Summer 2014

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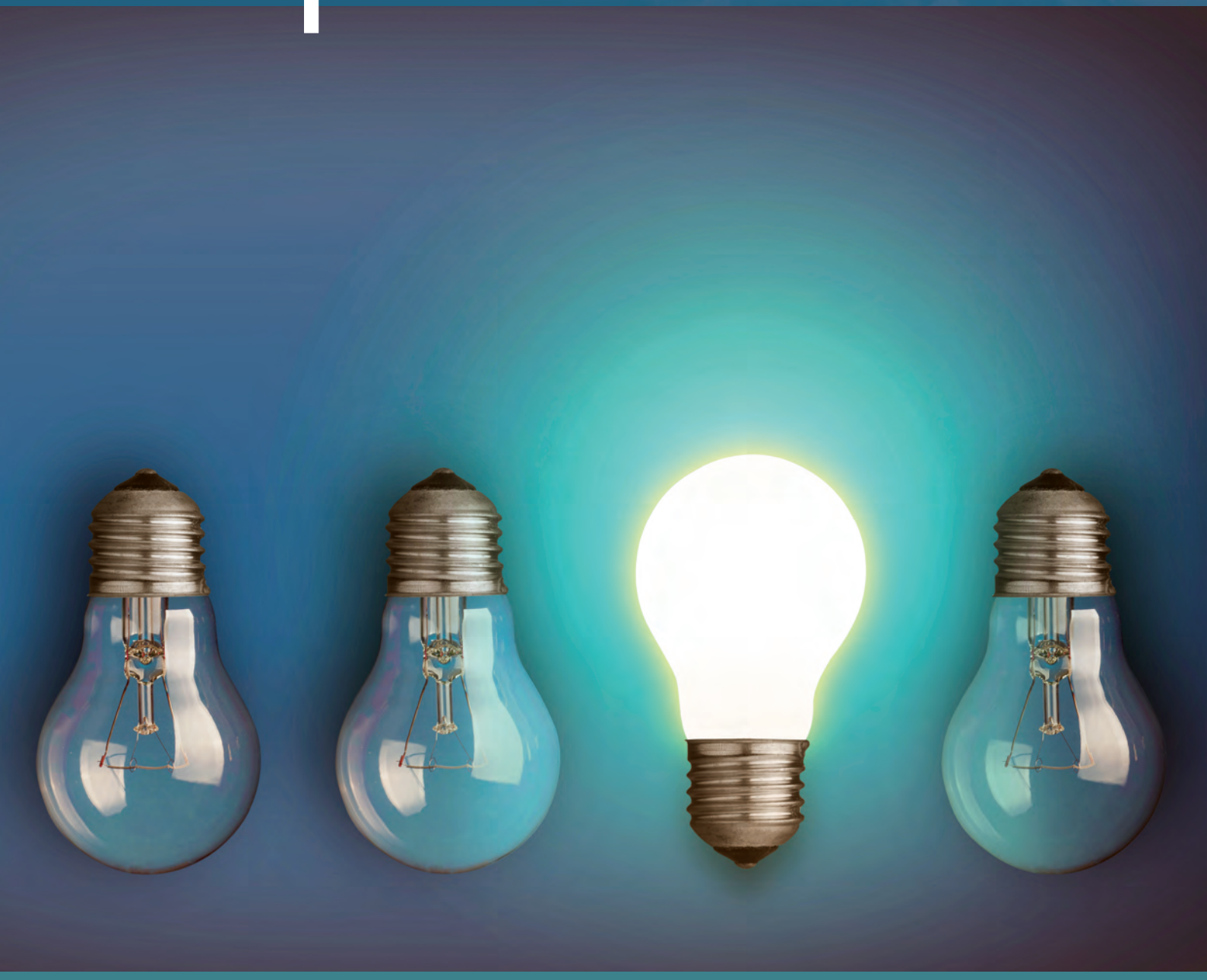

does being a Christian make a difference?

plus: ending FGM and gender violence, primary care in crisis, rethinking retirement, looking after your juniors

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contents

Assisted suicide: doctors should have none of it

Falconer Bill poses new threat

Lord Falconer's Assisted Dying Bill[1] would grant new powers enabling doctors to dispense lethal drugs to mentally competent adults, judged to have six months or less to live and who have a 'settled wish' to end their lives. As such it runs counter to the Hippocratic Oath and Judeo-Christian ethic and threatens to turn 2,500 years of medical history on its head.

The bill is firmly opposed by the BMA, RCP, RCGP and Association for Palliative Medicine along with all major UK disability rights groups. Since 2006, British parliaments have rejected similar measures three times: Lord Joffe's bill (2006), Lord Falconer's amendment to the Coroners and Justice Bill (2009) and Margo MacDonald's Scottish bill (2010).

However, The House of Lords is now more favourably disposed to a change in the law and the recent Supreme Court judgment[2] in the cases of Nicklinson, Lamb and 'Martin' has added a new dimension. The court upheld the current law but strongly hinted that, if Parliament does not make a satisfactory change, it would hear similar cases in the future and would consider creating means whereby individuals requesting assisted suicide could have their cases heard before a High Court judge.

Falconer's proposed law, however, puts doctors in the forefront of decision-making and implementation. Doctors would see the patients, fill out the forms and dispense the drugs. Inevitably some will push the boundaries. Some will falsify certification. Perhaps some, like Harold Shipman, will develop a taste for killing and they will be very difficult to detect. But many will simply be facing too many demands in our overstretched and underfunded NHS to make the objective assessments that this kind of law requires. Very few of them will really know their patients or their families. The experience from Oregon, on whose model Falconer's bill is based, shows that many people seeking assisted suicide do not use their family doctor but rather 'shop around'.

An obvious parallel is the Abortion Act, which has similar provisions. The law was supposed to allow abortion only in strictly limited circumstances, but now there are 200,000 cases a year – over eight million since 1967 – with about 98% falling outside the intended boundaries of the law.[3] There has been illegal pre-signing of authorisation forms, abortions for sex selection, abortions on demand for spurious mental health reasons and only one conviction of a doctor for illegal abortion in 45 years, in spite of the law's provisions being widely flouted.

The Abortion Act requires doctors to give notice of an abortion to the Government. Those who 'wilfully fail to comply' face a criminal conviction and a fine of up to £5,000. But the Department of Health confirmed in June 2014 that 49,000 abortion notification forms had been returned to doctors between 2009 and 2013 for failing to provide the required information.[4]

These abuses occur and go unchallenged because society is reluctant to question doctors. The profession closes ranks. Regulatory bodies lack teeth. The police are reluctant to investigate. The DPP hesitates to prosecute. The courts are unwilling to convict. Parliament turns a blind eye. In a recent interview for *Pulse* magazine Lord Falconer was asked if GPs were likely to get into trouble with the police for authorising assisted suicide, should his bill ever become law.[5] He said that the bill would make it 'very difficult' for GPs to face any proceedings in court as long as it was 'their genuine view' that this was the patient's position.

In other words, it will not be necessary for the patient actually to be mentally competent, at least 18 years old, with less than six months to live or with a 'settled wish' to end his or her life. All that is required is for the doctor to say that it is his 'genuine view' that these conditions apply and no court will be able to touch him. And the key witness, the patient, will be dead.

Recent months have shown how, in a cash-strapped target-driven NHS, it can be very difficult to regulate bad practice – neglect and abuse of patients at Winterbourne View and North Staffordshire NHS Trust and abuses of the Liverpool Care Pathway being poignant examples. How much more so with a bill giving doctors the power and authority to end life.

Falconer's draft bill has already attracted serious criticism[6] because of its paper-thin safeguards – for instance the huge difficulties in assessing mental competence, 'settled wish' and a six month life expectancy. Furthermore there is ample evidence of incremental extension and mission creep in other jurisdictions like Belgium, Oregon and the Netherlands.

We can be sure that any change in the law to allow assisted suicide would place pressure on vulnerable people – those who are disabled, elderly, sick or depressed – to end their lives for fear of being a financial, emotional or care burden upon others. These pressures will be felt particularly acutely at a time when health budgets are being cut and families are under pressure. Doctors should have none of it.

Peter Saunders *is CMF Chief Executive.*

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news reviews

U-turn on aetiology of sexual orientation

RCPsych concedes orientation is multifactorial

Review by **Peter Saunders**
CMF Chief Executive

The Royal College of Psychiatrists (RCPsych), in an extraordinary about-face, has conceded that sexual orientation is not wholly biologically determined. In a new position statement[1] issued in April 2014, they now consider that the causes are 'a combination of biological and postnatal environmental factors'.

The College has also modified its view on whether sexual orientation can change: 'It is not the case that sexual orientation is immutable or might not vary to some extent in a person's life.' They also concede that bisexuals have 'a degree of choice' as to which lifestyle they pursue.

This important statement follows trenchant criticisms of the College made by Core Issues Trust[2] and in this journal[3] which were reflected in the Pilling Report to the Church of England.[4] The dictum, and popular belief, that sexual orientation is fixed and unchangeable is also under attack from leading activists within the gay community itself.

Former Tory MP Matthew Parris[5] and 'Outrage' leader Peter Tatchell[6] argue that sexual orientation is both changeable, and in some people at least, in part a matter of personal choice. In a more recent example lesbian activist Julie Bindel, contends in her new book *Straight Expectations* that sexual orientation is not innate.[7]

They are not alone. The American Psychiatric Association (APA) has stated, 'some people believe that sexual orientation is innate and fixed; however, sexual orientation develops across a person's lifetime'. A report from the Centre for Addiction and Mental Health similarly states, 'For some people, sexual orientation is continuous and fixed throughout their lives. For others, sexual orientation may be fluid and change over time'.[8]

However, in spite of its recent concessions, the RCPsych persists in its support for the UK Council of Psychotherapy's (UKCP) 'Conversion Therapy Consensus Statement'[9] along with current legislative efforts before Parliament to ban therapy for people who want professional help in reducing same-sex desires.

They imply that such therapy does not work, but if such change is possible, the College has yet to explain why this might not take place in therapeutic contexts. The tides are shifting. The evidence for the effectiveness of so called 'change therapies' (Sexual Orientation Change Efforts (SOCEs)) has been recently reviewed in the CMF publication *Unwanted Same-Sex Attraction: Issues of pastoral and counselling support*.[10]

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NHS whistleblowers

Time for a change of attitude

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

'Learn to do right; seek justice.
Defend the oppressed
Take up the cause of the fatherless;
plead the case of the widow.'[1]
'Speak the truth in love'[2]

Why is it so hard to stand up and speak out against poor standards and bad practice in the NHS? This is a question that has vexed politicians, health professionals and patient groups for years. When the Healthcare Commission's 2009 report into Mid-Staffs asked why no staff had come forward to raise concerns about care standards, staff nurse Helene Donnelly wrote to their CEO explaining that she had on several occasions raised such concerns, even producing a detailed report on specific incidents, only for it to be buried by the trust management.

Others who have raised concerns about colleagues or units where standards were unacceptable have lost jobs, reputations and even careers. At the very least, their concerns have been ignored.[3]

Donnelly said, 'I'd stop and look round the department and think to myself, "If this was my mother or my grandmother, would I be happy with this?" And the answer is "No, I wouldn't be".'[4] Surely speaking up for the voiceless and against abuse or injustice should be a fundamental professional and Christian value? Why is it so hard?

Every Secretary of State for Health since Frank Dobson at least has made protection of whistleblowers a matter of policy – even bringing in legislation.[5] When the Francis Report[6] highlighted the practice of gagging orders against whistleblowers, Health Secretary Jeremy Hunt said the practice 'had a chilling effect' and sought to outlaw it.[7] So far, these political legal pronouncements have had little real impact. Doctors, nurses, managers and others are all scared to raise their heads above the parapet. At best they fear being ignored, at worst losing everything.

Professional bodies have often been weak, urging people to withdraw concerns or go for pay-outs rather than fight their cases all the way. This was another criticism from the Francis Report – if the BMA and RCN will not stand up for you as a whistleblower, then who will?

Yet there is help – the charities Public Concern at Work[8] and Patients First[9] are working with parliament, professions and individuals to help people raise concerns effectively and get support and protection when doing so.

The culture of the NHS, like most big institutions, is prone to silencing dissent and cutting down the tall poppies. For the sake of our patients and colleagues, and above all in God's name, we need to speak out and challenge this.

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Celebrating not censoring debate

Closing down discussion won't do

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

Anne Furedi, who heads up the British Pregnancy Advisory Service (BPAS), the UK's largest abortion provider, recently wrote a seminal article extolling the value and importance of debate.[1]

Furedi wrote the article after taking part in a debate organised by Cambridge Students for Life and the Cambridge Medical Society. The motion was: '*Genetics and disability should not be used as grounds for abortion*.' Furedi opposed the motion whilst I and Peter D Williams from Right to Life supported it.

However, the debate prompted a protest organised by the Cambridge University Student Union Women's Campaign. They did not just oppose the motion; they wanted to shut down the debate! Furedi commented that it was the first time she had encountered a protest asking people *not* to attend a debate.

Her article sends a clear message to those who are pro-abortion, that they must engage with their opponents and cannot simply close down the conversation when they disagree. Whilst I would not agree with Furedi's position on abortion, she nevertheless makes useful points about the importance of debate.

First, if we don't join the debate, people will only hear one side of the argument and may be more likely to be convinced by it.

Second, if we take our ideas seriously, debate is essential to test and develop our ideas and to convince others.

Third, pitting our arguments against an opponent is one of the best ways to learn to be more clear, concise and precise.

Fourth, when we try to silence someone, we tell the world we fear what they might say.

Our approach in the debate was to argue that allowing abortion solely because the baby is disabled is discriminatory. Furedi consequently observed that those who are '*"pro-life" are increasingly…focusing on… disability, gender selection and later abortion procedures because they think they are easier issues on which to gain public support*'.

She continues: '*Whether they succeed or not depends on how we engage with those arguments – which we won't do well unless we listen, answer and debate…Frankly, taking on able and informed opponents of my views was a challenge, but my opponents…were far less hostile than the protesters who purported to agree with me…but whose signs told me [not to engage in debate].*'

She concluded: '*You don't have to be a Cambridge intellectual to understand why debate and discussion should be encouraged.*'

My own take-home message was similar: the debate was a valuable and worthwhile exercise, and it was clear that focusing on specific issues where we can more easily gain public support is working.

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Pro-life doctors denied qualifications

FSRH ban may be illegal

Review by **Peter Saunders**
CMF Chief Executive

Doctors who object to prescribing 'contraceptives' which act after fertilisation are to be barred from receiving diplomas or fellowships in sexual and reproductive health even if they undertake the necessary training.

The ruling comes in new guidelines issued earlier this year by the Faculty of Sexual and Reproductive Health (FSRH)[1] of the Royal College of Obstetricians and Gynaecologists (RCOG).

Whilst many contraceptives act by preventing fertilisation, there is strong evidence to suggest that some, including most IUCDs (intrauterine contraceptive devices) and the morning-after pill EllaOne[2] (ulipristal acetate), also act by preventing the implantation of an early embryo. They are thereby embryocidal, or abortifacient, rather than truly *contra*-ceptive.

Many doctors choose to avoid using drugs or methods of contraception which act after fertilisation, a position consistent with the Declaration of Geneva adopted by the British Medical Association (BMA) in 1948. This originally stated, 'I will maintain the utmost respect for human life *from the time of conception even against threat*'.

The RCOG's move is thereby an extraordinary about-face by the profession from its historic position.

The FSRH may argue that they are not barring doctors from practising, but simply from obtaining certain qualifications. But as many job appointments will be conditional on applicants having these qualifications this is effectively also a bar on practice.

This seems extraordinary given that the use of contraceptives which have been proven to act after fertilisation is only a tiny part of the specialty of sexual and reproductive health (SRH) which encompasses a wide range of conditions, treatments and procedures.[3] Surely could not reasonable accommodation be made for pro-life doctors?

After all, doctors who have a moral objection to *abortion* are still able to complete the Faculty's qualifications because the Abortion Act 1967 contains a conscience clause which protects them. So the College appears to be taking advantage of the fact that there is no equivalent law protecting those who object to destroying human embryos. Or is there?

Under equality legislation, it is unlawful to discriminate against people who have 'protected characteristics' – treating someone less favourably because of certain attributes of who they are. This is known as 'direct discrimination'. These protected characteristics include religion or belief.

Examples of direct discrimination include dismissing someone, deciding not to employ them, refusing them training, denying them a promotion, or giving them adverse terms and conditions all because of a protected characteristic.

This action by the RCOG may therefore be not just discriminatory but also illegal.[4] If so the College could have placed itself in an embarrassing and dangerous position.

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Julia Marsh reflects on how God's paradoxical and sometimes upside-down economy has worked in her life

THOSE TWO IMPOSTORS, TRIUMPH & DISASTER

key points

- We can learn from Jesus' example, choosing obedience to God's will, however difficult that is.
- Experiencing brokenness will assist with empathy and sharing bad news with patients.
- God's grace is sufficient and we can trust him completely.

My work as a Consultant Oncologist is a major part of God's calling on my life and an important expression of service. I came to faith at the age of 18 as a first year medical student and my faith has shaped most aspects of my life. To live out my faith consistently has been a battle at times, as I'm sure it is for most of us. It's especially true once children come along and work responsibilities increase, with life always full on.

In March 2010, as an established consultant after ten years in post, I moved to fresh opportunities in a senior consultant role at a new institution. About five months later I was diagnosed with breast cancer at the age of 48. This came out of the blue and was a huge shock. It was complicated to deal with. Not least because of the nature of my own work in the field of cancer and my senior role in the same hospital in which I would need treatment.

I was well supported through the diagnosis and treatment by my husband, by those treating me and by a number of Christian friends. Even so, there were many struggles: the news was broken to me in a rather unintentionally clumsy way that haunted me for a long time afterwards. How did we tell our teenagers that mum has cancer? What about telling the rest of the family and colleagues locally, nationally, internationally? Some of them had to know I was unwell because of my involvement in various research activities. There were people at church who seemed to be avoiding me, unable to offer any words of comfort. There were others whom I hardly knew who felt entitled to discuss my illness with me because I had been mentioned in the corporate prayers.

From the time of diagnosis I had a strong sense of Jesus' presence with me. I was determined to try to walk well with him, learning whatever lessons there were to learn, trusting him for my future and

for that of my family. Some people wanted to pray for my physical healing, and I was glad of such prayers. But I was not afraid of what the future might bring and was more concerned about what God wanted to do through this. How might he refine me? What impact would it have on others? It was hard to explain to well-meaning Christian friends that actually the real struggle was inside and that, at least for me, the spiritual aspects of this cancer journey were profound.

Struggling with brokenness

I was fortunate to need only surgery and radiotherapy (no chemotherapy). So the physical treatments were fairly straightforward. However, during the radiotherapy I felt increasingly unwell and really began to struggle emotionally. I became overwhelmed by feelings of distress and pain and the sense of my own physical and emotional strength having been stripped right away. As the pain eased, it evolved into a feeling of being completely broken. I did not know how I would ever be able to return to my work, which requires considerable emotional strength in supporting patients experiencing their own cancer diagnosis and treatment. I prayed continually for God's help and healing in this area, asking him to shape the way forward. Healing came only slowly, helped by professional counselling.

It was hard to understand why I felt so broken. For a while, despite feeling the reassurance of his presence, God seemed silent. The only answers to my prayers seemed to be 'The righteous shall live by his faith' [1] and 'My grace is sufficient for you, for my power is made perfect in weakness'. [2] Getting back to my work with cancer patients seemed too hard. But I was reminded of Jesus in the garden of Gethsemane, choosing to be obedient to God's will, however difficult that would be. Choosing to trust Jesus and to be willing to go with him back into a working environment where everything revolved around cancer was an important step.

Healing through brokenness

The feeling of brokenness began to make some sense a little later when, reading the story of the feeding of the five thousand, [3] I was reminded that Jesus took the bread, offered it to his Father and broke it. It was the broken pieces that were used to feed the hungry people. Later, on Easter Sunday we were taking Holy Communion and I was struck by similar words: Jesus took bread, gave thanks and broke it. [4] The bread, his body, was broken; the forgiveness and healing for us comes from his brokenness. Maybe sometimes our Father allows us to be broken too in order that those broken pieces can be used for his purposes.

My own 'broken pieces' remind me that when I give the news of a cancer diagnosis, I must take care to do it gently and with care in order not to increase the burden. When I see patients or families struggling to know how to tell relatives and friends of a diagnosis, I must listen and reassure. I need to be sure that I am appropriate in my own interaction with others who are struggling, whether in the context of home or work. I need to show acceptance of those who are distressed even if it's not really clear to me why things are so difficult for them; I need to do my best to ensure that spiritual care is available to the patients and families I care for when needed, and that the gospel is accessible to those who want to hear. Above all I learned the need to remain completely dependent on Jesus and to be content to live out the paradox that it is when we are weak that we are strong.

Learning from brokenness

Looking back, there is a strong sense that in all this, God has worked for good. [5] Especially I have learned that his grace is sufficient and that there can be great strength in weakness. [6] During my illness I had more time than usual at my disposal to read the Bible regularly, to pray and to read Christian books. My journey of understanding and spiritual growth has continued and has been helped since by involvement in the Alpha course at our church and a Growing Leaders course.

I was able to return to work in a phased way and to manage the challenging emotional aspects of this with time. Quite quickly I took on new senior management responsibilities. I found myself facing the most challenging of work situations which seemed to test every aspect of character and integrity. The lessons learned during my illness that God's grace *is* sufficient and that we can trust him completely were very important during that period.

So did my illness result in triumph or disaster, success or failure? I would never have chosen the experience, but neither would I turn the clock back now. In reality it brought both. The experience was hugely painful and difficult, but yet the lessons learned are extremely valuable and go on having an impact in the way I am in my workplace, my home and my church. I am thankful for the spiritual growth it has produced and for the increasing sense of journeying with Jesus in the everyday. I am free of the shame brought on by my sense of brokenness. But I am also humbled, released perhaps from some of the inevitable pride I would tend to take in my role and position.

Julia Marsh *is a paediatric oncologist in London.*
This article was inspired by talks at the CMF London & South East Conference, 2013.

Maybe sometimes our Father allows us to be broken... in order that those broken pieces can be used for his purposes

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Steve Fouch reports on a crisis affecting the future of GP services in deprived urban and rural areas

Photo: © Martin Godwin/Guardian News & Media Ltd

PRIMARY CARE IN CRISIS

Naomi Beer (L) and practice manager Virginia Patania (R) outside the Jubilee Street Practice.

key points

- Almost 100 GP practices in areas of high social deprivation could face closure because they do not fit the government's funding model.
- NHS England states that its hands are tied and that it allegedly has no money to deal with the problem.
- As a percentage of GDP, we still spend less than most European nations on healthcare.

What will happen if nearly 100 general practices in areas of urban and rural poverty close down within the next twelve months? The implications are deeply concerning – patients turning to other, already overloaded practices and hospital emergency services for help, leading to potential meltdowns of services. We could see people with complex health with no continuity of service, and any attempt at integrated care going out of the window as remaining services struggle to cope as best they can.

If that sounds overly pessimistic, it is a possibility that some CMF members are genuinely concerned about. Naomi Beer, a GP in the Jubilee Street Practice in East London's Tower Hamlets is one such person. 'Give it a year and I think we will have to close', she told *The Guardian*.[1] The Jubilee Street Practice has won awards for the innovative and wide-ranging services it offers, helping to address the complex health and social needs of an ethnically and socially diverse community, with pockets of high social deprivation. It has been at the heart of this community for the last seventy years, but by the end of this year it may have closed down.

> This should make us pause as a nation and ask what kind of National Health Service we need and want – and how much we are prepared to pay for it

In March it was reported that NHS England had a shortlist of up to 98 practices in genuine danger of closing down due to a change in the funding formula for General Medical Services contract.[2] Various aspects of the formula have been changing over recent years, but the most significant is the ending of the Minimum Practice Income Guarantee (MPIG). Meant to act as a transitional relief from 2004 when the new GP contracts came in, many practices in areas with young but poor communities have been reliant on the MPIG to cover the shortfall in funding from the Global Sum (the main part of the General Medical Services funding contract). The Global Sum is a per patient funding mechanism, weighted for age, social deprivation

and other factors, but the weighting does not take into account the complex needs and repeat visits to surgeries of younger patients in more socially deprived communities. So for instance, while the typical number of consultations per patient per year around the UK is about five, in Tower Hamlets it is nearer twelve. The MPIG has covered the shortfall in funding that this increased demand puts on the practice.

A significant proportion of Jubilee Street's caseload consists of patients with complex social and medical needs. Often they are from ethnic minorities, or are younger and in need of long term care. The same is true for many other inner city general practices, and similar patterns can be found in rural practices. In both urban and rural cases, because patients are generally younger (eg university students, whose needs are also not recognised), the funding formula in the Global Sum does not cover the on-going, complex needs of these communities.

A financial cliff

To keep the financial pressures at bay, staff have had to take pay cuts despite increased working hours – but there are limits to what can be cut while still maintaining services. Jubilee Street, along with maybe 97 or more other practices, many (if not most) of which are in areas of social deprivation, are facing a roll towards a financial cliff, with no obvious means to stop them falling over.

NHS England has been asked to address the situation, but states that its hands are tied and that it allegedly has no money to deal with the problem. The BMA and the RCGP have been lobbying for government action. There is an active campaign in Tower Hamlets where several of the affected practices are based, and it is hoped that Dr Beer and her colleagues will get to see the Secretary of State for Health in the near future. But time is short, and without decisive action the point of no return may be reached very soon for many, if not all the practices on the 'at risk' list.

General practices account for 90% of all patient contact with the NHS, undertaking a staggering 340 million consultations a year on only 8% of the total national NHS budget. In Tower Hamlets, with over twice the average consultation rate, that is done on just 6.5% of the local health budget. And overall, the funding for general practice continues to fall as the demand increases.

The UN has said that developing strong primary care (particularly addressing social determinants of health and providing universal access to essential health services) is a vital component to developing Universal Health Coverage.[3,4] Primary care is the backbone of preventative medicine as well as the gate keeper for curative medicine and the provider of much care for long term conditions. It is therefore in no one's interest to see this fail.

A vital witness

About a quarter of CMF's members are GPs. Christians often deliberately seek to work in areas of social need, seeing it as part of their service to God. As Christians our commitment is also to justice. In this instance, Christians should want to see the poor, the marginalised and disadvantaged given the quality of medical care that they need, irrespective of wealth and other personal resources. It is no surprise that there have always been a large number of Christian general practices around the country, and many more Christian GPs, nurses and administrative staff working in secular practice. They remain a vital witness to Christ, especially in more deprived communities of the nation.

There are other issues – our patients expect more and more of the health service. Are some of these expectations becoming unrealistic and unachievable? We are managing more and more people with long-term conditions, many of which are preventable, yet we are struggling to see the incidences of 'lifestyle' diseases such as diabetes, lung cancer and obesity, decrease.[5] GPs are not the only ones who can have an impact here, and as we have argued before, managing expectations and helping educate and support people through lifestyle changes is something in which the church can play a key role.[6]

Finally, we are also facing a staffing crisis; with so many pressures and demands mounting, many GPs are retiring early, while fewer and fewer are going into general practice training.[7]

Dr Beer reflected that 'this is one of a number of crises that should cause us to pause as a nation and ask what kind of National Health Service we need and want and how much we are prepared to pay for it'. As a percentage of GDP, we still spend less than most European nations on healthcare.

A matter of justice

The Bible reminds us that we have a responsibility for the poor we have amongst us,[8] while our rulers are expected to adhere to biblical standards of justice.[9] Jesus taught that in following him, we need to look out for the least of our brethren.[10] Sustaining a strong primary care service is surely a matter of justice, providing essential services and support for the poor and vulnerable in society. So much of this service is also provided by Christian doctors, nurses and practice staff seeking to serve the Lord. It should therefore be a matter all of us take seriously, holding the authorities to account to make sure there is adequate provision to maintain the quality of service needed. But we also need to enter into a wider debate about how we resource and provide such services in the long term. Getting past this crisis is not going to be enough, and we need to be ready to look critically and creatively at a long term future for primary care as the backbone of a national healthcare system.

***Steve Fouch** is CMF Head of Nursing.*

Get involved

If you are concerned and want to support Jubilee Street and other practices, you can get involved in the following ways:

- **'Save Our Surgeries' Campaign:** *www.facebook.com/SaveOurGPsurgeries*
- **Twitter:** *@Jubilee_Street*
- **38 Degrees Petition:** *bit.ly/1nehnbx*
- **BMA 'Your GP Cares' campaign:** *bit.ly/1pFeBPG*
- **RCGP 'Put Patients First' campaign:** *bit.ly/190cjll*

Tower Hamlets GP practices, with over twice the average consultation rate, run on just 6.5% of the local health budget

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Ann-Marie Wilson reports on the global incidence of FGM and its toll on women

BREAKING THE CYCLE OF FGM AND GENDER VIOLENCE

key points

- FGM is not a requirement within any religion.
- At least 125 million girls and women have experienced FGM in Africa and the Middle East, but it happens in the UK too.
- Churches have an opportunity to provide pastoral care that allows survivors to share their experiences, pain and suffering.

Meeting Manha[1] was my first experience of the horrors of Female Genital Mutilation (FGM). I was working in North Sudan. Manha was just ten years old and pregnant as a result of rape. She had undergone FGM and was unable to give birth naturally. Her terrible suffering spurred me on to devote myself to ending the practice. After studying FGM, working on anti-FGM projects and gaining birth attendant and fistula experience, I founded *28 Too Many*.

This name reflects the 28 or so African countries where FGM is practised – that's 28 too many. Our focus is on research that enables local initiatives to end FGM. As well as working closely with other charities to stop violence against women (VAW) and other harmful traditional practices (HTPs).

My dream is that if one woman does not cut her daughter, then (as a mother herself) she will choose not to cut her daughter and then that daughter in turn will choose not to cut her own daughter. This breaks the cycle of FGM, and over the course of five generations I believe that FGM could be permanently eliminated.

Global statistics

FGM has been making headlines in Britain but the problem goes much wider and deeper. Recent reports have shown that at least 125 million girls and women have experienced FGM in Africa and the Middle East, As many as 30 million girls under the age of 15 may still be at risk over the next decade.[2] Shockingly, this equates to one women or girl undergoing FGM every ten seconds.[3] FGM is also carried out amongst diaspora communities within Europe, North America, the Middle East and Australia. Estimates show that 66,000 women and girls have undergone FGM in England and Wales, while 24,000 girls under the age of eleven are at risk of undergoing it.[4]

In Africa, the highest prevalence of FGM occurs in Somalia where an estimated 96.7% of girls aged 15-19, and an estimated 98.9% of women aged 35-39 have been cut.[5] More positively, change is being made in other African countries like Kenya where the prevalence rate for FGM in 15-19 year olds has dropped from 37.6% (1998) to 27.1% (2008-9). Although measurable progress is now being seen in a number of countries, the existence of the practice itself still shows that much work needs to be done to eliminate it worldwide.[6]

Health implications

There are harmful physical and psychological effects that women and girls suffer following FGM. The most severe immediate consequence can be death caused by haemorrhaging and/or shock after the procedure. Women and girls are also at risk of contracting tetanus because of the unsanitary conditions in which FGM is often carried out. The situation is made worse where the appropriate medical treatment is not available or there is insufficient medical knowledge to correlate it with the contraction of infection.

Women who have undergone FGM are at risk of shock, open sores, cysts and cheloid scarring and have an increased risk of contracting HIV/AIDS. Infibulated girls commonly suffer from bladder and urinary tract infections. Pelvic inflammation, painful abdominal cramps and internal infections are commonly experienced by girls once they have started their menses.

FGM can also cause infertility for women due to womb infection,[7] caused by stagnation of menstrual blood within the vagina. FGM also causes severe complications for both women and babies during childbirth. Postpartum haemorrhage, obstructed labour, prolonged hospitalisation following the birth of the child and increased need for caesarean deliveries are all common complications that occur for women giving birth. In Africa, FGM causes an extra ten to twenty deaths per 1,000 deliveries.[8] Girls who have undergone FGM also experience psychological trauma including feelings of betrayal, shame, hopelessness, post-traumatic shock and depression.[9]

Religion and FGM

It is important to note that FGM is not a requirement within any religion. Some Islamic scholars claim that it is allowed by the teachings of the prophet Muhammad, but others, including the leading scholars of Al Azhar in Cairo and the Chairman of the Shari'ah Islamic Council in the UK, say that it is not allowed. In both Christianity and Islam there is emphasis on the fact that the human body has been created by God, and that we are encouraged to look after the body and not mutilate it in any way.[10]

Through work carried out by the church and religious authorities, myths surrounding FGM can be challenged and dispelled. The evangelical tradition draws upon Scripture in order to support taking action against harmful acts such as FGM:

'Learn to do right; seek justice. Defend the oppressed. Take up the cause of the fatherless; plead the case of the widow.'[11]

This scriptural perspective is empowering people to use 'charity from the mission of God on earth… to proclaim a gospel of grace, forgiveness and love',[12] so that the suffering of women and girls who have undergone FGM does not go ignored. The role of the church then is to teach and discipline people so that they can learn about FGM and challenge those who support the practice.

The Bible's account of creation story states that once God had created the world 'God saw all that he had made, and it was very good.'[13] This highlights the perfection of God's creation, and so by implication women's bodies are not to be harmed or mutilated through HTPs as it denies them of their natural rights as mothers, wives and humans.[14]

Action against FGM

In Africa an important development involved 120 religious leaders of the Inter Religious Council of Ethiopia (IRCE), regional members of IRCE, United Nations Population Fund and the Royal Norwegian Embassy. They took part in a National Dialogue Forum allowing attendees to discuss the ways in which gender based violence (GBV) affects women or girls. The meeting concluded that there is no basis within Scripture to justify HTPs like FGM and that it is the responsibility of religious institutions to prevent these practices occurring. A consensus was reached that consistent moral and ethical education should be given to all through religious institutions as well as working with governmental and NGOs as well as supporting survivors of GBV through work with legal authorities.[15]

In the UK, the General Synod of the Church of England motioned the condemnation of FGM in 2002, enforcing the need for the elimination of the practice and urging the Anglican Communion to challenge HTPs including FGM.[16]

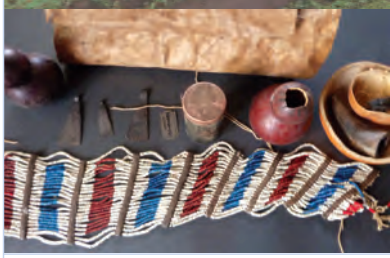
In February 2011, the Manor Gardens Health Advocacy Project hosted the launch of the first UK-wide multi-agency guidelines on FGM. Later that year the Project and a subgroup of Forum members organised the first-ever multi-faith conference against FGM in the UK. Panel members included leading religious scholars from the Muslim College, the Eritrean Bethel Church, the Muslim Council of Britain and the Salem International Christian Church. During the conference Sheikh Dalmar focussed on the 'common dignity…that extends to all human beings, regardless of faith…sex, [and] colour' and that anything that contradicts this, such as FGM, contradicts the will of God. The conference issued statements of support which were sent from mosques, churches and synagogues throughout the country.[17]

Action to stop FGM needs to take place at individual, community, national and international levels. Within the church there must be an emphasis on providing pastoral care that allows survivors to share their experiences, pain and suffering. The church should recognise FGM as sexual abuse and seek justice by supporting the punishment of perpetrators, and enforcing anti FGM legislation.[18]

Steps being taken by religious bodies include;

- Raising awareness in schools and among parishioners, social and religious leaders, implemented through the use of social, church and outdoor media
- Creating and supporting anti-FGM activities undertaken within parish youth groups
- Creating and supporting alternative, non-harmful initiation into adulthood within practising communities
- Working with non-governmental, faith based and community based organisations to increase awareness and stop FGM
- Encouraging people to become aware of the laws regarding FGM and to report cases to the appropriate legal authorities
- Using pastoral and development activities within the church in order to provide training for teens in family life education.[19]

Ann-Marie Wilson *is director of 28 Too Many, a charity UK opposing FGM and gender violence.*



Through work carried out by the church and religious authorities, myths surrounding FGM can be challenged and dispelled

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Vinod Shah compares and contrasts the Christian and secular visions

DOES BEING A CHRISTIAN MAKE A DIFFERENCE?

key points

- Christians follow a person, not an ideology.
- The Christian vision is about a grand narrative, allowing God himself to set the agenda.
- The genius of God can use your suffering and redeem any situation.
- We use knowledge for service not self-aggrandisement.

Douglas Johnson, founder of CMF, once asked this question: 'Does being a Christian make no difference?'[1] This is the question I am hoping to answer here. I think there are major differences between the Christian and secular worldviews. The most important difference is that the Christian vision is about following a person, not an ideology. Truth is a person because Jesus said 'I am the way, the truth and the life.'[2]

When Jesus called his disciples he never said, 'Come, let's bring about justice' or 'Let's reduce the disease burden in Judaea and Samaria.' It was not about ideology or any activity. The call was simply to follow him. When he called Matthew he said, 'Follow me.' When he called Peter and Andrew he said 'Follow me and I will make you fishers of men.'[3] So the key question is: Does it make any practical difference in real life if you follow an ideology rather than a person?

Let's consider some examples from history to illustrate the difference between following an ideology and following a person. Maximillian Robespierre (1758-1794) was one of the best-known and most influential figures of the French Revolution. He was hard-working, had a great concern for the poor and early on was known as 'the incorruptible one'. He gave a lot of his resources to the poor, but he became a bloodthirsty dictator. Why? The reason is he was committed to an ideology and not to a person. When he encountered resistance to his ideology he became paranoid. He began implicating people without evidence and eventually even without a trial. Late in life he tried to make himself a god – the head of a new religious order. He became so incorrigible that they had to behead him.[4] This is not an isolated story. Most of the mass-murderers in history had great ideologies: Stalin, Mao Zedong and Pol Pot started out trying to help the poor, but ended up as disasters. The Christian understanding is that any idealism that transcends God is likely to be deadly.

The Christian contrast: following a person

In contrast we have the life of Ignatius Loyola (1491-1556). He lived in troubled times: the post-Reformation period in Europe. He was a soldier who, after being seriously wounded in the Battle of Pamplona (1521), was converted on his hospital

bed. His life was transformed and he founded the Society of Jesus, popularly known as the Jesuits. In the early days the Jesuits were hit by a scandal and people asked, 'What will you do if the Pope closes down the Society?' Ignatius replied, 'I'll pray for 15 minutes, then I'll forget about it.' His calling was to a person, not an ideology. He was a soldier but he had a lot of resources at his disposal. He could easily have challenged the Pope and made a lot of trouble, but he said, 'I am not about an ideology, I'm about a person.' Because of that approach the Society of Jesus ranks as one of the most enduring NGOs in history. So then, the Christian vision is about following a person; the secular vision is about following an ideology.

Another dimension for understanding this is to look more at the meaning of 'vision'. There are three kinds of vision. When your vision is merely about yourself, I call that narrative. When the world dictates your agenda, that is better than being self-centred – that is *metanarrative*. But again, that is not enough. The Christian vision is about *grand narrative*, allowing God himself to set the agenda. It's not about the metanarrative – what's needed in the world. It's about what God really wants you to do.

Understanding suffering

The other big difference concerns how we understand suffering. In the Jain religion, suffering is seen as punishment for past sins, either in this life or a former life. This doesn't help very much when you are suffering. The secular understanding is that suffering is meaningless. In his book *The Birth of Tragedy*, the German philosopher, cultural critic and poet Friedrich Nietzsche (1844-1910) wrote, 'What is best of all is beyond your reach. Not to be born, not to be, to be nothing.' He wrote this when terminally ill. He said human suffering is so great that it would be better not to be born; but he says that since you can't control suffering the next best thing is to die quickly. This sets the platform for euthanasia.
In contrast, the Christian understanding of suffering is that it's redemptive. It is neither a punishment nor meaningless. It has a positive connotation. The genius of God can use your suffering and redeem any situation. 'In all things God works for the good of those who love him'.[5] For Christians, God is with us in our suffering. Understanding this equips us for our work as doctors; it enables us to engage with the suffering we see in our patients. I know of no secular approach that can adequately address the problem of suffering.

Is it important that we accept suffering positively? Does it make a difference to real life? Elie Wiesel was a Jew who was interned in Auschwitz. All his relatives died there. He wrote a book, *Night*. There came a time in the camp when they celebrated Jewish New Year. Part of it was giving thanks to God. He wrote, '"Blessed be God's name" – Why? Why should I bless him? Every fibre in me rebelled because he caused thousands of children to burn in these mass graves, because he kept six crematoria working day and night including Sabbath and holy days.' We have the story of another person who suffered in a concentration camp, Corrie Ten Boom. She hid Jews in her home, was discovered and sent to a camp where her father, sister and nephew died. While Wiesel could not say, 'Blessed be your name', she says 'However deep the pit, God's love is deeper still.' She was one of the greatest evangelists of the 20th century.

So how can we suffer well? On this Nietzsche had a point. He wrote, 'He who has a "why" [a goal] can suffer well'. Christian Reger, another survivor of a concentration camp, was a pastor who spent four years in Dachau for preaching against the Nazi doctrine of euthanasia of the old and weak. He was betrayed by his church organist. Reger said if you know the 'who' in your life, you can survive any 'how'. So we want our patients to know a person so they can suffer well. We need to tell this world is that you need to be connected, and that is what health is all about.

Attitudes to knowledge

The next huge difference between the Christian and secular attitudes is attitudes to knowledge. Paul says knowledge puffs up but love edifies.[6] He says love never fails, but knowledge will cease.[7] A secular attitude is to use knowledge for power. In India we have Saraswati, the Hindu goddess of knowledge – students worship her before exams. In the early Christian centuries the Gnostic heretics believed in salvation through knowledge. So do the Hindus. One of the most challenging and controversial plays written in Elizabethan times is Christopher Marlowe's *Doctor Faustus* (1604). Faustus sells his soul to the devil in exchange for power and knowledge and brings disaster on himself. Paul says if you use knowledge for power it will puff you up. If you use knowledge as a service tool then you'll be edified. We use knowledge for service.

The Christian vision is about relevance, not just exotic things. Faith needs to be relevant to people's need. Dr Paul Brand of Vellore came to India during World War 2. He was asked to develop a department of orthopaedics, but he started to see the needs of lepers. Vellore was the leprosy capital of the world. There were a million lepers living in the area. He saw their clawed hands; he saw their poverty. He said 'I want to do something about this problem. If I can straighten hands lepers could do useful work.' He discovered that by doing a tendon transplant he could reverse clawing. Thousands of lives were transformed.

So, back to the original question: does being a Christian make a difference? It makes all the difference. There can be no marriage between the Christian and the secular vision. And there will always be a great chasm between the two.

Vinod Shah *is Chief Executive Officer of the International Christian Medical and Dental Association (ICMDA) based in Vellore, India. Based on the 2014 Rendle Short Lecture, 'The grand narrative of the Christian medical vision'.*


Vinod Shah delivering the Rendle Short lecture

For Christians, God is with us in our suffering. This understanding equips us to engage with suffering in our patients. I know of no secular approach that can adequately address the problem of suffering

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Helen Wordsworth
introduces an emerging enterprise offered through churches

PARISH NURSING

FILLING GAPS IN NHS CARE

key points

- The NHS has gradually relegated the spiritual dimension from its work.
- Local churches have growing opportunities to offer wholistic healthcare support alongside the NHS.
- About 80 churches are involved so far and many more opportunities exist.
- Churches offering parish nursing report significant benefits to their local mission.

Churches and monasteries were foundational in the development of hospitals and healthcare. Florence Nightingale, although known for the development of nursing, was a theologian and public health specialist. In the late nineteenth century, deaconesses had to be trained as nurses before they entered theological college.

Yet the place of the church in the NHS has diminished. Prayers are no longer part of the ward routine. Discussion of spiritual matters is limited to a referral to the chaplaincy team, who, thankfully, are still doing a much needed and demanding job. Once a patient is discharged however, the likelihood of continuing spiritual care decreases, especially for those who have no history of church involvement.

The secular world view in the West is influenced by the 'Enlightenment' and the separation of spiritual things from more measurable indicators of health. The focus in churches has been to offer healing prayer and practical support, but has sometimes excluded the promotion of healthy lifestyles along with faith.

The Kingdom of God comes with physical signs as well as spiritual ones: Jesus heals people physically and mentally, but also addresses their level of faith or their need for forgiveness or thankfulness. The mission of God to his world is outward, inclusive, wholistic, ongoing, and the church's task is to participate in it.[1]

How then may churches act?

Those involved in the NHS today are on the frontline of Kingdom activity and the local church should be recognising this and providing regular prayer support. In 80 local churches from all denominations across the UK, there is even greater involvement. From these, a health ministry is developing, emanating from biblical principles. It is led by a currently registered nurse, working to Nursing and Midwifery Council (NMC) guidelines and relating to other health providers, but employed or appointed by the church as part of its ministry team. This practice, which originated in its contemporary form as 'Parish Nursing' in the Lutheran church in Chicago in 1986, is now sometimes called 'Faith Community Nursing'.

It exists in at least 25 countries. Here, although Anglican and some other denominations have ecclesiastical parishes, the word 'parish' can mean a secular geographical administration. The care is rooted in Christian faith and provided through a local church or Christian trust. Since it needs to be accessible by all in a community, not just those that adhere to a church, the term 'parish nurse' is used.

Gaps parish nursing fills

Professor Ann Solari-Twadell offers a generic definition of parish nursing derived from her research in the US, Canada, Swaziland and the UK.

'The practice of parish nursing includes care that supports: physical and psychological functioning, protection against harm, the family as a unit, effective use of the healthcare system, the health of the congregation and community as well as facilitating lifestyle change with particular emphasis on coping assistance and spiritual care. All this is dependent upon the parish nurse being able to effectively mobilise volunteers in the congregation to support this model of health ministry.'[2]

Parish nurses seek to complement other health providers, and build good relationships with GPs. They may help to reduce hospital readmissions, support carers, show people how to make better use of the health service, signpost to other voluntary or statutory services, providing time, hospitality and a sense of belonging for people of all ages, all faiths and none.

They link with groups that use church buildings: parent-toddlers, asylum seekers, homeless people who sleep near the church buildings, the youth club, and the over-sixties groups. Through these they may promote health, reduce risk, encourage exercise and monitor weight gain or loss. They can follow up on someone who is not attending for treatment or who appears to be deteriorating; perhaps go with them to an appointment. They may offer prayer with or for them, or refer to an alternative source of spiritual care if they prefer. Confidentiality, documentation and the interest of the patient are all in line with the NMC code of practice.

How does it work?

The service that can be offered by the church varies according to the needs of the community; the hours available, competency and experience of the nurse, existence of other health professionals in the church who can support this ministry and the number of volunteers that come forward for training. Some parish nurses are mental health trained and will focus on helping people with addictions or dementia. Others are paediatric nurses and work with children and parents. Some spend more time with seniors, while those trained in cancer care may work principally with people undergoing treatment. All do some home visiting and most hold a clinic session, usually alongside another church activity like a community coffee shop.

All parish nurses are part-time and many still work for the rest of the week in the NHS. They access study days through the local practice or community health facilities, or through Parish Nursing Ministries UK (PNMUK). The hours they do for the church may count as NMC practice hours. The church is the 'employer', and provides line management, expenses, and pay, though most nurses offer voluntary time. Each nurse has a locally chosen spiritual mentor, and a professional mentor (who may in future assist with the new revalidation procedure). In addition both church and nurse have a regional coordinator provided by PNMUK. This, along with the initial training week, resources for practice and professional networking is paid for through church contributions to the national organisation.

How parish nurses relate to GPs

Some GP practices have chaplaincy services that offer spiritual care. Referral to a parish nurse can provide a link to the local church, where practical resources to help in times of crisis can be found, where volunteers can be trained and coordinated. Thus a patient can find hospitality, a sense of belonging and purpose in life, forgiveness and the strength to forgive, an opportunity to serve as well as to be served, someone to listen, someone to be friends with. This kind of care both supports the NHS and fulfils the mission of God.

One GP surgery in rural Cambridgeshire gave some feedback:

'We have very much appreciated the work of our parish nurse. She has become a source of comfort and support to some of our most vulnerable patients and her combination of care, competence and humanity have been of immense value to patients at some of the hardest times in their lives.'

Making a difference to the mission of the church

A study of how parish nursing enhances local mission was completed in 2011. Some 15 parish nurse churches were compared with 77 similar churches without a parish nurse. The range of missional interventions was increased in all four categories: spiritual, physical, mental and community health; more time was spent with people outside of the church; the number of volunteers trained and coordinated increased, and the profile of the church in the community was heightened. All 15 ministers agreed the mission of the church had been enhanced through parish nursing, and most of them strongly agreed. Case stories told of people who had come to faith, returned to faith, or prayed for the first time. Some were now involved in volunteering themselves.[3]

Our vision

PNMUK has a vision that eventually people in all parts of the UK will be able to access a parish nurse if they wish. There are 40,000 churches and around 60,000 currently registered Christian nurses, so maybe that's attainable, at least in the longer term. To do it we need supporters and advocates. We currently have just one part time PA and finance officer alongside a volunteer CEO. Regional coordinators work just a few hours each week, depending on how many projects they cover. If you are excited by our vision and would like to partner with us, please visit our website and register your interest: *www.parishnursing.org.uk*

Helen Wordsworth *is a Baptist minister with a nursing and community health background. She was a founder of Parish Nursing UK and is now its Chief Executive Officer.*

The mission of God to his world is outward, inclusive, wholistic, ongoing, and the churches' task is to participate in it

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Sarah Maidment recounts why her first hospital post proved so satisfying

LOOKING AFTER YOUR JUNIORS

key points

- A good induction sets a clear keynote.
- Taking supervision seriously is important.
- Give priority to teaching and learning.
- Imitate Christ.

Reaching the end of the first hospital post of my GP training, I realised this had been the most enjoyable six months of my career.

Reflecting on what had been so different about this post, I realised that the senior doctors in the department had gone out of their way to look after their juniors. Because we were happy in our jobs, we worked well as a team and supported each other. We enjoyed work and I am certain this led to better patient care.

Here are some thoughts, written during these months, reflecting on practical ways in which senior doctors can look after their juniors.

1. Recognise that things are different for juniors 'these days'

'I don't cope well with change. Having moved house five times in the three years since leaving medical school, I was not looking forward to upping sticks and moving yet again. This was going to be another big change: moving to a new area, a new house with a new housemate, starting a new job in a different specialty in a big hospital. Having spent a year trying to make friends, establish relationships and settle into church, I would have to start afresh, yet again. In addition, having done a year of Paediatrics, I faced the transition back to working in adult medicine. The pink cannulas looked monstrous, compared with the tiny yellow "neoflons" I had used all year. I was nervous.'

Since the restructuring of medical careers, juniors have had to move around far more frequently: between hospitals, deaneries, cities and different specialties; moving miles from family and friends to pursue their chosen specialties. This often means leaving behind a solid support network. It takes time to set down roots in a new place, make friends and settle into a new church family, especially whilst working unsocial hours.

Senior doctors frequently comment that juniors 'have it easy' these days. Whilst the European Working Time Directive has put an end to 72 hours on-call, juniors face different pressures: busier hospitals, more intense working, cross-covering other specialties, caring for many unfamiliar patients on a number of different wards, the fatigue of shift work and more defensive practice (to name but a few).

2. Ensure your team has had a proper induction

'It was an early start but thankfully I'd managed to arrange a couple of days off prior to starting this new job. (This is not always possible, with juniors sometimes being expected to work a late shift or night shift in one hospital trust and turn up for induction at 7:30am the following morning at a different hospital in a completely different region.)

'Some Trust inductions run over several days. This was an example of a well-organised induction process: run over one morning with short, sharp, focused sessions

on a wide range of topics. We spent the afternoon orientating ourselves on the ward, meeting key members of the team and receiving teaching in some of the basics of the specialty. Above all, we were made to feel welcome and we felt ready and well-equipped to start work the following day.'

Trust and departmental inductions have a reputation for being dull and long-winded. This model induction process helped to lay the ground rules, gave us confidence in our new roles and set us up for the weeks and months ahead.

3. Take clinical/educational supervisor roles seriously

'On our first day in the department, each junior doctor received a welcome letter, giving us details of our clinical supervisors and inviting us to arrange a "start of placement" meeting.

'My clinical supervisor was genuinely interested in finding out about me. He clearly knew how to navigate the ePortfolio system. Consequently, instead of sitting in front of a computer screen and ticking boxes, we discussed my CV and came up with realistic, manageable learning objectives for the six months I would spend in the department. Importantly, he appreciated that my learning needs as a GP trainee were different to those of the Core Medical Trainees, which allowed us to consider how I could make the most of my time in the department.

'At the end of the placement, we reviewed an audit project I had completed, discussing how change could be implemented in the department. He completed my assessments and provided constructive feedback.'

Seniors can stand out by taking supervision roles seriously, being proactive in arranging meetings, completing assessments in a timely fashion, showing enthusiasm, and providing encouragement, support and feedback.

4. Promote teaching and learning

'At the end of the first ward round, in which a learning point had been drawn from every patient we had seen, the consultant gave us a short tutorial on a core topic. His enthusiasm was infectious. Teaching was a priority in this department and attendance at formal teaching sessions was encouraged, with middle grades and consultants covering the workload when necessary.'

Could you look out for opportunities to teach, or share some wisdom, whilst on the ward or in clinics? We're really keen to learn…

5. Imitate Christ

'Therefore, as God's chosen people, holy and dearly loved, clothe yourselves with compassion, kindness, humility, gentleness and patience.'[1]

As Christians, we are called to imitate Christ in our lives, glorifying him in everything we do. This is challenging in an environment where stress levels run high, morale is low and cynicism is rife. But living out our faith, counter-culturally in the workplace, remaining positive, seeking to be salt and light – even in the smallest of ways – does not go unnoticed.

I have found it hugely encouraging to discover that another member of the team is a Christian, so do 'flag up' your faith.

Compassion

'Recognising I was not well one Monday morning, I was sent home from work. On my return, the consultant made a point of asking how I was doing and checking I was feeling better.'

Doctors are well known for their 'I'll be fine' attitude, but the reality is that we all become unwell from time to time. It is not uncommon for juniors to feel overlooked, overworked and anonymous. Learning the names of the junior doctors and looking out for their pastoral needs will pay off in the long-run and make for a healthy, happy team.

Kindness

'At the end of the ward round, the consultant would treat the juniors to coffee and buns in the cafe.'

Remember to thank your team. It may not be possible to sit down together for coffee on a regular basis but a simple, 'Thank you' at the end of a ward round – an acknowledgement for the hard work that so often goes unseen – will go a long way.

Humility

'Having been called away to a cardiac arrest, I returned to the ward to find my registrar rewriting a drug chart. Rather embarrassed (this shouldn't have been his job), I thanked him and set about the next task. "Lunch?" he asked. I explained I was too busy and would get some jobs out of the way first. "No. Come on. Those things can wait. We're off to the canteen and lunch is on me!"'

Gentleness and patience

Despite the changes that came with the European Working Time Directive, it is still possible to work in excess of 120 hours in one stretch without a day off.

'After the busy weekend of long days on-call, I would dread Monday morning: turning up on the ward exhausted and bleary-eyed, surrounded by fresh, rested chattering colleagues… Inevitably something would go wrong on the ward round. As much as I tried to be organised and have everything under control, I would forget a crucial blood result, drop the notes on the floor, or search for a missing drug chart.'

If your juniors are not quite so on the ball as usual, could it be that they have just finished a set of night shifts, worked the whole weekend on-call, or come to the end of a twelve day stretch at work? Please be patient and go gently with us!

And finally...

'Do everything without grumbling or arguing, so that you may become blameless and pure, "children of God without fault in a warped and crooked generation". Then you will shine among them like stars in the sky.'[2]

Sarah Maidment *is GP trainee in Oxford and a member of the CMF Junior Doctors' Committee.*

As Christians, we are called to imitate Christ in our lives, glorifying him in everything we do. This is challenging in an environment where stress levels run high, morale is low and cynicism is rife

references

1. Colossians 3:12
2. Philippians 2:14-15

Huw Morgan issues a timely challenge to doctors approaching retirement

RETHINKING RETIREMENT

Huw Morgan (pictured) in action.

key points

- Most doctors can look forward to two decades in retirement.
- These years can be fulfilling and there are many opportunities at home and abroad.
- There are almost unlimited opportunities for senior doctors to use their skills in resource-poor settings.

Rick Warren, best-selling author and pastor of Saddleback Church in Lake Forest, California, said recently that he is preparing for retirement, but he's not planning to spend it in 20 or more years of leisure. Explaining his perspective on retirement from a biblical context, he calls it a 'transition.'

'The Bible says that as long as your heart is beating God has a plan and purpose for your life… to grow personally, to get to know God, to serve others, and make the world a better place. In retirement, what we have to ask is "What's going to be the centre of my life?" because if you don't have a solid centre it's going to fall apart. Then we have to say, "Who are going to be my life companions; who will be my associates, my circle of influence; what is going to be the character of my life; how am I going to keep growing?"'[1]

These are all questions that we do well to ask as Christian doctors, if we are near 'retirement'. There is only one Bible passage that refers specifically to retirement. In these verses God tells Moses that the Levite priests in the Tent of Meeting must retire:

The Lord said to Moses, 'This applies to the Levites: Men twenty-five years old or more shall come to take part in the work at the Tent of Meeting, but at the age of fifty, they must retire from their regular service and work no longer. They may assist their brothers in performing their duties at the Tent of Meeting, but they themselves must not do the work.'[2]

Despite this specific context, the wisdom of God's message regarding the cessation of regular work is still helpful to us today. God created work, and our work is his divine calling, but there will come a point in our lives when we stop doing regular, full time paid work. The word 'work' in the Numbers passage is the same word used to describe mankind's daily labour in Genesis which declares, '*The Lord God took the man and put him in the Garden of Eden to work it and take care of it.*'[3] In the context of Genesis 2:15, the work is Adam's tilling of the ground in the Garden, and by extension all the various types of labour that will follow. It is these and all occupations (tilling the ground, serving in the Tent of Meeting, and the daily work of our own careers in medicine) from which we will one day retire.[4]

Of note is the fact that the retired Levites' *may assist their brothers in performing their duties.*' To 'assist' means to help, to guard, or to attend to others. To retire from regular work opens the door to new and different ways to serve God and others.

As a retiree you can assist, help, guard, and attend to the next generation. This may include your family members, neighbours, society in general and the wider global community. For Christian doctors, it surely includes continuing to mentor, support and help our younger colleagues in their journeys of faith and service in medical practice.

Transition and choices

Perhaps the major choice that faces Christian doctors transitioning from paid work to retirement is the issue of whether to carry on, albeit in a reduced capacity, in a similar field to that which we were engaged in before retirement, or to branch out in a completely new (perhaps non-medical) direction. Our education and experience has equipped us with many transferable skills in leadership and problem solving (and perhaps communication skills and teaching) that can be put to good use in many areas of voluntary work. If we have spent significant time working in the NHS, the current generation of retirees also have generous pensions that preclude the need to find further paid work (unfortunately future generations will not fare so well).

Continuing with part time medical work requires remaining in the appraisal-revalidation system, which may prove difficult if we work in a much reduced capacity or in a non-clinical setting, but with some effort this issue can generally be overcome.

Planning and assessing options

It is wise to plan ahead prayerfully prior to actually leaving full-time paid work, rather than waiting until that time arrives before deciding what to do. Many people (particularly those who've been full time in the NHS up to their last working day) will want to have a complete break for a while after stopping work, perhaps to travel, spend time with family or just to relax and unwind. There is nothing wrong with this and it can prove a helpful way of marking the transition from paid work to the next phase of one's life. So what then? For Christian doctors there are a number of possible options to consider. The ones below are just some examples.

1. Working in resource poor countries

There are always opportunities for senior doctors to use their skills (in management, teaching and leadership, if not in clinical practice) in resource-poor settings in developing countries. The CMF International website [5] is a good place to look for openings, from a few months to several years in duration. If you are already an medical educator, PRIME is always on the lookout for those willing to make recurrent short (1-3 week) trips to teach, and sometimes has longer term opportunities for medical teachers in mission contexts. [6] Retired doctors make up a substantial number of PRIME's tutor database, and many have contributed very significantly to the development and delivery of teaching and training programmes across the world, embedding Christian values and a spiritual perspective in medical curricula and practice in many places.

2. Pastoral counselling

Many Christian doctors have developed skills in listening and pastoral support through their years in practice, and some in retirement move more into this area, perhaps doing further specific training. The whole area of counselling is now tightly regulated and requires appropriate training and supervision which involves substantial investment of time, but there are other types of pastoral support (whether through churches, para-church organisations or secular agencies) which retired doctors may be able to offer voluntarily without undertaking very lengthy further training. Simply being available as a mentor and listening ear to younger colleagues (such as through the CMF Links scheme [7]) is a valuable service, very much in line with the biblical mandate described above.

3. International Poverty and Justice

We live in a world where at least 80% of humanity lives on less than $10 a day, and the poorest 40 percent of the world's population accounts for 5 percent of global income whilst the richest 20 percent accounts for three-quarters of world income, and where climate change is disproportionately affecting the poorest. [8] Christians need to be working actively to try and end international trade injustice and exploitation of the poor world by the rich. Retired Christian doctors have the intellectual capacity and other skills necessary to play an active voluntary role in working, speaking and campaigning to end the disparity between rich and poor and the many injustices and environmental problems that sustain and flow from it. There are many organisations both Christian and secular who will welcome competent volunteers to assist their work in seeking to 'make poverty history'. [9]

4. Hospitality and using your home

The energy and time released by the cessation of paid work may free us up to use our homes more in offering hospitality and support, not just to family and friends but to others in need. For example, some retired Christian doctors have developed specific ministries of informal support to missionaries in need of rest and recuperation, by offering use of their homes and an impartial listening ear.

The list could go on. Whatever form the assistance and help we offer to others in our latter years takes is between us and God. But we should take care to remain active, bless others, share and give. As the Psalmist prayed, 'Even when I am old and grey, do not forsake me, my God, till I declare your power to the next generation, your mighty acts to all who are to come.' (Psalm 71:18)

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

The major choice facing Christian doctors transitioning to retirement is whether to carry on in a similar field or to branch out in a completely new direction

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7. *www.cmf.org.uk/links*
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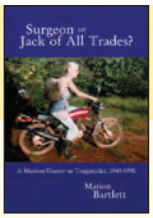


Surgeon or Jack of All Trades?

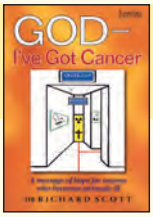
A Mission Doctor in Tanganyika 1949-1990
Marion Bartlett MB, FCRCS

- Self published, 2013, £22.00, Pb 354pp, ISBN 9781909075139
Available from Timothy Fox, 40 Lakebar Avenue, Lancaster LA2 7JN
- Reviewed by **John Martin**, CMF Head of Communications

Marion Bartlett's chronicle of life as a pioneering surgeon is a useful contribution to the social and spiritual history of Tanzania, and an inspiring story of self-sacrifice driven by unswerving, rock-like faith. Missionary autobiographies are unfashionable among commercial publishers, so self-publishing is almost the norm for this genre. Occasional repetitions point to lack of a seasoned editorial hand, but an enjoyable read loses little as a result. Daughter of evangelical CMS missionaries in China, Marion sensed a vivid call to mission aged just four. She initially looked to CMS, spent time at its training college but withdrew and found a spiritual home in high Anglicanism. She found an opening for her skills with the Universities Mission to Central Africa (later merged to become USPG).

The narrative details ten years preparation: war years at the Royal Free, then various UK posts as the author gleaned needed experience for all-round surgical work. Her four decades in Africa are marked with an ever-present determination to maintain standards and in the great UMCA tradition prioritises training for Africans. Her crowning achievement is the 300-bed Teule Muheza Hospital (with CMF members Richard and Heather Scott getting a mention). In her mature years Marion finds a marriage partner and with Canon David Bartlett forms a formidable training team in God's service.

I'm glad Dr Bartlett, now in her 90s, has recorded her story for posterity.



God – I've got cancer

A message of hope for anyone who becomes seriously ill
Dr Richard Scott

- TerraNova Publications, 2013, £9.00, Pb 192pp,
ISBN 9780957047365
- Reviewed by **Liz Croton**, a GP from Birmingham

The back story underpinning this book is Dr Scott's own experience of being diagnosed with rectal cancer in 2011 and his subsequent surgery, chemotherapy and radiotherapy. This book is written for cancer patients and their families, both believers and non-believers. It offers a powerful message of hope that there is something bigger which we can turn to and rely on if the 'Big C' strikes.

To echo one of the reviews on the back cover, Dr Scott is writing from a unique position as someone who has professional and personal knowledge of cancer coupled with a saving faith. There is a rigorous literature review of the many benefits of faith in facing illness and the chapters mirror some of the tumult of emotions that one must go through when diagnosed with cancer ('It can't be true'; 'Who will pray for me?'). The difficult question of healing is raised – why does God heal some when others do not survive?

This is a buoyant, encouraging read backed up by expository Bible teaching and personal testimony, which ultimately glorifies God, who is the creator and sustainer of all things.

Guinea Pig for Breakfast

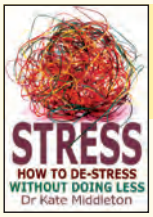
A Rich Tapestry of Tragedy, Hope and Love in Ecuador
Andrea Gardiner

- Grosvenor House, 2012, £8.99, Pb 305pp, ISBN 9781781485804
- Reviewed by **Huw Morgan**, retired GP and medical missionary

This is the story of a young British Christian GP who set up a village clinic and child sponsorship scheme in Ecuador, following a visit there as a teenager when she was moved by the poverty and lack of access to medical facilities of many rural people. She describes first hand her struggles with the local bureaucracy, with cultural adjustment, loneliness and coping with life in a very different climate.

Anyone who has worked in a primary care setting in a resource-poor country will identify with the daily pressure to prescribe antibiotics and vitamin injections inappropriately, as well as the requests to give false sickness certificates. The author is honest about her struggles, questions and failings, and her patient stories clearly illustrate the suffering resulting from poverty and injustice.

The book is written almost as extracts from a daily diary, and this reviewer found himself asking many questions that are never answered (Was she with a mission agency? Did she have any cross-cultural briefing prior to going? What was her relationship with the local church?). However it is an easy to read and moving account which would be helpful for any doctor planning to work in rural South America, and the author's faith and compassion shine through.



Stress

How to de-stress without doing less
Dr Kate Middleton

- Lion Books, 2009, £7.99 Pb 192pp, ISBN 9780745953731
- Reviewed by **Paul Vincent**, General Practitioner

This title intrigued me. The usual solution to stress is: do less, delegate, prioritise and learn to say no. Middleton acknowledges the need to step back, but part of the solution is to do more: eg keep an anxiety diary. I am sceptical that this is possible in an acute phase of stress, and it isn't clear whether such tools were for prevention, recovery or analysis, nor whether they are solo activities or require a therapist. The first section describes backgrounds to stress; its accessible style is suitable for lay readership. However, despite occasional reference to literature, opinion tends to be stated as fact and Middleton makes no distinction between stress and its causes. Anxiety and stress seem to be used synonymously. This imprecision is unwise since the lay understanding of stress is variable, and there are multiple types of anxiety.

The second section is better. Middleton helpfully analyses personality types in relation to stress, and makes a good case for the effect of childhood experiences. The chapter on 'emotional kindling' offers a helpful description of adverse thinking patterns. This part was for me was the strongest and most interesting part of the book.

Does the book do what it says on the cover? Although a reasonable introduction it is best not considered as a self-help guide since the recommended exercises are only briefly sketched out.

What happens when I die?

And other questions about heaven, hell and the life to come
Marcus Nodder

- Good Book Company, 2013, £3.99, Pb 96pp, ISBN 9781908762337
- Reviewed by **Julian Churcher**, CMF London Staffworker

Take a complex and emotive subject that eludes description except by analogy and simile, and lies beyond shared human experience. Let it be one that so affects every person that the firm convictions of Christians are liable to cause offence in those looking to take it. Now write a short, engaging and helpful book on it. That is what the author – senior pastor of a water-borne London church – has bravely attempted.

This title – in the series 'Questions Christians ask' – is aimed at sustaining and encouraging the believer in their future hope, and challenging the seeker. Hell is briefly alluded to, and the author addresses sensitively the concerns of the bereaved. Practical related questions such as 'Are ghosts for real?' and 'Cremation or burial?' are addressed in turn at the end of each chapter, and plentiful quotes from diverse sources make the whole very readable.

The promise of a renewed physical creation is described, correcting any caricatured 'clouds and harps' preconceptions. The historicity and ramifications of Jesus' resurrection are central.

There is a right emphasis on the need to focus on our future hope to sustain us, but I would have welcomed more on the Holy Spirit's ministry as the 'deposit guaranteeing our inheritance' without whom this would be a losing battle of imaginative effort. Overall this is a useful primer, especially suitable for new believers.

On Eagles' Wings

Models in mentoring
David Cranston

- Regnum Books International, 2014, £9.99, Pb 105pp, ISBN 9781908355461
- Review by **Chris Lavy**, Consultant Orthopaedic Surgeon

Failing his finals at the end of medical school was, in retrospect, God's opportunity for David Cranston to live with and be mentored by Dr Monty Barker in Bristol, and to spend time at Trinity Theological College with Dr Jim Packer and Rev Alec Motyer. Writing with forty years of reflection he says the rewards of that period and the influence on his Christian life of those mentors were profound.

In the NHS we talk a lot about mentorship. In my Trust we look at the best ways of transferring knowledge and experience from senior surgeons to trainees and new consultants. A large part of this comes in the close relationship of mentoring. Like David Cranston, many of us can point to great men and women whose influence and mentoring has shaped us. In this short book David gives his understanding of mentoring, using examples from history, royalty, the Bible, and his own life. These are woven throughout the book and illustrate God's mentorship of him during his life as a surgeon and a Christian. The book is full of quotations. One of my favourites is spoken by the Queen Mother mentoring the newly crowned Elizabeth II. At lunch when the young queen is offered a second glass of wine her mother says: 'Are you sure you should have another my dear? Remember you have to reign this afternoon'.

Beyond Human?

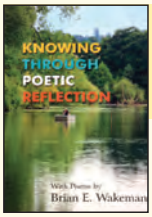
Science and the Changing Face of Humanity
John Bryant

- Lion Hudson, 2013, £9.99, Pb 253pp, ISBN 9780745953960
- Reviewed by **Peter May**, retired General Practitioner

The author is Professor Emeritus of Cell and Molecular Biology at the University of Exeter. He is also an accomplished writer. His detailed research interests have not narrowed his vision or his wide interests in contemporary affairs. He opens this book with three chapters scanning the history of humanity. I suspect that younger readers, who learned little history at school, will find these chapters particularly informative. This overview sets the context for evaluating the benefits and challenges of medical science today.

A short chapter on moral philosophy leads into a longer review of genetics and human disease. Having always found grasping the complexity of genetics something of an uphill struggle, this treatment was for me informative, clear and readable. Written with the layman in mind, the book is an excellent primer for medical students, and its detailed index makes it a valuable reference work for professionals of various sorts, who find it difficult to keep up with these current and challenging developments.

The big question is whether they are transforming humanity. The interface of biology with technology is fascinating and Bryant offers shrewd comments on media speculations and moral values. For me, this book became all the more rewarding as it progressed.



Knowing through poetic reflection

Brian Wakeman

- Penn Press, 2013, £7.99, Pb 280pp, ISBN 9781780036175
- Reviewed by **John Martin**, CMF Head of Communications

Quite a few books of poems cross the *Triple Helix* editor's desk. Most are simply random collections. Here is something different, a poet who supplies notes alongside his offerings, to assist preachers and speakers to use the poems to inform and educate as well as to entertain. There are questions for reflection at the end of each chapter and substantial references and bibliographies. In the final chapters the author shares his methodology for deriving teaching from poems. Useful stuff indeed for speakers/preachers looking for models that will help them use poetry.

The author, who has links with Oxford Centre for Mission Studies, makes a serious case for rehabilitating poetry as tool for teaching. The art of using poetry for mission and communication of the faith is somewhat lost in our times.

Another cogent factor that makes this volume credible is the quality of the poems themselves. I love, for example, the author's tongue in cheek take on The Capable Woman (Proverbs 31). She is energetic, capable, a completer-finisher, relational, gives time to her offspring, holding down a demanding job. The sting in the tail, however, is that as she climbs exhausted between the sheets at the end of the day, she remembers: she's forgotten her quiet time.

eutychus

Still clueless about AIDS

Many British people remain 'clueless' about HIV and public knowledge has not kept pace with medical research. New data published on the 30th anniversary of the identification of the virus says many are unaware of preventative measures such as post-exposure prophylaxis (PEP), and that ignorance fuels reluctance to get tested. Major defaulters are the 18-24 age range. Currently 98,400 British people have HIV. Of these 21,900 (nearly a quarter) are unaware of being infected. New cases among men who have sex with men hit a record high of 3,250 in 2012. (Report, National AIDS Trust, 23 April 2014 *bit.ly/1hnEVov*)

Religious music helps

We know King Saul's 'downers' lifted when listening to David's harp. Now The Gerontologist reports that for older Christians, religious music has a plethora of positive effects: decrease in anxiety about death; increases in life satisfaction, self-esteem, and sense of control over their lives. Gospel music particularly is singled out for its positive benefits. Benefits moreover know no cultural barriers: associations are similar whether black or white, male or female, and individuals of both low- and high-socioeconomic groups. (Gerontological Society of America, 18 April 2014 *bit.ly/1j6DcEq*)

Smart drugs 'no magic pill'

The cover story of the Spring issue of *Triple Helix* (2013) drew attention to the hazards of 'smart drugs'. A new report says their use continues to grow among students, and this is a concern say government health advisers. Side effects can include psychiatric symptoms, prolonged anxiety and digestive problems. Smart drugs are often bought online on sites hosted outside the UK. Andrea Petroczi, a professor of Public Health at Kingston University, says there is little evidence that suggests taking them actually makes people more clever. 'It's not a magic pill,' she said. (BBC Newsbeat, 8 May 2014 *bbc.in/1s5OAWx*)

NI: no free abortions on NHS

The High Court in London has ruled women from Northern Ireland are not legally entitled to free abortions funded by the NHS in England. More than 1,000 women each year travel from NI to have abortions in UK. This case was brought by a 15-year-old girl and her mother who live in Northern Ireland. Unlike the rest of the UK, abortion is only allowed in very restricted circumstances in Northern Ireland. As things stand people who do travel must pay for their transport, accommodation and the cost of the procedure. (BBC NI, 8 May 2014 *bbc.in/1kQjQF8*)

Polio spread hits emergency levels

The spread of polio is an international public health emergency, the WHO has declared. Outbreaks in Asia, Africa and Middle East are an 'extraordinary event' and require a co-ordinated international response, it says. Pakistan, Cameroon and Syria pose the greatest risk and the WHO recommends citizens of affected countries travelling abroad should carry a vaccination certificate. There were 417 recorded cases of polio worldwide for the whole of 2013. For 2014, there were already 68 cases by 30 April – up from 24 in the same period last year. (WHO Media Newsletter, May 2014 *bit.ly/1nl5Rxe*)

Heath app explosion

There are thousands of health apps, claiming to do anything from curing phobias, tracking symptoms and measuring heart rates. Can they be trusted? In 2013, the NHS launched a Health Apps Library, a 'one-stop shop' for trustworthy apps. Some 200 apps are registered and come with expert assessment and approval. Charles Lowe, president of the RSM's telemedicine and e-health section, says: 'My vision is that in two or three years' time, a GP will diagnose depression in a patient and say, "Here is an app which can help you".' (BBC Health, 4 May *bbc.in/1o1ypw0*)

Concern about care for dying

An audit by the Royal College of Physicians (RCP) has expressed concern about care of dying people in English hospitals. 500,000 people die in England each year, half of them in hospital; standards of care are patchy. The audit found only a fifth of hospitals provided specialist end of life care seven days a week, a decade after this was recommended. Just 45% of patients had been assessed to see if they needed artificial nutrition and 59% for hydration. Mandatory training in care of dying for doctors was only required in 19% of trusts. (RCP press release, 14 May 2014 *bit.ly/1nMZO4O*)

Crisis in healthcare for Syrian refugees

Syrian refugees in Lebanon are unable to access crucial medical care because of a shortfall in international support, says Amnesty International. The agency says the situation is so desperate that in some cases refugees have resorted to returning to Syria to receive the treatment they need. The report, *Agonizing Choices: Syrian refugees in need of health care in Lebanon*, identifies serious gaps in the level of medical services available to refugees. In some cases Syrian refugees, including those requiring emergency treatment, have been turned away from hospitals. (Amnesty International, 21 May 2014 *bit.ly/1jqhIYb*)

Beware Wikipedia

A US-based study claims that online encyclopaedia Wikipedia – the world's sixth most popular website – contains errors in nine out of ten of its health entries. The study compared entries about conditions such as heart disease, lung cancer, depression and diabetes with peer-reviewed medical research. Wikipedia is a charity and has 30 million articles in 285 languages. It can be edited by anybody, but many volunteers from the medical profession check the pages for inaccuracies, said Wikimedia UK. But the open-access nature Wikipedia 'raised concern' among doctors about reliability. (Headlines and Local News, 27 May 2014 *bit.ly/1kn9Wz1*)

Why the UK child death rate is high

Britain can rightly claim one of the most advanced health systems in the world, but it has one of the worst child mortality rates in Western Europe. Why? Research by the Royal College of Paediatrics and Child Health indicates that many deaths in under-fives are due to risky behaviours, such as smoking, during pregnancy. This, it observes, is more common among women who are socially disadvantaged. The research shows that drinking during pregnancy is another key risk factor. So too, it says, is babies inhaling second-hand smoke and patterns of unsafe sleeping. (RCPCH, Why Children Die, 2 May 2014 *bit.ly/1np8zhS*)

THE DAY I MET JESUS

I met Jesus the other day. He was lying in a sleeping bag on the bench outside the church hall, his boots under the bench. Paul was his name – from Cardiff – his only family a sister in Australia. Ex-army – Welsh Guards – fought in the Falklands war. 50 years old now, he told me, so he must have been just a lad then – shattering experiences.

'Foxes have holes; the birds of the air have nests, but the Son of Man has nowhere to lay his head', quoted Paul – ('Yes, I used to go to Sunday school as a kid in South Wales'). Been on the road eleven years. 'Ever go to a hostel?' I ask. 'No thanks; can't stand being shut in'.

'What's the longest psalm?' asks Paul. 'Psalm 119', I tell him.

'And the shortest?' – 'Psalm 117', I reply. 'Good man!' he says.

'And Psalm 23?' I quote the opening verses and he gives me a big (slightly beery) bear hug.

'There was another Paul' says I, 'met Jesus on the road'.

'Yes' replies this Paul, 'and He's with me all the days...

I'm going to Lymington; can you give me the train fare?'

'Sure' I reply, 'but don't spend it all on beer'. He smiles a slightly shame-faced smile.

'You won't see me again', he says, 'but you'll see me 'up there!'... another bear hug.

'Yes, brother Paul. God loves you. God doesn't look on the outside; He looks on the heart. We'll meet again'.

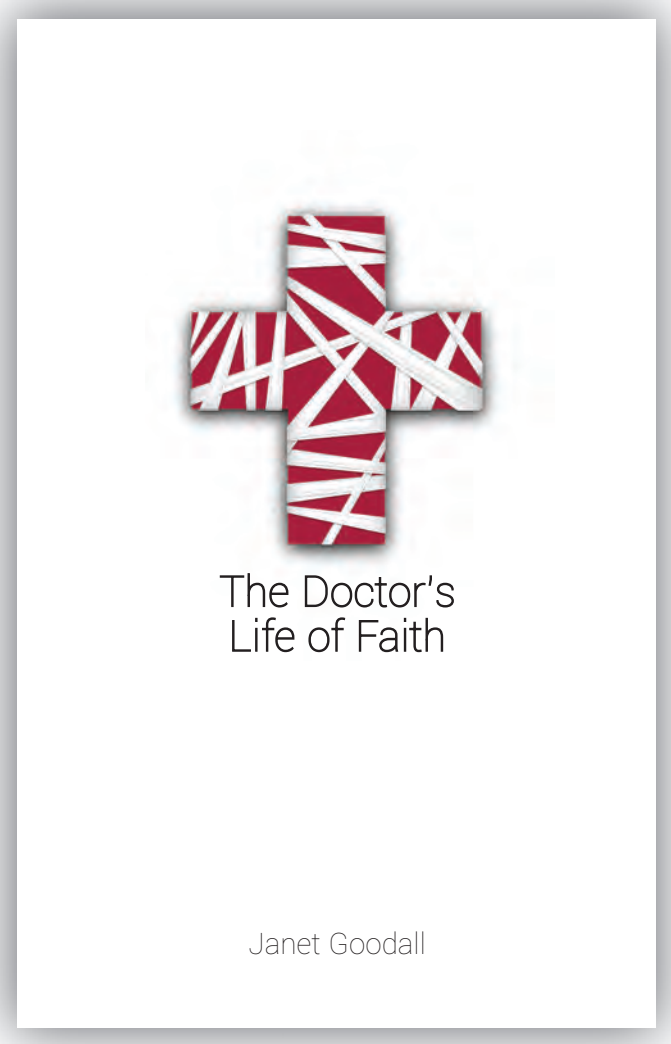
So Paul stuffs his sleeping bag into his pack, humps it onto one shoulder and moves off – for Lymington? For where? For the Father's home.

Paul will probably never know how much he meant to me. He gave God's grace to me. 'Truly I say to you, as you did it to one of the least of these my brothers, you did it to me'.

Yes, I met Jesus this morning. I'm so glad I stopped to talk with him.

Anonymous

New from CMF



The Doctor's Life of Faith

Janet Goodall

'Am I what I wanted to be?' 'Am I on the right track?' 'What's life all about anyway?'

When life is hard or our plans run into the ground, these questions quickly arise. But perhaps these are the wrong questions. We should be asking, 'Am I the sort of person *God* intended me to be?' 'What is God's intention for my life?'

The Doctor's Life of Faith opens up the Bible's story to reveal not only God's plan for your life, but his eternal master plan for his people. At the heart of God's plan for the world is his intention of making sinful men and women more and more like Jesus.