a gift from God*. The apostle Paul taught that 'the authorities that exist have been established by God'[1] and 'the decision maker' is 'God's servant to do you good'.[2] Thus Government (and governance) which seeks to deliver justice and a fair distribution of resources is a 'means of a common grace', something God has given us to ameliorate the impact of evil in the world. Given how hard times are, decision makers have a lot of difficult decisions to make and they need our help.

Second, because *we are called to be salt and light*.[3] Some Christians argue that as 'strangers in a foreign land' we should avoid involvement in secular structures. But Jeremiah, writing to the people of God in exile, instructs them to work for the peace and prosperity of the city in which God placed them.[4]

Third, *we have the necessary expertise and wisdom*. Many of the 'decision makers' are managers and commissioners without a clinical background.

They want to do the right thing but they need the technical clinical expertise that we can offer as clinicians at the 'coal face'. Too often managers experience clinicians who will not share their expertise, but then complain about poor decisions made without it. We have a responsibility to share our expertise and God's wisdom with those called to make difficult decisions. We also have examples of God's people involved in large scale civil governance projects. There is not space to detail all of these, however they include Nehemiah running a major capital investment programme (as well as social reforms, a welfare system and religious revival); Daniel running large scale service delivery and Joseph handling huge fluctuations in resource availability.

Finally, *we must use our influence because we have no choice*. In reality our practice and behaviour have a profound impact on the decision makers around us. Our actual choice is – are we going to influence decision makers intentionally or unintentionally influence them through our behaviour?
Will our influence be for good or for ill? Do we allow ourselves to be carried along with being angry, cynical, bitter and complaining? Or do we seek to do what we can do to make things better?

How do we influence decision makers?

Understand how the decision is going to be made. We need to make some effort to understand the systems in which we work. We need to understand who will be involved in decision making and when and where the decision will be taken. This is not about trying to cynically manipulate decisions; it is about helping people make the best possible decisions.

Servant leadership. Paul wrote to the Philippians, 'Do nothing out of selfish ambition…have the same mindset as Christ Jesus who, being in very nature God, did not consider equality with God something to be used to his own advantage; rather he made himself nothing by taking the very nature of a servant'.[5] Servant leadership is lived out in several ways. Firstly, we need to listen actively to others, rather than coming with advice and solutions based on our own preconceptions. Secondly, we need at least to consider the possibility that other people who take a different view from ourselves may be right. Thirdly, we need to be prepared to work for the good of the wider service, rather than just a small part of it, and we need to understand what other people need to accomplish and help them.

We need to be present, reliable, helpful and truthful. It is important to decide where we can have an influence and then reliably turn up for the meetings that are making decisions. This includes turning up for meetings which are important to others, not just the ones important to us. If we understand what needs to be achieved we can often find win/win solutions that leave everyone happy. We need to be truthful. Distorting information to get our own way is not only wrong, but people have long memories and they will not believe us a second time.

Be proportional. Effectively influencing decision makers means we often have to work through the hierarchy and it is important to respect a leader or manager's view. This can be particularly challenging when dealing with someone who appears to be making the wrong decision. I recently listened to a very useful talk by a senior airline pilot who described the different levels at which a junior pilot could respond to a senior pilot when the latter was involved in 'destructive goal pursuit' (ie crashing the plane). Interventions started with *hinting and hoping*: 'Aren't we flying a little low Sir?'. The next level of intervention was *stating the situation*: 'If we continue in this direction we will crash'. The third level of intervention was to *be direct*: 'Pull up at once'. The final level was to *take control* of the aircraft directly. We need to know what our bottom line is and how to respond proportionally.

Practise positive behaviours

Manage anger. 'In your anger do not sin'.[6] The health service is full of gossip and misinformation and it is very easy to get angry at things which are half-truths or gossip but even when the situation is very serious it has been my experience that 'anger does not produce the righteousness that God desires'.[7] One practical tip is do not send an email when you are angry and do not copy it to all and sundry. You will inevitably do much more damage than good.

Be a peacemaker. Actively seek to understand others objectives and viewpoints. Challenge gossip and misinformation when it is leading to division. Even when people have to make difficult decisions that you disagree with, do not allow these decisions to destroy your relationship with them.

Practise hospitality. Care for the people you work with and make decisions with. My experience is providing biscuits to manage the hypoglycaemic irritability that occurs in the middle of long meetings is much appreciated.[8]

Be Enthusiastic. 'Whatever you do, work at it with all your heart, as working for the Lord.'[9]

Pray continually.[10] Pray 'for all those in authority'[11] and pray 'for wisdom'.[12] We need to pray for our practices, services and hospitals and for leaders and decision makers.

'For we are God's handiwork, created in Christ Jesus to do good works, which God prepared in advance for us to do.'[13] Part of these 'good works' is to use the skills and gifts that God has given us to influence and support those he has given the responsibility to make decisions in order to make those decisions as fair and compassionate as possible.

Nick Land *is Medical Director to the Tees, Esk and Wear Valley NHS Foundation Trust. This article is based on a talk given at the 2014 CMF East Anglia Day Conference.*

Too often managers experience clinicians who will not share their expertise but then complain about poor decisions made without it

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Florence Muindi was propelled into leadership when she encountered the poorest of the poor

GROWING
TO FULL POTENTIAL

key points

- When we trust in and surrender to God's will, he will take us in surprising directions.
- Poor communities need transformation through hope for the future, not just medicine alone.
- Spiritual disciplines such as prayer and Bible reading must go hand-in-hand with practical training and experience.

I recall when I committed my live to Christ. I was in third grade. A fellow third grader introduced me to the simple message of salvation, prayed with me and I received Christ as Lord and saviour. At that age and in a church environment, there was little immediate change in do's and don'ts. But, growing up in rural Kenya, one thing that surprised me was my reaction to my fellow poor neighbours. Passing by their house and seeing their torn bedding hanging out to dry would keep me awake at night, praying that God would somehow meet their needs.

After his conversion, Paul said he no longer lived, but Christ lived in him.[1] After our commitment to Christ, we begin a race *marked out for us*. I remember struggling with that, wanting to run the race my way. Not willing to die to the plans I had for me so I could surrender to his good and perfect will. I am so thankful that by God's grace I trusted in his plan and surrendered to his good and perfect will.

After a time of soul-searching while graduating from high school, it became clear that the underlying purpose of life is to glorify God. With that realisation – I asked the Lord to own me. To take all that I was and all that I will ever be. I wanted to live in obedience and yield totally to his will. It has been 34 years since I took this step.

Following God's path

Soon, the Lord began to reveal his plan for me, step by step. He made a way for me to enrol at medical school. He guided me into public health. The path led on to disaster management training and civil defence. I went to Switzerland, Belgium and Pakistan for training. When it was time to move to the next stage, the Lord opened a door for me, my husband Festus, and our two children (babies then) to go as missionaries among the Maasai of Kenya. That was for two years. Then in a very clear way, he guided us to Ethiopia as cross-cultural missionaries, the country whose suffering had been on my heart all through medical school.

Serving the rejected and oppressed

During our language learning in Ethiopia, we connected with people affected by leprosy in an urban slum, and we began to serve them. As I served with this rejected and oppressed community where most were dependent on begging, I knew this was where God wanted me.

Clinical medicine cannot help much in this situation. We saw many children with several active infections. One child would have worms, skin disease, ear infection, pneumonia, typhoid. After a prescription, they would soon be back with the same infections over and over. This destitute community needed the sick treating, yes, but they also needed interventions to prevent them getting sick and to meeting their hygiene, nutrition, water and other basic needs. It needed empowering and instilling with hope for a better tomorrow. But it was not going to be dependent on me or my family alone. It was going to be done in such a way that:

- Local churches are involved and the body of Christ is exalted.
- The poor participate and own their development.
- The impact is God-glorifying and not leading to us being praised as heroes.

Our aim was not only to meet their temporal needs but most importantly their spiritual needs. This strategy involves transformational development that empowers the church to serve the urban and rural poor. We serve alongside local churches to empower them to become the agents of change and graduate that process every three years. We started as a family of four in 1994. After a time of piloting, amazing favour and expansion into other urban poor communities in Ethiopia, a ministry organization was born, Life in Abundance International (LIA).

An international mission

LIA served initially in Ethiopia, then as we followed God's leading, we got involved with displaced people in war-torn Sudan. It then expanded into the slums in Kenya, targeting the poor in the slums and marginalised situations. In each community, LIA is meeting felt priority needs in a designed programme so that transformation can come. This is the mission of Jesus as spelt out in Isaiah 61. It includes medical camps, clinics, health education, poverty alleviation strategies in partnership with local churches, sharing the gospel with the poor and the vulnerable. It has been an awesome 20 years in this service.

Today, LIA is established in eight countries in Africa, and two countries in the Caribbean – Haiti and Jamaica. To date, almost 50 destitute communities, with an average population of 20,000, have been transformed and graduated. LIA has a staff team of about 160, serving in communities and clinics. We run seven clinics in these nations and have two training bases, equipping the church to serve. Over the next three years, LIA will reach a quarter of a million people in the ten countries where we currently work, and expand to serve in four others. We plan to graduate 226 communities, releasing the poor to worship God.

I tell this story to encourage you. The Lord has a good plan for you, beyond what you can think of. You can confidently trade in your well-crafted plans for his.

What does it take?

Prayer is vital. Wherever I find myself, I seek a prayer partner to fast and pray with, to hear God together, to hold me to account. Prayer unlocks resources, allows God to speak to us and gives us the direction. For LIA we take time each Monday to fast and pray. This has been our greatest investment.

It takes *obedience* without compromise or rationalisation. This must become a lifestyle and a desired discipline. We must meditate on *Scripture*. God said to Joshua, 'Keep this book of the Law always on your lips; meditate on it day and night, so that you may be careful to do everything written in it. Then you will be prosperous and successful.'[2]

Do not conform to the ways of this world. This includes the opinions and expectations of family and friends who may mean well. It is contrary to human wisdom. Sometimes I pray that God will protect me from myself. There also needs to be *sacrifice*. We must count much as loss for the sake of the call, purpose and obedience. Sometimes it will make you uncomfortably different, it will demand of you and it will cost.

Training and equipping are essential too. God will not entrust much to us, unless we have developed our character and we will develop that through a close walk with him, becoming his likeness.

But above all, we need to surrender. It may take a long time to completely yield, but until then, we remain alone, as a seed not willing to die to grow and produce a hundredfold. If I could go back to medical school, to the time of internship or post graduate and have the opportunity to choose again, this is still the path I would take.

This is the race that Christ invites us to run, that only ends with death. A lifestyle of growth, not arriving, to a full potential because so long as we have life, we have room for greater potential. It's progressive.

Let us invest in this race 'until we all reach unity in the faith and in the knowledge of the Son of God and become mature, attaining to the whole measure of the fullness of Christ'.[3] I pray that the location of your commissioning, whether it's your home, hospital, clinic or the nations, will be impacted, that because Christ has you, he will be worshipped and glorified in the place you occupy. I pray that as you give an account of your days on earth, you will hear the words 'well done' from your Father in heaven.

Florence Muindi *is a medical doctor and founder and CEO of Life in Abundance.*

Life in Abundance is an indigenous mission movement, training and equipping churches in Africa and the Caribbean to restore health, renew hope and inspire lasting transformation for the world's most vulnerable families.

It aims to:

- Promote health and prevent disease
- Empower the poor with economic opportunities
- Equip the vulnerable to break the cycle of powerlessness
- Educate the marginalised

The Lord has a good plan for you... you can confidently trade in your well-crafted plans for his

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3. Ephesians 4:13

Cameron Swift takes a fresh look at the scenarios concerning an ageing population

THE DEMOGRAPHIC TIME BOMB (THAT PROBABLY ISN'T!)

key points

- By 2050 there will be around 19 million people over-65 and eight million over 80 in the UK.
- The widely cherished notion of a good old age contrasts with the increasingly negative perception of an ageing population.
- Human longevity is identified biblically as a blessing, but like all good gifts it presents both opportunities and challenges.

A somewhat negative perception of population ageing in developed and developing societies has become a perennial cliché. In the UK in 2010, ten million people were over 65 years old. Current projections are for 15.5 million by 2040 and around 19 million by 2050. In 2010 there were three million people aged over 80, projected to reach nearly six million by 2030 and eight million by 2050. Alongside these crude population statistics, the Department of Health asserts that the average current cost of providing hospital and community health services for someone aged 85 years or more is around three times greater than for someone aged 65 to 74 years.[1]

The predominantly negative, explicit, public and indeed policy responses to this encompass incredulity, economic apocalypse, avoidance, and knee-jerk (rather than proactive) strategies. Similarly, private personal responses include fear (both older people themselves and their families and carers), resentment, stoicism, denial and strained relationships.

Yet there is still a widespread individual and societal incentive to care that is genuine (as well as perhaps born of enlightened self-interest). There are many wonderful examples of personal and organisational inter-generational harmony and provision that are fulfilling and inspirational – including the challenging area of dementia care. The growth in public awareness and research investment into the dementias is good news.

The concept of a good old age with mutually affectionate and strong interrelationships is still widely cherished. In stark contrast, however, are continuing recurring reports of abuse and neglect, and contemporary endeavours to promote planned assisted suicide on spurious grounds of absolute personal autonomy[2] or societal obligation.[3]

The phenomenon of population ageing is here to stay and the centrality of health and healthcare as cause and consequence requires that Christian medics confront the issues. The topic is wide and complex, but some core considerations are proposed:

Truth and scientific integrity, however counter-intuitive, must transcend prejudice (ageism). Public and professional prejudice perceives ageing as an inevitable, intractable process of declining health with diminishing returns for intervention – whether preventative, diagnostic and therapeutic, or prosthetic (supportive).[4] It is invoked often in policy[5] as an excuse for strategic non-investment in all three areas. But this is wrong. Here are some reasons:

Biological ageing (with associated disease propensity) is not primarily a consequence of self-destructive genetic pre-programming or 'wear and tear' but substantially driven by stochastic (random) molecular and cellular error, and is potentially amenable to intervention.[6] If a remaining life expectancy of less than 15 years (rather than crude chronological age) is used to define the dependent population of older people, there has been a downward trend in its size since the late 1970s. Together with an overall increase in numbers in work, this has resulted in a decreased actual population dependency ratio. The apocalypse may be a fantasy![7]

Chronological age *per se* does not predict an attenuated response to therapeutic intervention. The horse has not bolted! For example, the proportional reduction in further acute coronary events with statins after myocardial infarction is at least as good in older versus young individuals.[8] The proportional prevention of stroke, heart failure and premature mortality by treating hypertension is at least as good in the over 80s (other things being equal) as in younger people.[9] A major battle has long been to persuade the pharmaceutical industry to forego upper age limits in clinical trials (deployed on the pretext that the inevitable reduced efficacy in older groups might tarnish the marketing shine of their product!).

It is therefore crucial to distinguish ageing from

age-associated disease. For example, there is evidence that the prevalence of dementia in the older population is now declining.[10] Intuitively, this may reflect the positive cohort effects of evidence-based therapeutic intervention and lifestyle change on the vascular component of the condition.

Numerous advances in technical sophistication and risk reduction (eg enhanced and minimally invasive diagnostic imaging and surgical or cardiovascular intervention) may significantly benefit older people. Therefore timely access to such sophistication must not be withheld under the mantle of 'care closer to home'. When I was a house physician (F1) – admittedly in the early 1970s – my consultant encouraged reluctance to accept acute admissions over 65 on grounds they would block beds, and in most cases were probably beyond the pale or 'social'. Thankfully, by contrast, the British Orthopaedic Association now asserts (in harmony with NICE) that it's both cheaper and better to treat elderly hip fracture sufferers well (notably prompt surgery, physician collaboration, on-site multidisciplinary practice) than to do it badly (delay, prolonged non-operative management, protracted pain, dependency).[11,12]

'Joined up care' in line with population need is not an optional pipe-dream, not least because it is cost-effective.

Because advancing age confers some reduction in 'physiological functional reserve capacity', acute or ongoing health problems increasingly have wider adverse consequences for functional independence and personal and societal relationships; but these are transient and reversible till proved otherwise. Classic examples are problems of mobility or falling, problems of continence, and problems of cognition (notably delirium). To address this, individual medical, rehabilitative and social assessment and care for older people (*always, on site, and without delay*) need to happen together, crossing all boundaries and enabling efficient, shared, interdependent, mutually supportive teamwork, communication, continuity, coordination, training and accountability to take place.

Over the years, progressing from modest beginnings in isolated old workhouse infirmaries forward into the NHS mainstream, wherever this 'comprehensive' partnership principal has been fully implemented and organised, the results in terms of 'meeting the challenge of dependency' have been overwhelmingly positive for patients, carers, professionals and the system as a whole.[13,14] Importantly, that most expensive of NHS commodities, acute hospital bed occupancy, has been reduced without marginalising older people from that much needed environment.

Sadly and alarmingly, many contemporary trends are contrary, notwithstanding the rhetoric of 'joined-up care'. Social and health care, primary and secondary care, statutory and independent provision, have retrogressively divided. The continuing perennial instances of abuse or neglect within the burgeoning business market of social care, or of older people similarly languishing in hospital beds till their desperate relatives eventually extract them, reflect, at least in part, this fragmentation of the system, alongside inadequate multidisciplinary engagement and training.

Commercial incentives and an emerging pressure to keep older people out of mainstream acute hospitals (rather than equip the latter efficiently for demographic change) risk at worst re-inventing the concept of the old, dreaded, clinically marginalised workhouse infirmaries in glossy, sanitised forms. Instead of jointly owned responsibility, the 'alibi phenomenon' is rife; accountability always lies with someone else. Even from today's specialists in the medicine of ageing, the chorus 'we can't do it all' sounds out. True of course – but where else lies accountability? Robust clinician advocacy is required.

A centuries-long ethical heritage, safeguarded by a principled and balanced legal framework, must not be derailed by secularist ideology or economic pragmatism.

The age-old mantra that the moral health of a society can be gauged by the way it cares for its older generation still applies, and there are growing contemporary nuances that should stir us to unease as Christians in medicine.

The 'demographic time bomb' (that probably isn't!)[15] is widely mis-invoked to justify cost constraint as the primary principle, even when the historical evidence for cost-effective models of care is compelling. The fifth commandment[16] and its New Testament application[17] encapsulate intergenerational harmony and interdependence as rooted in the inestimable value of the individual in relation to God, the family and others. But dismissal of this heritage by secularist biological and economic pragmatists is insidiously surfacing in contemporary debate, whether concealed within the euphemism of 'assisted dying'[18] or within the recent invocation of 'economic productivity' as a component of the cost-benefit equation in therapeutic evaluation.[19]

Human longevity is identified biblically as a blessing, and we should celebrate the gift of its demographic realisation. But like all good gifts it presents both opportunities and challenges. Christian medics in the NHS need urgently to read the contemporary signals and be ready to respond:

Firstly, by loyalty to the truth (scientific and biblical) in our understanding and in influencing policy, secondly, by getting involved ourselves in professional practice and leadership in this field, and thirdly, by actively demolishing barriers of speciality, profession and organisational structure to ensure that every older patient we encounter has their needs met collaboratively, comprehensively and with Christ-like integrity.

Older people need tough (young) medical advocates. Are we up for the job?[20] 'Those involved in the NHS today are on the frontline of Kingdom activity'.[21] The rewards for ourselves of doing it well, as well as for society and for our witness to Christ, are tremendous. The long-term risks of not doing so may be very serious indeed.

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Julian Churcher offers advice on discussing faith with patients

RESPECT, TRUST & CONSENT

key points

- We can no longer assume a shared worldview with patients; this makes raising spiritual matters a minefield.
- A triad of respect, trust and consent is central to a healthy relationship between clinician and patient.
- Love for your patients will mean that you are willing to risk your security for their highest good.

There was a time when a Christian doctor working in the UK could reasonably presume a shared worldview with her or his patients. In *most* areas, *most* people would identify themselves as 'Christian'. The gospel story was familiar, even if not understood, or personally embraced.

Today, competing belief systems, including the atheistic secularism that rejects any supernatural belief, have made raising spiritual matters a minefield. There is lots of potential misunderstanding and offence.

A triad of *respect*, *trust* and *consent* is central to a healthy relationship between clinician and patient. Their presence – or absence – affects every part of a consultation.

Respect

Respect for our patients should be a given, grounded in our understanding that every human is made in the image of God. If I respect someone, I recognise their adult freedom (and responsibility) to choose for themselves, as Jesus demonstrated in his conversation with the rich young ruler.[1]

If we respect our patients then it follows that we should be sensitive to them – sensitive to their attitudes, priorities and unspoken concerns. Our sensitivity will be demonstrated in our dealings with them on the basis of freely given consent and in an environment of mutual trust.

Respect, moreover, extends to fellow professionals. It will for example involve our being careful not to disparage them in conversation with our patients, however tempted or provoked. Respect is due to the authorities to whom we are properly accountable. This includes the General Medical Council (GMC) with its mandate to protect patients from abuse of every kind, by doctors with any and every belief.

Trust

Trust is fragile in any new relationship, not least when the stakes are as high as for someone first meeting a 'new' doctor. They will be asking themselves: 'Can I trust you?' or in other words, 'Do I believe that I can rely on your sincerity, benevolence and truthfulness?' and vitally 'Am I right to cede power to you to act on my behalf and in my best interest?'[2]

A medical indemnity provider has usefully described patient trust as deriving from the combination of the *affection* that results from the care given, and the *respect* that results from the competence demonstrated by the clinician.[3]

We all recognise the powerful effect of that first encounter. If we start on the right foot, for example making an astute diagnosis or giving timely and effective treatment, we may swiftly gain the patient's lasting trust. But if we miss the obvious and the patient suffers unnecessarily, then we may remain 'on trial' for a long time. Often the small 'pebbles' count as much as the 'boulders' of diagnosis and

clinical outcome. 'People build, or lose, their trust in you from the tiny fragments available: the way you listen (or don't), whether you've read the notes … "If they can't get the small things right," patients reason, "What about the big things?".'[4]

Changes in society have made the 'trust' question one for doctors too: 'Can I trust you?' Redressing the traditional power imbalance between doctor and patient has been necessary, but an increasing readiness to take offence damages the bond of trust and is counter-productive. This makes it more difficult for doctors to work with a necessary degree of confidence.

Consent

Consent is 'permission for something to happen or agreement to do something'.[5] Consent in medicine is usually the former. It may be explicit (stated verbally or in writing) or implicit. The act of choosing to see a doctor implies consent to the consultation that follows.

'Consent' is worth distinguishing from 'assent', implying a shared journey of continuing trust. I may grudgingly give assent, but 'grudging consent' is an oxymoron. Consent is the patient's gift to give rather than something for the doctor to take, as argued in a recent essay.[6] A legal description – in the context of sexual intercourse – is 'agreement by choice, having the freedom and capacity to make that choice'.[7]

Most of the questions we ask patients are unique to medicine, whether concerning stiff joints, loss of vision, accusing voices, itching, bowel function, or feelings of panic and despair. Then examination uses all our senses, both from a distance and close up. If our patients don't perceive our actions as professionally clinical, they will see them as either intimately personal or abusively impersonal.

Preparation ensures valid consent and frequently we must offer unhurried explanation of *why* we need to ask this question or perform that examination. Anything less makes our actions intrusive. Problems arise when there isn't a *shared* perception between doctor and patient of the appropriate boundaries for history and examination. If we first offer and explain, respecting the patient's autonomy and integrity, then we can nearly always negotiate our way to an effective and productive encounter. The same goes for conversation about matters of faith and belief.

Discussions of faith

The increasing privatisation of faith means that raising the matter – even in passing – can feel awkward. The power differential in the doctor–patient relationship has sometimes resulted in doctors feeling at liberty to preach without permission. Even when well-intentioned, this can be driven more by the doctor's need to see themselves as a faithful witness than by Christ-like love for the patient.

Even when I am as sure as I can be that I have consent to discuss matters of faith, the patient may subsequently complain. My words or manner may feel intrusive, and be seen as my agenda for the consultation rather than a helpful response to *their* agenda.

Secularists' indignation at discussions about faith *ever* arising in the consultation springs from their belief that transcendental belief is at best misguided and irrelevant, and at worse delusional and destructive. Therefore, they claim, it has no place in 'scientific' medical practice. This is clearly an a *priori* faith position, neither proven nor provable, but it is often vigorously held, with an arrogance that allows no possibility of error and a fervour that betrays its fragility.

The GMC's key document *Good Medical Practice* states: 'You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.'[8]

Ensuring continuing consent is fundamental to the Saline Solution – a day course run by CMF that helps Christian healthcare professionals recognise God-given opportunities and respond effectively to patient enquiries about their faith. 'Permission, sensitivity and respect' are watchwords of the course. Guidance includes: 'Ask permission to speak further… Be sensitive to your listener… Check regularly to see if they are still with you.'

If the gospel offers rescue to the drowning (as we certainly believe it does) we must remain committed to the distribution of lifebelts, deck-chairs and beach-balls – indeed *anything* that floats. We are witnesses of the resurrection, called to testify faithfully to our personal encounter with the once-crucified, forever risen saviour. When another person asks us to 'give the reason for the hope we have'[9] we do just that. Then it is the Holy Spirit's role to convict of sin and open their heart. But we don't cease to be their professional carer at the same time.

Be sure that your attitude is one of unfeigned respect and that you have the patient's freely-given consent when discussing matters of faith. It would be sensible to ask whether someone else – relative, friend or other healthcare professional – might object to such conversation, and find out why. This will tell you about their ego-strength and the dynamics of their relationships; take it all into account. Observe appropriate boundaries: you are their doctor or nurse and not their pastor, best friend or parent-substitute.

All this truly calls for the wisdom of serpents and the innocence of doves. Love will mean that you are willing to risk your security for the patient's highest good. The Holy Spirit's leading, whether prompting or restraining, will be your surest compass.

If you would welcome an opportunity to consider these issues in greater depth, share your experiences and gain confidence in addressing patients' spiritual needs, please contact the CMF office for details of a forthcoming Saline Solution somewhere near you or to help us with future course planning.

***Julian Churcher** is CMF Staffworker, London and South East.*

The increasing privatisation of faith means raising the matter – even in passing – can feel awkward

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Andrew Sloane explains why doctors need a philosophy (and theology) of medicine

PHILOSOPHY GROWS NO CABBAGES

My parents had little time for useless abstractions and philosophical reflection. My Dad was very much a surgeon. There were clear jobs to be done, things to be fixed. My Mum was a no-nonsense pragmatic Scot. As Mum once quellingly said, 'philosophy grows no cabbages'.

Perhaps you think likewise. Philosophy doesn't help me run my practice, deal with difficult patients and colleagues, keep up with the latest research, fill in forms. It grows no cabbages. True. But medicine is a rich and complex practice in which questions of what it is and what it is for have great bearing on what we do and how we do it.

Let me begin in a fairly obvious place: the current debate surrounding euthanasia, 'assisted dying' and end of life care and why it seems to be gaining prominence in public discourse in the Western world. There are a number of factors behind this, including changing political climates, shifts in social values, ageing (baby-boomer, choice-is-king) populations and late modern capitalism. These factors, and the specific arguments used for and against euthanasia, have been well-canvassed elsewhere. So too have the divergent understandings of humanity that inform them: we are autonomous individuals, determiners of our own life story; we are made in God's image, endowed with unique dignity and called to be responsive to him, respectively. My interest here is to reflect on how these arguments imply or require a particular understanding of medicine.[1]

The pro-euthanasia position implies an understanding of medicine in which its primary aim is to enable people to choose the treatment that will alleviate their suffering (or enable them to pursue their life goals). It is a service that the community provides to ensure that suffering people are cared for and, where possible, find effective relief. Like other social services, it is made available to people who choose which of those services best fit their needs. Of course, it is a bit more complicated than, say, calling a plumber. This is because doctors are custodians of specialised knowledge and skills. Nonetheless, once the doctor informs someone of their options, it is the patient's (or client's) decision as to what they then do. Suffering and autonomy (human freedom) are what it's all about. And so, when a patient's suffering (of whatever kind) can no longer be alleviated, and they determine that they would like to end their life in order to end their suffering, there is nowhere for a doctor to go. Their job is to provide this last service.

The anti-euthanasia position presupposes a different view of medicine. Medicine, I would suggest, is best seen as a way in which human communities provide care for vulnerable people. At the heart of that care is a needy person, whose inherent frailty is exposed by their physical or psychological condition and whose capacity to act in the world is limited by it. So they come to someone they believe has the knowledge and skill to help them. Christians engage in this practice, I would suggest, because we are aware of our limited creaturely existence, of our fractured fallenness, and of the infinite care of our Triune God who sustains us and all creatures. God draws us to his desired end, and calls us to mirror that compassion and provide brief glimpses of that destiny in our care for our fellow humans.[2]

So medicine is more than a good way to make money and evangelise people. It is itself a sign of God's compassion, a foretaste of the coming kingdom. And that, in turn, makes medicine a deeply moral (and even theological) practice. Medicine is not (just) a service; nor is it (just) about the alleviation of suffering. Medicine is a *profession*, an *inherently* moral practice; and it exists in order to embody God's compassion and a properly functioning community's care for those whose vulnerability has been exposed by their ailment.[3] This view of medicine has implications for much more than the question of end of life care.

What role should bureaucratic control and a focus on 'patient outcomes' play in the practice of medicine? What does 'efficient' geriatric care look like? What kinds of 'health outcomes' can palliative care produce? We need to think a bit better about medicine if we even consider that 'outcomes' are the right yard-stick by which we should measure geriatric or palliative care. We should be concerned when the burdens of reporting make General Practice more a managerial than a medical practice. We need to reflect on the nature of medical practice and what it exists to do.

The role of 'conscientious objection' in medical practice raises similar questions. This emerges from the nature of medicine itself: at its heart is the exercise of knowledge and power by doctors for patients' benefit. As Christians we see the holding of power as ethically (and theologically) loaded, and the notion of beneficence as deeply moral. Again, however, this depends upon a particular philosophy of medicine, a vision of what it is and is for.

So, it is true. Philosophy grows no cabbages, treats no patients, fills out no forms. But philosophy and the theology with which it is necessarily connected, can help us figure out why we're practising medicine in the first place and how paperwork and patient care fit into what we're doing and our understanding of our calling as God's people in God's world.

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reviews

Face the Future: *Books 1 & 2 for seniors*

William A M Cutting

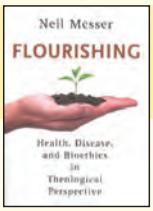
- Onwards and Upwards, 2014, £8 inc P&P, Pb 216pp and 230pp, ISBNs 9781907509971 & 9781910197110. Available from Amazon, bookshops and william.cutting@talktalk.net
- Reviewed by **Andrew Fergusson** who is over 60

Following mission work in India, CMF member William Cutting had a wide-ranging international career with paediatric trainees, but after retirement in 1998 'the paediatrician metamorphosed into a concerned amateur geriatrician' and these first two volumes of a tetralogy arise from his pastoral care for 'seniors', those over 60.

Described as 'a doctor's collection[s] of stories, biographical glimpses, jokes, poems, and practical advice with Christian devotions about health and wellbeing', the books' presentation suits the elderly. They are easy to hold, with big print, lots of white space, and occasional illustrations. The content is geared to older readers: delightfully digestible, always thought provoking, and with a gentle devotional edge that would not put any senior off.

Book One reminds seniors that they 'can inspire, apply wisdom and moral values' and Book Two presents 'challenges, joy and faith'. I read them while leading a weekly Bible study for a very mixed group, mostly my age or older, and I had enormous pleasure recycling some of the jokes. Their points were appreciated by the whole group.

Book Three will consider making the most of one's own health and of the health services, and Book Four practical matters including facing dementia and preparing to finish well in this life.



Flourishing

Health, disease, and bioethics in theological perspective

Neil Messer

- Eerdmans, 2013, £23.99, Pb 238pp, 9780802868992
- Reviewed by **Cheryl Chin**, CMF Public Policy Researcher

There are times when I wonder what exactly I'm doing as a doctor. If we think the purpose of medicine is to defeat death, the failure rate is 100% – death comes to all of us. What should we understand by health, disease and illness? And what difference does loving and following Christ make to our understanding of these concepts? What does it mean to 'flourish' in light of what Jesus has achieved on the cross?

In this book, Neil Messer traces and reflects on the varying accounts of health, disease and disability to guide us into a comprehensive theological understanding of health and disease. He draws from theological giants such as Aquinas and Barth to form a complex and nuanced perspective. 'Health is a penultimate, not an ultimate good.' Our ultimate end is our union with God and therefore human good such as health must be placed within the context of understanding our ultimate end.

This book has an academic tone and would appeal to the philosophically and theologically astute reader. Messer painstakingly combs through varied accounts of health and disease in order to synthesise and conclude his theses regarding health; the last two chapters are worth their weight in gold. Our understanding of these fundamental concepts, now often forgotten, have important consequences for health practice and for life practically.

Sharing the Journey: *From grief to hope*

David Chaput de Saintonge

- PRIME, 2014, £9.95 Pb 68pp, ISBN 9780955952760
- Reviewed by **Anthony M Smith**, retired palliative care consultant and PRIME tutor

This is a book of deeply sensitive poems and photographs. David shares his experience during the five years after being diagnosed with incurable cancer until very close to the end of the path. Since publication, David has gone to be with the Lord. Selections from his photographs beautifully illuminate the story.

The poems trace David's life through reminiscences of childhood, memories of courting and holidays in Devon and the Lake District. Throughout, the poems meditate on separation and loss, but increasingly there is confidence in God's care and trust in the sure and certain hope of life to come.

David Chaput was a brilliant medical doctor and a deeply spiritual Christian. After taking early retirement he became Director of Education for PRIME, the charity of which he was a founder trustee. There he continued to occupy his skills and intellect in teaching and training medical and nursing students and fellow professionals about whole person medicine.

Yet in these pages he acknowledges a sense of isolation and hopelessness at times on his own journey of weakness and dependency. In all these experiences he tells us he increasingly recognised the importance of asking the deep and difficult questions about purpose and direction. David wishes to assure us, in the words of his introduction, that we do not travel alone.

Single mission

Thriving as a single person in cross-cultural ministry

Dr Debbie Hawker and Rev Tim Herbert (eds)

- Condeo Press, 2013 £7.00, Pb 302pp, ISBN 9780989244039
- Reviewed by **Mary Hopper**, missionary nurse/midwife and counsellor

Here is a long-awaited resource for single missionaries and anyone working alongside them, both on the field and supporting from home. It draws upon appropriate theory and is scripturally based, but its biggest impact comes from the lived experiences of over 30 individual contributors serving around the world in a rich variety of roles and settings. I have great appreciation for their honesty in sharing often intimate details of their personal struggles with singleness. Issues regarding ministry are openly discussed, validating the role of the single person and dispelling the myth that there is something inherently wrong with them that will be rectified once they are married. Difficulties in the area of sexuality and dealing with the assumptions and expectations of others are raised sensitively, acknowledging their significance. The highlights and lowlights of the journey from singleness to marriage, and occasionally back to singleness again, are discussed with personal examples from each leg along the way.

Useful appendices offer resources for cross-cultural marriage, dealing with abuse, and ideas for coping with loneliness, none of which are exclusive to single people. Indeed a further publication might focus on lived experiences and specific issues for married couples in cross-cultural ministry.

eutychus

Lord Carey versus the 'flat earthers'

No doubt it was sharp sub editing. But to author a Daily Mail article labelling opponents of creating three-parent embryos as 'flat earthers' does no credit to Lord Carey, the former Archbishop of Canterbury. Later in the same article, he wrote: 'The truth is that in spite of a few reservations about whether hereditary characteristics would be affected by the technique, there are absolutely no grounds for opposition.' Absolutely no grounds? Peter Saunders (*News Review*, page 5), offers a different view.
Daily Mail, 22 February 2015, *dailym.ai/1BKxy9o*

Legal highs: A regulatory headache

Legal highs mimic the effects of illegal drugs. They are achieved through taking substances bought legally over counters of retailers such as hardware stores. The high profile assault of the 4 foot 6 inches tall Alan Barnes of Newcastle had a legal high link. Few users realise legal highs cause serious long term damage to health. Somerset teenager Dan Jessop is awaiting heart test results having become addicted to a legal high nicknamed 'Spice'. Currently these substances are outside legislative control, a ticklish problem for the government.
Daily Mail, 24 February 2015, *dailym.ai/1B6r5Fj*

'Ignorance' causing deaths in custody

Staffs of psychiatric units, prisons and police cells are too often ignorant of mental health risks and 'basic errors' are leading to avoidable deaths of people detained in these facilities. Human rights advocates claim many of these deaths were caused by repeated 'basic errors' by staff unaware mental-health risks. The Equality and Human Rights Commission, which undertook a seven-month inquiry, concluded that despite repeated warnings, 'serious mistakes have gone on for far too long'. It continued: 'The same errors are being made time and time again, leading to deaths and near misses'.
Independent, 23 February 2015, *ind.pn/1B4Sp7b*

Liberia to end Ebola curfew and reopen borders

Liberia plans to lift a night curfew imposed six months ago and reopen borders closed to contain the spread of Ebola, as the threat from the virus recedes, the president said on 20 February. Liberia was once the epicentre of an epidemic that has killed over 9,000 people in West Africa, but new infections have fallen off dramatically in recent months. Most recent reports from Liberia say there have been no new cases for some time.
Reuters, 22 February 2015, *reut.rs/1De47eQ*

Wind farms: A health risk?

Are wind farms a threat to human health? Probably not, but maybe yes. A report by the National Health and Medical Research Council (NHMRC) found there is 'no direct evidence' that windfarms negatively affect health. The findings, however, are somewhat tentative. According to Professor Bruce Armstrong, chairman of the NHMRC wind farms and health reference group, available studies on the subject were of too poor a quality to rule out any link. However, says the NHMRC, 'It's important to note that "no consistent evidence" does not mean no impact on human health'.
Guardian, 19 February 2015, *bit.ly/1zaHVNK*

Come home plea

The appeal of sunnier climes in Australia and New Zealand means a constant stream of UK doctors seeking posts as flying doctors and a better work-life balance. The NHS is reportedly embarking on a recruitment drive to bring some of them back home. Health officials hope they can persuade hundreds of UK-trained doctors to return to an under-staffed and demoralised GP workforce. Some NHS trusts are already actively recruiting internationally. NHS Shropshire and Staffordshire have advertised in Australian medical journals, offering funding for expatriates' return, and induction schemes.
Independent on Sunday, 22 February 2015, *ind.pn/1zaauuW*

Two-thirds of deaths of under-75s preventable

Two in three deaths of under-75s could be prevented, say health watchdogs. They call on councils to limit fast food outlets and do more to combat smoking and alcohol. New guidance from the National Institute for Health and Care Excellence (NICE) calls on local authorities to help work at reducing risk of death from diseases often caused by unhealthy lifestyles. NICE says 150,000 people in England die before the age of 75 each year, and estimates 103,000 of these could be avoided.
BBC News, 23 February 2015, *bbc.in/1vsvCRP*

Male suicide on the rise

Numbers of men taking their own lives in the UK is at its highest level for over ten years according to the Office for National Statistics. Data shows 19 deaths by suicide for every 100,000 men in 2013. Some 6,233 suicides were registered in men and women over the age of 15 in 2013 – up 4% on the previous year. Overall suicide rates had been falling consistently from 15.6 deaths per 100,000 in 1981 to 10.6 per 100,000 in 2007. In 2013, 78% of suicide deaths were men. The most vulnerable age group is between 45 and 59.
BBC News, 19 February 2015, *bbc.in/1A8XIS3*

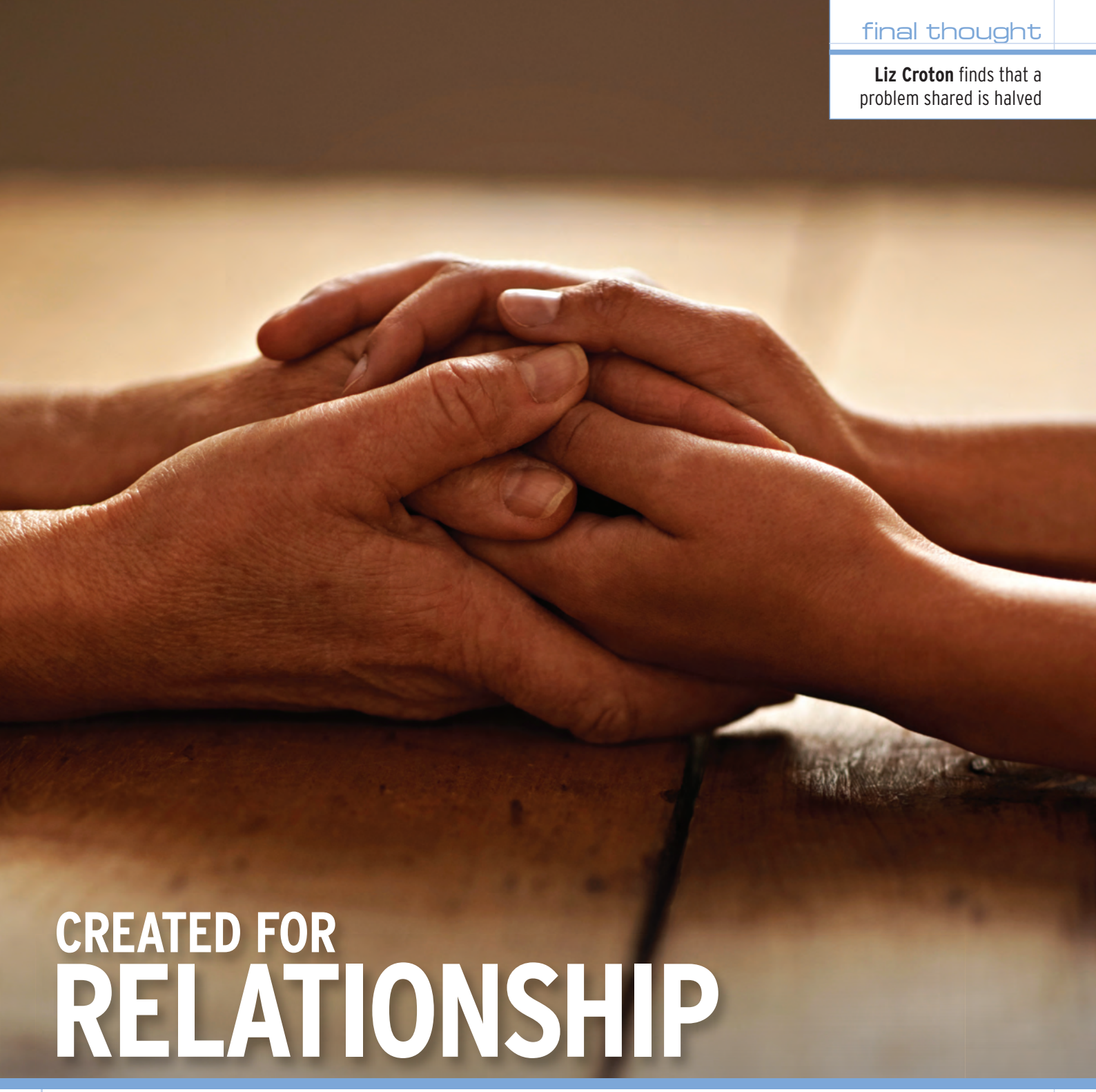
Teenage pregnancies down

Rates of conception among under-18s in England and Wales are at an all-time low, new official figures show. Pregnancy rates for young women aged between 15 and 17 were 24.5 conceptions per thousand, according to the Office for National Statistics (ONS).That amounts to a 13% drop in the estimated number of conceptions for women under 18 in 2013, down to 24,306 in 2013 compared with 27,834 in 2012. Even so, teenage pregnancies remain worrying. The percentage of pregnancies resulting in abortions among the under-18s in 2013 is at 50.7% in England and Wales, up from 48.7% in 2012.
Daily Mail, 24 February 2015, *dailym.ai/1aMCErq*

Mid Staffs inspection costs revealed

Sending in inspectors to the troubled Mid Staffordshire health trust has cost almost £19.5m. Monitor, the government regulator, said investigating Mid Staffs 'took longer and cost more than originally planned'. The original budget was £15.25m. Moreover, the timescale of the inquiry was extended twice. The University Hospitals of North Midlands Trust took over Mid Staffs in November last year and the hospitals involved were renamed. Back in June 2013, police were brought in to investigate about 300 deaths at Stafford Hospital, after evidence showed they could have been caused by neglect.
BBC News, 3 March 2015, *www.bbc.in/1EgedPs*

Liz Croton finds that a problem shared is halved



CREATED FOR RELATIONSHIP

Society seems to place high value on independence. It's one of the things my patients tell me they want most for their lives. And it is important, to a point, but it's not the whole story.

God didn't create us to be alone but in relationship to one another.[1] We are *inter*dependent, which is a higher level than independence. We need other Christians for fellowship and support and this was something that the writer of Hebrews recognised as being of the utmost importance.[2]

Working in medicine is a high-stress occupation. We are exposed daily to suffering and death. We face huge dilemmas when it comes to need and resource allocation. Recently I got to the end of morning surgery and felt overwhelmed with the weight of difficulties and suffering I had experienced. I wanted to cry to discharge some of the frustration. Part of me wanted to shut up, put up and maintain the facade that all was well.

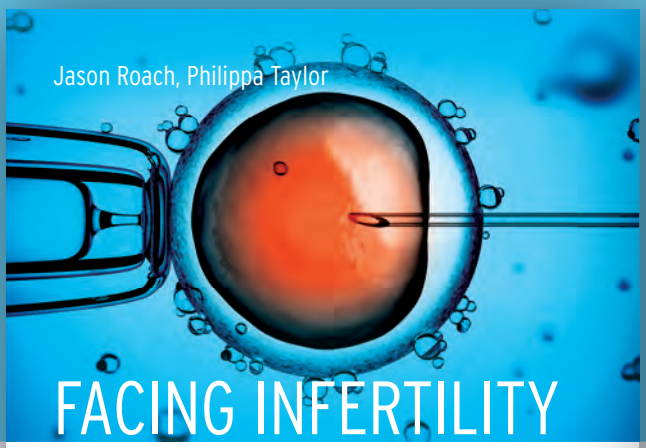
Thankfully there was a larger part that told me that I needed to share what was going on. A problem shared was a problem halved. The only person available to me that day was a junior colleague. My ego has a tendency to equate emotion with weakness and it would certainly have been 'weak' to offload my emotional baggage onto a junior colleague. Thankfully my colleague was a Christian and the Lord used her words to comfort and restore me. The perceived worldly hierarchy in my head was thrown straight out of the window. The Lord brings fellow believers into our lives to encourage and enrich us. Scripture teaches us to 'bear one another's burdens'.[3] We cannot bear them alone. We need each other and we must never be too proud to ask for help.

Liz Croton *is a GP based in Birmingham.*

references

1. Genesis 2:18
2. Hebrews 10:25
3. Galatians 6:2

TIMELY HELP WITH HARD QUESTIONS



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