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for today's Christian doctor

triple helix

Nepal's agony

Christian doctors in action

Also: after the sexual revolution; prayer, personality and temperament; fellowship in suffering; problem solving in the NHS

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contents

The NHS at a crossroads

Crisis equals threat plus opportunity

The NHS is at a crossroads. Simon Stevens, NHS England's Chief Executive, says we need a new plan based on a 'triple integration': primary and specialist services; physical and mental health; healthcare and social care.[1]

The Five Year Forward View,[2] launched last October, is a collaboration between six leading NHS groups including Monitor, Health Education England, the NHS Trust Development Authority, Public Health England, the Care Quality Commission and NHS England.

But achieving this integration against shrinking budgets in real terms will be almost impossible. Financial pressures are powerfully squeezing the ability of the NHS to deliver. The Nuffield Trust has shown that because of population growth, ageing and cost increases, by 2020–21 the NHS will require some £30 billion (25%) more than it is getting now just to maintain services at their present level.[3] But while real average NHS spending has increased by at least 3% per year since 1951, this has fallen to 0.75% per year since 2010. The major driver of this fall has been the UK's national debt.[4]

Britain's new government will need to contend with a public sector net debt that has risen from £697.5 billion (or 47% of National GDP) on 1 January 2009 to £1468.5 billion (79.6% of GDP) by February 2015. This national debt matters. It must be serviced with regular interest payments, diverting money from frontline public services.

Even at rock-bottom interest rates, the Government will spend almost half as much on interest in 2014/2015 as on the NHS (£52 billion[5] *cf* £113 billion[6]). As the national debt escalates, courtesy of £100 billion+ annual deficits, and interest rates inevitably rise, we may end up spending more on government debt than on health.

This will result inevitably in a growing gap between need and supply. But there will be a huge opportunity in the next five years for charities, corporates and communities to provide health and social care services both in the community and through healthcare institutions.

Might this be a gap that the church could help fill? Over the last few years we have seen an explosion of compassionate Christian initiatives seeded through churches but professionally delivered: foodbanks, debt counselling, crisis pregnancy centres, drug and alcohol rehabilitation, street pastoring. Is this the dawn of new opportunities in healthcare provision where Christian doctors might play a leading role?

Britain's glorious Christian history has had a profound influence in shaping our language, culture, laws and institutions. Christian involvement in healthcare has a long pedigree in the UK and elsewhere, stretching back to the monastic hospitals of the medieval period. Many major hospitals which provided the foundations for the NHS were originally set up by Christians. Just in London there are St Bartholomew's, St Thomas', St Mary's and St George's. Similarly many of the country's leading medical schools began with Christian initiatives.

But anyone observing events in Britain today would be clear that we are living in a post-Christian society and working in a post-Christian health service. The mountains of our culture – those institutions which shape its cultural trajectory – parliament, the judiciary, the universities, schools, media and entertainment – are now increasingly occupied by people who hold to an atheistic worldview and the values of secular humanism.

I believe the 2006 analysis *Breakdown Britain*[7] accurately attributed our country's cultural decline to the 'five pathways to poverty': family breakdown, educational failure, economic dependence, indebtedness, and addiction. These cost us £102 billion per annum. But this breakdown of Britain and its five 'drivers' are merely symptoms of a more general spiritual malaise – a loss of Christian faith and values – of Christian belief and behaviour. What is missing is the sense of accountability, responsibility, human dignity and empathy that has its roots in a Christian worldview.

The real problem with Britain is that, like a dying rose, it has been severed from the very roots which were responsible for its, now fading, bloom. Christian values cannot be manufactured. They issue from Spirit-filled lives. The sweeping political and social reforms witnessed in nineteenth century Britain and culminating in the welfare state in the twentieth century, started with Christian revival in the eighteenth century.

Britain's Christian values were revived in the sixteenth century by the Reformation, and by the seventeenth century Puritanism that drove the Pilgrim fathers and the non-conformist movement. This continued in the eighteenth century evangelical revival under Wesley and Whitefield (and parallel Great Awakening in America). This led both to the nineteenth century social reform catalysed by the likes of Wilberforce and the Clapham Sect and also to the world missionary movement, beginning with Carey in 1793, which profoundly shaped the Christian culture of the British Empire.

Is it time for the church once again to step into the gap? Can we grasp this opportunity? Can we pray for a new move of God's Spirit amongst his people? Is Jesus calling us again both to preach and to heal?[8]

Peter Saunders *is CMF Chief Executive.*

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news reviews

Plans for 'seven-day' NHS

Where will the money come from?

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

In May, the Government announced a move towards a fully seven days a week service in hospital and primary care.[1] This proposal sounds good in theory. Running GP surgeries seven days a week would increase equity of access and reduce pressure on overstretched A&E departments. Meanwhile mortality rates for patients admitted to hospital at the weekends can be up to 16% higher than those admitted on weekdays,[2] so running the same standards of staffing and services at weekends also sounds sensible. The major problem is cost. It will require more staff, paid at higher rates for working unsocial hours, the running and maintenance of complicated medical equipment, heating and lighting. However, with the NHS needing another £30 billion a year by 2020 just to maintain services,[3] where is the extra money going to come from?

The second issue is staff. Initially we could recruit nurses from overseas, but we are not going so readily to recruit more consultants and GPs. The current intake of GP trainees is running at 70% of capacity – and the gap widens year on year. Newly qualified doctors are put off becoming GPs as they see all the non-medical work and stress it now entails.[4] Yet to reach the Government's target of 5,000 new GPs, half of all medical graduates would have to train in family medicine.[5]

Many nurses, living with long term wage freezes and possible cuts to overtime pay, are getting weary and angry enough to consider industrial action.[6] Others are leaving the profession; projections suggest a decline in the nursing workforce of 0.6 to 11% between 2011 and 2016.[7]

The general election campaign showed that none of the parties were addressing the critical challenges facing the NHS. Staffing and funding are just two of many issues, including an ageing population with growing expectations, increasingly costly medical technologies, and a rise in chronic diseases often brought on by poor lifestyle choices. The NHS was founded in the forties to address very different needs. We need a major rethink of what kind of health service we now need, and how we fill the gaps left behind.

The church could be a key part of addressing some of these gaps. Much of the psychosocial support now given by GPs is what local minsters undertook in the past. Churches already promote health through clubs for the elderly, parent and toddler groups and Parish Nurses.[8] Can the church reengage in other areas of primary healthcare, as it has done so successfully with debt counselling, food banks and street pastors over the last few years? Maybe it's time for church and state to rethink our roles?

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Assisted suicide bills

One down, one to go

Review by **Peter Saunders**
CMF Chief Executive

One assisted suicide bill has been defeated and another resurrected in six weeks of roller coaster activity in British parliaments, keeping the debate very much alive. Patrick Harvie's Assisted Suicide (Scotland) Bill[1] was defeated by 82 votes to 36 in the Scottish Parliament on 27 May.[2]

Harvie proposed an 'Oregon-type system' with trained 'licensed facilitators' but with a wide scope for mentally competent adults (>16) with a 'terminal or life-shortening illness' or a 'progressive and terminal or life-shortening condition'. The bill was heavily criticised for its relativistic definitions, poor reporting provisions, minimal penalties, a 'saving' clause protecting doctors acting in 'good faith', no specification of 'means' of suicide and the absence of a conscience clause.

Scottish First Minister Nicola Sturgeon had already signalled that she would not support the bill.[3] In addition over 15,000 Scottish people had signed a petition[4] against it.

After winning the Private Members' ballot, Labour MP Rob Marris has resurrected Lord Falconer's Assisted Dying Bill in the House of Commons.[5] His bill should come forward for a second reading debate on Friday 11 September. Marris's bill, essentially identical to Falconer's, would allow assisted suicide, for mentally competent adults (>18) deemed to have less than six months to live, subject to a series of 'safeguards' including a final decision by a High Court judge.

Elsewhere in the UK, elected representatives have repeatedly refused to consider a law which would undermine the position of disabled, elderly, sick and vulnerable people in society. In December 2014, members of the Welsh Assembly rejected a motion in support of Lord Falconer's bill by 21–12.[6] And in February 2015, members of the House of Keys (lower chamber of the Isle of Man's Tynwald) declined to consider an assisted suicide bill by 17–5.[7]

In spite of wavering public opinion the legalisation of assisted suicide is opposed by those who would be most affected, not least disabled people and healthcare professionals, on the grounds that such laws steer vulnerable people who perceive themselves to be a burden toward suicide. Such a change in the law is unethical, unnecessary and uncontrollable.

For Christians the matter is even simpler – all human beings are created by God in his own image,[8] and it is written 'thou shalt not kill'.[9] The current law is clear and right and our priority should be care, not killing.

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Fears grow over HPV vaccine

How safe is it?

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

Recent reports[1] have added to an evolving story of inadequate research into the HPV vaccine that almost every teenage girl in the UK has been given since 2008.[2] Apparently, thousands have endured various debilitating illnesses after receiving the routine injection. Interestingly, Japan stopped recommending this vaccine in 2013 because of side effects. Concerns have also been expressed recently in Australia.[3]

This issue presents a dilemma. Vaccination always involves balancing risks and benefits. Risks from mass vaccination of young girls must be weighed against the increasing incidence of cervical cancer, which claims thousands of lives worldwide. A vaccine that helps prevent this is to be welcomed. To deny it could be foolish, and potentially very harmful to many young girls at risk.

But there is still little long-term research on the effects of the vaccine. One study stated in 2008, when the vaccination programme started in the UK: '*There were definitely promising results…but more long-term studies were called for before large-scale vaccination programmes could be recommended*'.[4]

A BMJ case study on ovarian failure in a teenager led to concerns about compromised research on vaccine safety.[5] These included: underrepresentation of the target age group, incomplete and short-term follow-up, and non-reporting of new medical conditions after seven months. This all: '*…compromised safety studies' observation of ovarian health.*'[6]

30% of cervical cancer can still occur in vaccinated individuals. This means screening is necessary for sexually active women. So is there any advantage over routine screening? Could it increase risk taking amongst adolescents who consider themselves protected, especially since the primary cause is downplayed (that girls are only at risk once they become sexually active)? Will vaccinated girls be less likely to pursue vital screening?

I am not against the vaccine *per se*. But I am concerned about inadequate research on safety, unreported side effects, lack of information about risks and young girls making decisions at an impressionable age. This, together, undermines principles of informed consent. Importantly, the context in which the vaccine is promoted fails to advocate any preventative approach, namely sexual abstinence and faithfulness. While I support its use for those at high risk, should it be imposed on all girls (which it effectively is), particularly when regular screening could prevent 90% of malignancies?[7] Christians have a responsibility to promote premarital abstinence and marital faithfulness. Parents will have to weigh up the issues carefully, in discussion with their daughters, to decide whether they should be vaccinated, to protect them from their or indeed others' sexual immorality.

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DNA editing

A case still to be made

Review by **Peter Saunders**
CMF Chief Executive

Manipulating the human germline has been off-limits for decades but new technology has brought it one step closer. A new tool called Crispr enables scientists to 'edit' the genome by adding or deleting DNA sequences.

In response to a growing interest in the field, two leading science journals issued statements aimed at curbing the practice. In *Nature*, Edward Lanphier, a leading figure in Crispr-related research, called for a voluntary moratorium on modifying the genome of eggs, sperm or embryos, saying that germline therapy 'could start us down a path towards non-therapeutic genetic enhancement'. A similar statement in *Science* by experts in Crispr urged that germline modification be 'strongly discouraged', 'even in those countries with lax jurisdictions'. These cautions echoed UNESCO's statement that germline interventions 'could be contrary to human dignity'.[1]

However one month later Chinese scientists announced that they had used Crispr to genetically engineer human embryos.[2] Researchers at Sun Yat-sen University obtained defective human embryos from an IVF fertility clinic and targeted a gene which can cause beta thalassemia, a serious blood disorder. The results were unimpressive. Of 86 embryos injected only 28 had successfully spliced the target gene and only a fraction of these contained the correct replacement gene. There was also collateral damage in the form of 'off-target' mutations.

More recently, researchers in California have used a DNA editing technique successfully to treat mitochondrial disease in mice.[3] This new research involves injecting affected embryos with RNA which leads to the production of enzymes which specifically target and remove faulty genes.[4] The treated embryos were transferred to female mice where they developed normally and resulted in healthy pups with low levels of the targeted mitochondrial DNA. These pups later gave birth to healthy offspring, demonstrating this is a viable approach for preventing transgenerational transmission of mitochondrial diseases.

Furthermore, it avoids some of the ethical problems associated with mitochondrial replacement techniques, such as cell nuclear replacement (cloning) technology, DNA donation and using DNA from three biological parents. Might this be an elegant and more ethical alternative to the controversial so-called three-parent embryo? As a technique it is certainly more about correcting a defect (restoration) than creating something altogether new (enhancement). Time will no doubt tell, but in the meantime there are big issues to address in the context of animal research, not least about safety.

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Glynn Harrison outlines a Christian response to the sexual revolution

AFTER THE SEXUAL REVOLUTION

key points

- In less than a generation, the Christian moral vision has seen a profound loss of cultural power.
- We need to get to grips with the ideologies that form the plausibility structures of the new moral order.
- The sexual revolution is not held as a list of facts in the popular imagination – it is held as a story. Arguments alone can't beat this, we have to tell a better story.
- The challenges of the sexual revolution call for a radical re-imagination of the biblical narrative about sex, marriage and flourishing.

In his Rendle Short Lecture of 2001 Andrew Fergusson suggested that Prof Rendle Short, whose life spanned the tumultuous years of the first half of the twentieth century, was one of history's 'men of Issachar'. These were the Israelite chieftains who, in offering strategic support to the future King David in his rise to power, 'understood the times and knew what to do.'[1]

I am returning to Andrew's theme because we need to face the reality that, in less than a generation, the Christian moral vision – that human beings flourish when sexual interests are boundaried in life-long covenant made between a man and a woman – has seen a profound loss of cultural power. Moreover, those holding to Christian sexual ethics not only find themselves on the wrong side of popular opinion but allegedly on the 'wrong side of history' too. And so, like the men of Issachar, we need to understand the times we live in, and work out together what we must do.

> We need to acknowledge and repent of excluding and judgmental attitudes that have made it hard for some to find a home in our families and our fellowships

Understanding the times

A revolution of ideas

The sexual revolution, like all revolutions, is rooted in ideas. 'If you want to change the world,' said Martin Luther King, 'pick up a pen and write'.

The idea that sits at the heart of this revolution is that traditional Christian morality is bad for you: not only does it hinder human flourishing but it is antithetical to it. According to radical feminist thought, for example, the Christian moral vision diminished women. Tied to a traditional patriarchy

in which the man brought home the bacon and she cooked it, Christian morality spawned a culture that neglected the education of girls, shamed single mothers and closeted lesbians.

Ancient Gnosticism is another big idea at work behind the scenes. Indeed, according to theologian Tom Wright, it is the great 'controlling myth' of our time.[2] In the Gnostic worldview, the 'outer world' of society and religion, and indeed the outer world of one's own body, are irrelevant and deceptive. Buried beneath layers of cultural and religious repression lies buried your real, inner, private 'self'. So dig deep, liberate the authentic you, and become the you that you want to be.

Queer theory, the other big idea driving forward the sexual revolution, may be considered a variant form of Gnosticism. Drawing on the work of the philosopher Michel Foucault and thinkers such as Judith Butler,[3] queer theorists construe gender categories as being mere social constructions, perpetuated to serve the power plays of the religious and cultural elites that stand behind them. In this understanding, there are no compelling biological realities behind these categories, far less natural, organically embedded norms in which we are expected to walk. These are the outer layers that need to be cast off in the search for authenticity.

These are the ideas – radical feminism, Gnosticism, and Queer theory – that form the plausibility structures of the new moral order and drive forward the revolution's vision of human flourishing. We need to get to grips with it.

A moral cause

The storm troopers of the sexual revolution not only believe they have an intellectual case, but a *moral cause* as well. The work of social psychologists such as Jonathan Haidt may assist us here.[4]

Haidt suggests that when faced with a moral problem, we tend to think intuitively along a limited number of cognitive systems or channels. One such 'gut level' reaction is 'don't cause harm'. Others include our instinctive sense of fairness; the desire to protect the weak; deeply held respect for received wisdom and tradition ('what we have always believed about this'); and a strong sense holding to what is sacred for the good of the community ('we meddle with this at our cost').

Haidt has shown that, when asked to make moral judgments, human beings differ in the relative 'weight' they give to these different gut level responses. Those who are politically on the liberal left, for example, consistently score highly on care/harm and equality/fairness for the individual. Social conservatives, on the other hand, score highly in respect for tradition and their strong sense of community sacredness.

We experience these kinds of sub-divisions when we debate sexual ethics. Those adopting a conservative stance tend to emphasise the sanctity of marriage and the authority of the Bible. Those on the liberal side focus on the suffering of the individual and the need for compassion, fairness and freedom from oppression. And so we talk past one another, and descend further into animosity. If we want to be like the men of Issachar we need to understand what is going on here.

Those holding to the traditional moral vision must be prepared to demonstrate that their moral concerns are motivated by the same compassion and desire for human flourishing as those on the liberal side. We need to accept that we are often perceived as hard, excluding, lacking compassion. We need to acknowledge and repent of excluding and judgmental attitudes that have made it hard for some to find a home in our families and our fellowships.

And then, with courage and conviction, we must also insist that compassion for the individual must not trump wider social goods that hinge upon the defence of sacred values (such as Christian marriage). In other words, we need to find winsome language for our convictions that it is no use meeting the needs of a subset of the bees if in doing so we destroy the whole hive. That is not compassion; it is emotionally driven folly.

Narrative power

Finally, we need to understand that this revolution has narrative power. According to the philosopher Charles Taylor, facts woven together in the form of narrative have additional persuasive power. To counter narratives effectively it is not enough simply to offer rival evidence and data – *you need to tell a different story*.[5]

The sexual revolution is not held as a list of facts in the popular imagination – it is held as a story. It's a story about the freeing of the human spirit from the stifling shame of Christian tradition and those at the margins who had the courage to swim against the tide of hatred and prejudice. These stories are narrated, over and over, through sitcoms and romcoms, in documentaries and dramas. In response we have often deployed complicated arguments, or listed the 'deviances' and the diseases. This simply doesn't work. We have to tell a different story. A better story.

So what must we do?

A better critique

First, we need a better critique, one that starts by addressing the sexual revolution on its terms, rather than our own. Has it delivered the freedom, the equality and the flourishing that *it promised*?

For example, the sexual revolution promised sexual liberation but in his book *Sex by Numbers*,[6] the statistician David Spiegelhalter presents compelling evidence that over the past 30 years sex as a recreational activity has been in steady decline. How come the sexual revolution, ironically, is delivering less sex? Maybe it's because idols promise more and more but always deliver less and less.

But more importantly it is time to begin to speak up for children. We could spend a lot of time

Those holding to the traditional moral vision must be prepared to demonstrate that their moral concerns are motivated by the same compassion and desire for human flourishing as those on the liberal side

With courage and conviction, we must insist that compassion for the individual must not trump wider social goods that hinge upon the defence of sacred values

discussing the scandal and tragedy of the revolution's pornographication and sexualisation of childhood. But I need to focus on the collapse of marriage: the sexual revolution promised fairness and equality but has helped to heap structural injustices and inequalities on the most vulnerable of all.

Marriage – having a mum and a dad bound together by promises of life-long fidelity – is good for children. Of course some individual marriages are very bad for a child; and some non-traditional family arrangements (such as adoptive same-sex parents) can be very good for a child. But in the round the welfare of children is best served by a culture of strong marriages.

As the sexual revolution got underway in the 1960s and 1970s divorce rates rocketed, and it is still the case that 42% of marriages will end in divorce. Now, by the age of 16, only one half of children will be found living with both their mother and father. And, although studies have to be interpreted carefully, divorce is generally very bad news for children. [7]

Cohabitation is even worse news for children. A smaller percentage of people got married in 2008 than in any year since records began [8] – cohabitation is the new norm. And yet, according to data from the Marriage Foundation, independent of mothers' age and education, only one quarter of couples who marry and then have children split up. In contrast, over half of those who give birth and then marry split up, and two thirds of those never marrying split up. [9]

The difficulty for the children of these torn relationships is that most will live in lone parent households. We have witnessed the progressive increase of fatherlessness over the period of the sexual revolution and we cannot escape the significant association at population level between fatherlessness, poverty and low education. [10] Men who are not married to the mother of their children are much less likely to invest financially, practically, and emotionally in those children's lives. [11]

The simple genius of marriage is that it binds men to their responsibilities for the children they help to bring into the world. Single mums do a wonderful job but we cannot remain silent about the ideal that overall kids do best with both a mother and a father in the home. There, I've said it.

Now of course these data raise all kinds of methodological questions – not least the question of causation. Does marriage produce virtues of faithfulness and commitment, or is it simply the case that people who have these virtues are more likely to get married? We will never completely disentangle this but it is becoming increasingly clear that 'both-and' explanations are needed. It needn't be one or the other.

There are things that government must do in terms of child support, education, and reducing income inequalities. And there are things we must all do to promote the goods of marriage, especially the way in which it binds men to their responsibilities for children, and cements cultural expectations that boys and men develop the necessary virtues of commitment and faithfulness.

A better story

Finally, we need to be able to tell a better story. Our culture has a good sense of what we are against, but what are we for? In the biblical worldview, what is sex for? What is marriage for? What are families for?

There can be no 'going-backery', no return to some bucolic moral paradise that never existed. The challenges of the sexual revolution call for a radical re-imagination of the biblical narrative about sex, marriage and flourishing. This involves a re-imagining of what it means to be human – to be made in the image of God as male and female. It requires the re-imagination of how his covenant love and creative fruitfulness is etched into the shape of our most intimate relationships. It is the story of how, in honouring their solemn vows, married couples become signposts to the mystery of God's life-giving, covenantal love in Christ; and how those who heroically embrace chastity so long as they remain single also bear witness to this greater reality.

We need to speak this vision, and then live it out in holy lives. Speaking out requires a step change in our intellectual engagement with this issue. We must never abandon the public square because the goods of the Christian moral vision are for everybody and not just for ourselves. But first this moral vision must be re-imagined in our own hearts and lives, in our churches, in the work of pastors and teachers, and youth groups and house groups.

We have been here before. Two thousand years ago the belief that Jesus of Nazareth had been raised from the dead inspired Christians to create a culture so attractive to Pagans – the way they treated women, children, the sexually exploited, slaves and the poor – that by the fourth century AD an entire empire was on the edge of faith.

Of course there are many questions. And there are good ways and there are bad ways of making our case. We shall need wisdom as well as courage. But for the sake of our children, for the sake of the gospel, for the life of the world, the biblical vision is a story we must be prepared to tell once again, and then to live.

Glynn Harrison *is a psychiatrist, academic, speaker and author. Based on the 2015 Rendle Short Lecture.*

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Alice Madgwick reports on a pioneering training venture

IMPROVING HEALTHCARE IN SOUTH SUDAN

'I've seen very many people in South Sudan suffering, others dying when giving birth, children are suffering of malnutrition, others are not even being immunised. So I felt like I should also be one of the persons who could serve those people.'

Lillian, midwifery student
at the National Institute of Health Sciences, South Sudan.

With a maternal mortality rate of 730 per 100,000 live births (in the UK it's 8 per 100,000),[1] a 15-year-old girl in South Sudan is more likely to die during childbirth than to complete her primary education.[2] Less than 50% of the population have access to healthcare within 10km; as a result many die from easily preventable diseases.

The main reason for these statistics is a lack of trained health workers – there are fewer than 200 doctors in the whole country (though there are 200 pastors in the capital alone!).[3] In response, the International Christian Medical and Dental Association (ICMDA) along with the government of South Sudan and the Episcopal Church of South Sudan & the Sudan, have developed the National Institute of Health Sciences (NIHS). The NIHS is supported by a UK charity with nearly four years' experience working in South Sudan, Anglican International Development.

At one point, it looked almost impossible that the Institute would open. A month before the start of term, fighting erupted in Juba, the capital of South Sudan, and spread across the country. The town of Bor, the proposed location for the NIHS, was destroyed and all who lived there fled. Seeking an alternative location took months, but Mengo Hospital in Kampala, a Christian hospital and Uganda's oldest, offered a home to the NIHS and use of its facilities so it could begin teaching.

Thanks to this partnership, on 31 May 2015 (only five months later than planned), 51 students made the twelve hour bus journey from Juba to Kampala and were able to begin their three year courses to become nurses, midwives and clinical officers. Clinical officers do important work throughout rural areas in East Africa, taking on many of the same jobs as doctors but also carrying out managerial roles in primary healthcare centres (PHCC).

Without much time to adapt, students were plunged into intensive teaching with classes 44 hours a week. At the end of the first term, Dr Anil Cherian, a consultant paediatrician and Director of the NIHS, said, 'I am happy to report that most of them have done well and have shown commitment and determination to study and cope with the pressures of student life.'

As well as developing students academically, the NIHS weaves biblical principles throughout the syllabus to develop an understanding of how the Bible shapes medical ethics and practice. Students have the opportunity to attend weekly Bible studies and prayer meetings at the Mengo Hospital.

Currently, there are about 1,000 PHCCs across South Sudan; the NIHS is not only providing workers to fill the country's health needs, it is raising up faithful servants of Christ who can take news and proof of his love across the country. The Institute, while temporarily based in Kampala, remains exclusively focused on South Sudan, training only students who want to go back to work in their country.

The success of this project has been largely the result of partners, such as Mengo Hospital and the ICMDA, uniting to improve healthcare in South Sudan. Key to this partnership is the teaching staff: Dr Cherian, his wife Dr Shalini Cherian, respectively a consultant obstetrician and gynaecologist from ICMDA India, and three Ugandan nurses have committed to teaching at the Institute for at least its first three years.

Dr Cherian says, 'Even though we have five full-time teaching staff, the team will need additional help to reduce some of the teaching burden.' In August 2014, three Egyptian nurses from the Egyptian Christian Nurses Fellowship (CNF) joined the team at NIHS. Dr Cherian hopes to welcome more like them and would love to have one or two medical volunteers who can work at the NIHS at any point during the year.

The launch of the Institute was made possible thanks to international donors. Ongoing operational funding is needed for student fees and staff salaries. For information about volunteering at the NIHS contact: *john.inglis-jones@interanglicanaid.org*. Visit the website for details of the financial needs of NIHS: *www.interanglicanaid.org*.

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Pablo Martinez explores how our psychological makeup influences how we feed our spiritual lives

PRAYER, PERSONALITY & TEMPERAMENT

key points

- Every Christian is unique; the character of our spiritual life is different from other people.
- Our personality type will be reflected in how we pray. An introvert will be comfortable with silence and meditation. An extrovert's prayer will be short and action oriented.
- The big challenge in Christian discipleship is being willing to welcome people whom God has made very different from ourselves.
- Being aware of our personality preferences will help us find modes of prayer that 'work' for us.

- *Why do I find it difficult to pray?*
- *Why do some Christians seem to have a natural ease to pray?*
- *Why do I find it hard to feel the presence of God when I pray?*
- *Is my problem a lack of faith?*

These frequently heard questions reflect an important reality: our prayers are not only affected by spiritual conditions but other things as well. Three factors have a powerful effect on our prayer lives. Two of them have a permanent, continuous influence: our *temperament* and our *personality*. They are closely linked to our character. The third one, the circumstances of the moment, fluctuates according to factors like tiredness, stress or even our daily rhythms.

There are two main purposes for offering this article: firstly, I want to help ordinary Christians who may be struggling unnecessarily with their prayer life and spirituality. Many Christians believe their struggles are sinful, not understanding that very often they are the result of their own emotional makeup. We need to think of prayer without guilt, because too often we associate the two. Prayer should not be just one more burden in life, but a pleasure to enjoy.

My second purpose is to help Christians develop their prayer lives to their full potential and to be more aware of how these can be affected by their temperaments and personalities. We pray differently because we are different from one another. Mutual acceptance between individual Christians and churches can be greatly enhanced as a result of grasping the basic principle that variety is a treasure than enriches, not an obstacle that bothers.

In analysing the psychological factors of prayer, I do not want to minimise the role of the one who 'intercedes for us with groans that words cannot express' (Romans 8:26b). Nothing could be farther from my intention. It would be a mistake, however, to ignore the remarkable influence that our psychological makeup has on our spiritual life in general and on our prayer life in particular.

Why do our temperament, personality and circumstances affect us so much? The answer is that we are a unity of body, mind and spirit. These three interact in such a way that when the body suffers, our mind and spirit are also affected. When CH Spurgeon, the famous preacher, suffered a painful attack of gout, he had severely disturbed moods. A physical problem was affecting his mood and it may have affected his preaching sometimes. We all know examples of this interaction between our different parts.

Christ's prayer in Gethsemane, one of the most impressive prayers ever, is a striking example of this principle. Jesus prayed with tears in his eyes and anguish in his soul (Hebrews 5:7), but these emotions did not stop him wholeheartedly seeking the face of his Father. That evening he was under severe stress – lonely (the disciples had fallen asleep), tired, facing torture and death – but this never interrupted the precious fellowship with the Father. In fact, the words of Jesus in Gethsemane give us a masterpiece of prayer. Jesus needed to cry: he was deeply anxious. That didn't make him a sinner – depression of itself is not a sin. His tears while praying did not make him less spiritual but more fully human. His need to pour out all the anguish in his heart showed he truly 'has been tempted in every way, just as we are – yet was without sin' (Hebrews 4:15).

How temperament affects us

Let us see briefly how temperament actually influences our prayer lives. Temperament is the most constitutional – or genetic – part of our character, being mainly determined by biological factors. Temperament cannot be changed but it can be shaped into the likeness of Christ and controlled by the Holy Spirit. It would be futile to expect a drastic change in the genetic makeup of our person, but we can expect the 'polishing' work of the Holy Spirit. The new birth does not change temperament, although grace helps us to live with it.

One of the most helpful classifications of temperament was developed by CG Jung (later popularised in the Myers-Briggs test). I like it because it emphasises flexibility and a certain possibility of change. This is important because no one likes to be labelled in closed boxes. We should remember, too, that every human being is unique and therefore classifications are always somewhat relative. Stereotypes are the opposite of divine variety. Jung's classification revolves around two fundamental axes:

- One's general attitude in life: introversion – extroversion:
- One's predominant psychological function. Jung describes four psychological types: thinking, feeling, sensorial and intuitive.

A detailed study on the subject, especially on how each temperamental type influences our prayer life, is developed in my book *Praying with the grain: How your personality affects the way you pray*.[1] Here I will just give you one example: the prayer life of extroverts. Their natural tendency is towards action rather than meditation. They will be the ones doing things in the church because they like to be active all the time. Consequently, they find it difficult to maintain a regular prayer life. The more extrovert a person is, the more difficult they find it to pray and to concentrate while praying – too much to do! Introverts, on the other hand, are much more methodical and will set time apart.

Extroverts find difficulty in cultivating their inner life, their thoughts and feelings flow spontaneously outwards. So beginning to pray is rather like having to make an enormous leap. They will usually choose praying with others rather than privately. Prayer meetings give them the opportunity to relate with others, which is precisely the source of energy they need to start praying. Once they are in the atmosphere of a group, they enjoy participation; this community flavour is just the kind of stimulus they need to warm them up spiritually. For them, prayer is linked with service and action. The focus of their requests is the needs of the world rather than the inner world, unlike the introvert.

The hard part of discipleship

Paul's exhortation to *accept one another* (Romans 15:7) – some versions render it 'receive' or 'welcome' one another – is a hard part of discipleship. The coming together of genetic, biographical and circumstantial factors makes each individual a little universe that is very different from all the others. This is reflected in the way in which we understand and live out our faith.

For this reason we must understand that many of these differences do not stem from a greater or lesser amount of faith but are the result of the way we are. Remember that no temperament is better than any other. All of them have admirable features when viewed from a divine perspective. The Lord can use each of us just as we are, with all our virtues and defects, and he often uses us not so much in spite of our weaknesses but through them. God has given the intuitive type an enormous capacity for mysticism. But the latter should not then condemn the sensation type as superficial and simplistic because their prayers are briefer and more spontaneous. In the same way, the sensation type must not accuse the intuitive of always having their head in the clouds. The thinking type must not complain that the feeling type is hypersensitive, all heart and no head. The feeling type should not reject the thinking type as just cold intellect.

From the temperamental point of view, no type of spirituality is superior to any other. The church is a many-dimensional body containing a multitude of differences. One of these differences is temperament. Fortunately the unity of the church does not depend on the uniformity of its members.

It is reassuring to reach the conclusion that temperament is the seal that stamps an individual uniqueness in our relationship with God. Our temperamental code is so personal that it admits no possibility of being copied. Therefore, just as no two human beings have the same fingerprints, neither will two believers have an identical spiritual experience. This personal and distinctive seal of our faith, so deeply grafted into our temperaments, constitutes one of the most precious possessions in the life of each believer and of the church.

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Prayer should not be just one more burden in life, but a pleasure to enjoy

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Tom Roberts hears the stories of CMF members caught up in the Nepal earthquake

NEPAL
WALKING THROUGH PAIN & HARDSHIP TOGETHER

key points

- Two large earthquakes have left 8,600 people dead, thousands more injured. Around 600,000 homes have been damaged, and 140,000 destroyed.
- While things are recovering in the cities, in the affected rural areas many health posts and hospitals need rebuilding from scratch, which is a huge challenge.
- The quakes leave an increased risk of landslides as the monsoon season approaches, as well as a risk of a food shortage after crops were destroyed and seeds lost.
- We must continue to pray for those in the front line of relief work and for the many churches and relief organisations working in the more remote areas and in Kathmandu.

On 25 April 2015, Nepal was struck by a 7.9 magnitude earthquake, causing utter devastation. This was followed on 12 May by a 7.3 magnitude aftershock, causing further damage and disruption. At least 8,600 people were killed and thousands more injured.

CMF has twelve members living and working in Nepal, all of whom were unharmed. We contacted several of them for their reflections on this tragic event.

What was it like?

'We had all been waiting for the "big one" as Nepal was overdue a large earthquake' said Rachel Karrach, working with United Mission to Nepal (UMN), 'Despite all the training I think we all hoped it would not happen our lifetime.' Amanda Douglas, a missionary doctor, was at church teaching the children when the quake struck: 'Suddenly there was a rumbling sound and the ground started to move violently. Children screamed and rushed for the door. I shouted at them to get down on the floor and those near me huddled together as I covered them with my arms. Plaster started falling around us.' Soon, they were told to leave and managed to get outside where the quakes continued: 'Every ten minutes or so the ground would start moving again. Each quake lasted only 30–45 seconds, but it left us all feeling we were pitching and rolling like on a ship.'

> Suddenly there was a rumbling sound and the ground started to move violently. Children screamed... those near me huddled together as I covered them with my arms

What are the health needs?

In the aftermath, there are still significant needs. Around 600,000 homes have been damaged, and 140,000 destroyed. Many health facilities have also been damaged or destroyed. One CMF member working for a large relief agency explained the situation: 'One of the most pressing health needs is to keep the health service running and staffed with skilled personnel. Many health centres are now based in tents provided by development partners, but this won't last long. We need to move quickly to formal temporary structures and then permanent buildings. We also need to keep working hard to make sure the neediest get the help they need. Some people live several days' walk from the last road. These communities are the hardest to assist logistically.'

As the weeks go on things are improving, but there is much to be done. Liz Galpin, who works with International Nepal Fellowship (INF) told us, 'Hospitals in Kathmandu are functioning, some

with different levels of repairs needed. Patients are no longer sleeping on the ground floor or outside, but in some places clinics or even theatres and deliveries still need to be under canvas due to the damage caused. However, in the affected rural areas many health posts and hospitals need rebuilding from scratch – a huge challenge.' It is clear that the rural communities are the ones in the most need due to their inaccessibility and lack of resources.

Those in less badly affected areas, such as Tansen (310km/192 miles from Kathmandu), where Rachel is based, were able to send teams out to help: 'One orthopaedic operating team went to Kathmandu and helped with treating the injured. A pair of doctors was among the first to reach the villages in Gorkha devastated by the first quake. We sent a team of paramedics to Dhading at the request of the district health officer and another of our doctors was released to help work out the best response for Christian medics as part of DRCC (Disaster Relief Christian Committee) and another joined the Samaritan's Purse team. In the acute relief phase, after the injured had been rescued the biggest need was for shelter, food and water not healthcare. The teams we sent found that they were treating minor ailments and many people were suffering from acute anxiety symptoms.'

As people struggle to get back to normal life, there is still an atmosphere of fear and uncertainty. Liz explains: 'We're now picking up life again and regaining energy – still with the occasional aftershock to throw us backwards. Rumours of worse earthquakes to come terrified many, and anxiety levels have been so high that some neighbourhoods resounded with screams each time a new aftershock came, even a month on.' Amanda echoes this experience, speaking of the continuing unease people feel, made worse by the second quake: 'Folks had started to adjust to the "new normal" around one week after the first quake. But when the second hit this seemed to be too much. Most people moved back outdoors again and settled in to stay. So much fear and exhaustion. Daily aftershocks sent people running outside shouting "*aayo aayo*" ("It has come!").'

What does the future hold?

Now the aftershocks are subsiding, the work of rebuilding can begin. But this is no easy task: 'The rebuilding and relocation of several villages may take years,' Rachel tells us, and danger still lies ahead. 'The monsoon will start soon. The hillsides have been destabilised by the quakes and there is an increased risk of landslides.' 'Those without homes are in need of strong shelters,' Liz adds, 'there is likely to be a food shortage as some crops were damaged and farmers lost seed needed for planting'. Rachel explained that this may lead to a wider crisis: 'Some of the recent improvements in maternal mortality and infant mortality will be reversed in some of the worst affected districts. We expect that many families who were living on the edge before the earthquake will now not be able afford medical treatment and we anticipate more demand for free care.'

Some working in Nepal had to return to the UK after their homes were destroyed or due to their organisations moving them for safety. Amanda has been struck by the number of people asking 'Are you going home now?' but told us, 'The idea of leaving now has not even crossed our minds. We came to live alongside, to share with, to love and (in some small way) help the people of Nepal – how could we just walk away when they are hurting so much? This is our home now, we need to serve as best we can where we are. We are not saying that we will never leave no matter what, but we know that for now and this season, this is where we are meant to be'.

How does the gospel help?

When faced with the scale of this disaster, it is not surprising that it causes people to reflect on their faith. Liz's experience forced her to depend on God: 'In the midst of the loss and devastation, I am grateful to be alive and for God's presence through this – I don't understand, but have to trust him. It is humbling.' Amanda and her family found an opportunity to follow Christ's example. She speaks of a moving incident where her husband Angus 'sat with a Nepali colleague as he wept, saying how much it meant to him and the community that we had stayed in Nepal. Walking through the pain and hardship together meant so much to him. That is what Jesus does: he is "Immanuel" – God with us. And that is what he calls us to.'

Others have been forced to reflect on the effects of the fall in our world: 'Living through a major natural disaster with your family, and then being part of the recovery effort puts you face to face with the harsh reality of human suffering. The Christian faith helps with understanding suffering in the world. Since the rebellion of the first man and woman against God we live in a resultant imperfect world, both structurally and personally. My wife encouraged me with the words: "Just remember the world was not meant to be like this". For now, we do the best we can to help and love each other faced with the reality of an imperfect world, but we hold firm to a greater hope that one day we will inherit a new world that's free from the problems of our current existence.'

How can we pray?

We must continue to pray for those in the front line of relief work and for the many churches and relief organisations as they continue to work in the more remote areas and in Kathmandu. Pray for the healing of Nepal and protection over the coming months and years as they work to rebuild. Above all, pray that the light and peace of the gospel will shine even brighter in the darkest of times.

***Tom Roberts** is CMF Communications Coordinator.*

Patients are no longer sleeping on the ground floor or outside, but in some places clinics or even theatres and deliveries still need to be under canvas due to the damage caused

David Pitches says Christian servant leadership can make a difference

PROBLEM SOLVING IN THE NHS

key points

- There are situations where well-established 'command and control' routines lead to a solution.
- For more complex management puzzles the problem-solving approach will be team-based and democratic.
- Then there are altogether more complicated problems where there are no a concise and simple answers.
- Applying the biblical concept of servant leadership may often create a context where stubborn problems can be overcome.

How does someone become a good leader? Some say leaders are born not made, but many disagree, leading to a vast industry seeking to develop potential leaders. Others argue that leaders' success is situational – Churchill might have been an outstanding wartime prime minister but his earlier military adventures left something to be desired. The pressing question for any large organisation such as the NHS is how to ensure that it has good leaders. With so much at stake, we cannot bury our heads in the sand. We can't say we are not cut out to lead or that good leaders' success is merely opportune.

Three types of problem

A useful starting point for defining leadership is 'a process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task'.[1] Those common tasks essentially boil down to how to solve three types of problem: 'critical', 'tame' and 'wicked'.

Critical problems need military-like command and control – when the cardiac arrest bleep goes off, you do as the leader of the arrest team tells you, following a carefully rehearsed sequence of procedures to resuscitate the patient.

Tame problems, however, are typically perceived as something of a management puzzle; the leader must identify a solution that worked in the past and try to apply it to the current problem. This requires 'transactional leadership'. Rewards, sanctions and democratic participation by teams of professional people characterise this problem-solving approach. This works well when tasks are reasonably clear and outcomes from various scenarios are predictable. Much of the day-to-day administration of healthcare probably functions at this level.

Unfortunately, part of our problem as doctors in positions of leadership is that we tend to have a scientific mindset which works on the sequence:

problem ▶ diagnose cause ▶ implement evidence based solution ▶ problem solved

When it comes to running health services we have already solved most of the 'easy' or tame problems. What remains are the hard or 'wicked' problems – first categorised by the design theorist Horst Ritter in the 1960s.[2] Wicked problems medical leaders might encounter include how to introduce seven-day working without additional resources whilst ensuring that weekday activities do not suffer, or how to make urgent care sustainable when Accident and Emergency departments are acutely short of new trainees while the workload seems to rise every year.

The sorts of problems NHS leaders face are characterised by there being no clear statement of the problem, with incomplete and contradictory information, changing requirements and constantly shifting goalposts. It is impossible to know if or when the problem has been solved. There are no

'right' or 'wrong' answers, just 'better' or 'worse' options. It is impossible to reverse a solution if it appears not to be working since by definition solutions change the starting parameters. Wicked problems tend to be symptomatic of other wicked problems elsewhere in the system that you probably have no control over.

'Transformational leadership' is needed to identify solutions to these problems. It requires individuals who are inspirational, motivational and charismatic. Transformational leaders communicate well, 'lead when they are not in charge' and possess high levels of emotional intelligence. They appeal to the common good, foster high moral standards and promote cooperation and harmony. In theory, at least.

The failure of NHS leadership

The NHS has long struggled with how to lead such an enormous and complex organisation. Early in Margaret Thatcher's first term as Prime Minister she brought in Sir Roy Griffiths, deputy chairman of the supermarket chain Sainsbury's, to advise how the NHS could be improved. He famously remarked that 'if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge'. [3] His recommendations led to a series of reforms making the role of managers much more pronounced.

Subsequent decades have seen ever-increasing emphasis on reform and management, at worst resulting in 'top down' leaders who are overconfident, lack insight into their shortcomings and are simultaneously ineffective and bullying. Lately, there has been undue confidence in the ability of 'turnaround teams' and management consultants to solve wicked problems, along with misplaced faith in transformational leaders to achieve the impossible and a distinct lack of humility from the leaders. What a stark contrast with greatness in God's sight, which is measured by how faithfully the leader serves God and others! [4]

Poor leadership, combined with the chaos of organisational and structural upheavals, culminated in the debacle at the Mid Staffordshire Hospital. Many patients, particularly the old and vulnerable, received grossly inadequate and undignified care because patients had become a lower priority than organisational development. The legacy of major failings in Stafford, and the burden of unsustainable increases in demand with no additional funding, means current thinking in NHS leadership has had to do some soul-searching.

Many of the elements of transformational leadership – communication, self-awareness, leading by example – are important to find solutions to complex problems that transcend organisational boundaries. Yet the NHS Leadership Academy is belatedly recognising the value of more muted styles of leadership that take the best attributes of transformational leadership, but have a rather richer heritage.

Servant leadership

The principle of leading by example, helping those subordinate to us to flourish and putting the needs of others first, finds its greatest endorsement in the Lord Jesus, who said, 'Whoever wants to become great among you must be your servant, and whoever wants to be first must be servant of all'. [6]

Paul's experience establishing the church in Corinth reveals his approach to servant leadership. He was in Corinth no longer than the typical NHS chief executive is in post – 18 months. He founded a church from a disparate bunch of Jews, God-fearing Gentiles and pagans with no New Testament and limited familiarity with the Old Testament. His congregation tended to degenerate into anarchy as soon as he left. Yet servant leadership was critical to the success of his mission there.

Medical servant leaders will engage with anyone prepared to help achieve excellence in healthcare. Servant leaders have the potential to inspire and influence their organisation and wider society; they want to excel in the way they treat their patients and colleagues, which in turn promotes trust, loyalty and innovation. The servant leader is humble, caring, capable, empowering, ensures that meeting other people's needs is their highest priority [7] and is especially looking out for the weakest in society. [8] They combine the strengths of the transformational leader without their shortcomings.

The new NHS Healthcare Leadership Model is well worth reading. Its nine domains have been shaped by thinking about the inadequacies of existing leadership frameworks and how elements of servant leadership can be taken up by the new generation of leaders who will be required to take the NHS through the very difficult years that lie in the aftermath of Stafford. [9]

A note of caution. Servant leadership is not about only picking the menial tasks – it is about enabling others to do their best. The clue is in the phrase that includes both the word 'servant' and the word 'leader'. [10]

Servant leadership can be bad news for traditional theories of leadership. Some people maintain that being a good leader is a trait you must be born with. Others make their living promoting the idea that good leadership can be taught – yet despite vast sums spent on business training courses we still have many poor examples of leadership in the health service. The really good news is that servant leadership can be successfully practised by any follower of Jesus Christ.

When you lead by serving in humility and loving obedience, God will use your gifts and your attitude to enable you to lead within and across organisational boundaries and solve problems you thought were too complex to begin taking on.

David Pitches *is a consultant in public health and currently works for Medair in the Democratic Republic of Congo.*

Servant leadership is not about only picking the menial tasks – it is about enabling others to do their best

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John Wyatt on the growing pressures ahead for Christian health professionals

THE FELLOWSHIP OF SUFFERING

key points

- As pressures in the NHS grow, Christian health professionals need to prepare for opposition and suffering.
- The Bible makes a mysterious but profound connection between suffering and *koinonia* –'fellowship', 'participation', 'sharing', or 'communion'.
- *Koinonia* is at the heart of the relationships within the Trinity and a model for the community of Christians, especially in hard times.

We don't know what the future holds for Christian healthcare professionals, but challenges and dangers seem to abound. The pressures on the NHS seem to increase year on year from a toxic mix of economic, demographic, organisational and political forces. There is growing hostility to Christian influence in healthcare from a small but highly effective group of secularists. There is the very real threat that assisted suicide or other forms of medical killing may become institutionalised. Meanwhile, the inspiring example of Christian medics and nurses confronted by Ebola has reminded us of what faithfulness to Christ may cost in a time of plague. An ancient proverb says simply, 'Those who would be a Christ must expect a cross'. So I think we have to prepare ourselves for more opposition and more suffering.

Suffering is not exactly a dominant theme in contemporary Christian worship and teaching. Yet it's a strand that runs through the New Testament. The apostle Paul in particular highlights a profound and mysterious connection between suffering and the Greek word *koinonia*.

Koinonia is one of those deep biblical concepts that translators struggle to put into common language. The word occurs more than 15 times in the New Testament and it is variously translated as 'fellowship', 'participation', 'sharing', and 'communion'.

> In some extraordinary way, the *koinonia* that is within the Godhead is meant to be expressed in the Christian community

Koinonia – three dimensions

koinonia has three dimensions. Firstly, *koinonia* is about the inner life of the Trinity – it is at the heart of the Godhead. Our God is a God of *koinonia*. Every time we say the Grace we are referring to it. 'May the grace of our Lord Jesus Christ, the love of God and the *koinonia* of the Holy Spirit be with us all' (2 Corinthians 13:14). Augustine famously called the Holy Spirit 'the kiss between the Father and the Son'. In a mysterious way the *koinonia* between the Father and the Son is enshrined in the person of the Holy Spirit.

Theologians tell us that at the heart of the Trinity is union and communion. Union is about merging, oneness, identity. Communion, *koinonia*, on the other hand, is about difference. The Father is different from the Son and yet the persons are in communion.

The very differences between the persons of the Trinity are part of the richness of the Godhead. That is part of the contrast between the God we as Christians worship – God as revealed in Jesus – and

Allah. As I understand it, in Islamic theology Allah is alone, pure unity. So the idea of communion with Allah would be seen as blasphemous.

Secondly, *koinonia* is about the new community of God's people. In some extraordinary way, the *koinonia* that is within the Godhead is meant to be expressed in the Christian community. We, too, are called to express union and communion in our life together. 'So if we walk in the light as he is the light, we have *koinonia* with one another and the blood of Jesus his Son cleanses us from all sin' (1 John 1:7). We are to be united in Christ; but we are a community, a *koinonia* of different, diverse and unique individuals. So in some remarkable sense our Christian fellowship, is meant to reflect the unity and diversity of the Godhead.

Thirdly, and mysteriously, *koinonia* is related to suffering. In particular Paul speaks of *koinonia* with Christ's suffering. 'That I may know him and the power of his resurrection and the *koinonia* of his sufferings, becoming like him in his death, that by any means possible I may attain the resurrection from the dead' (Philippians 3:10–11).

This seems to reflect a strange reality of the Christian life, that in suffering there is a *koinonia*; a deep communion. In the natural world suffering so often leads to isolation, it leads to people being pushed apart, separated, alienated from others. But in the mystery of God's love there can be a *koinonia* of suffering; *koinonia* between those of us who are experiencing suffering, *koinonia* for those of us who are trying to be there, to care for those who are suffering; and also – amazingly and wonderfully – with the suffering Christ himself.

It's part of the reality of the body of Christ – if one member suffers, then all suffer. As we pray for and support persecuted believers, as well as those closer facing personal tragedies and losses, we experience something of *koinonia* – we are together sharing the suffering of the whole body of Christ. And it seems mysteriously that suffering goes right into the heart of God.

Koinonia and the incarnation

In the Old Testament we hear the laments of suffering believers, godly men or women pouring out their anger and pain to God. Lament is a very significant part of the Psalms – the faithful believer expressing pain to a God who, so often, seems silent. But in the person of Jesus, God comes into the world, and he takes on to his own lips the words of lament. He laments over Jerusalem, he weeps at the grave of Lazarus and sweats drops of blood in Gethsemane. Then on the cross he takes on the awful lament of Psalm 22, 'My God, my God, why have you forsaken me?'

So it seems that lament is taken into the heart of God. God the Son is lamenting to God the Father. On the cross Jesus experiences total abandonment and isolation, so that we can be brought into *koinonia*. God is present but he's also a co-sufferer, suffering with us. Even now the glorified Lord Jesus carries the scars and is identifying with us in our sufferings and identifying with his suffering Body. The worst evil of the world is penetrated by God's suffering love.

At some point in life most of us are hit by tragic, inexplicable evil and suffering. But there is nothing we can experience which cannot by God's grace be turned in some strange and wonderful way into blessing and healing. God loves to take the very evil thing itself and turn it into a means of blessing.

God's mysterious plan for this age is not to abolish suffering; he has promised that he is going to do that in the new heaven and the new earth. But his plan for this age is to redeem it; to transform it from its evil, destructive impact, into blessing and healing. God takes delight in transforming the broken and damaged part of our lives, our failures and our sins, sufferings and losses, and he uses those very things to bring blessing and healing, if only we will allow him to work in these parts of our lives. Nothing is wasted and nothing is lost.

I think this has something to do with the motherly compassion of God. In the Hebrew language, the compassion of God is a motherly word. It's very closely related to the word for 'womb'. Part of what mothers do is scurry around making sure that nothing is wasted. 'I'm sure we can use that food from yesterday … I'll keep that piece of material in case it's useful in the future.' God is a motherly God who is able to take the debris, wreckage, mistakes and sins of our lives, so nothing is wasted, nothing is lost. It can all be transformed.

But the path from suffering and loss to healing and blessing is not one that happens automatically. Suffering can be destructive rather than redemptive. It requires our humble acceptance of God's working in our lives and our co-operation with his love and power.

GK Chesterton said there were two equal and opposite sins against Christians hope: the sin of presumption and the sin of despair. I have to confess that at different times in my life I've been guilty of both sins. At times I've been presumptuous that God is going to bless me, yet at other times I've been despairing and hopeless. These are both sins. In contrast there is the daily discipline of Christian hope, setting our minds and hearts on the hidden realities of God's kingdom and purposes, whatever evil, suffering and loss we to face.

What will be the cost of being faithful to Christ in the future as the Christian Medical Fellowship? Perhaps for some this *koinonia* will include suffering. But we must resist the temptation to anxiety and despair. We need to remind ourselves that in the deep mystery of God's loving purposes we are being called to union and communion with one another, and with the suffering Christ himself.

John Wyatt *is Emeritus Professor of Neonatal Paediatrics at University College London. Article based on a talk at the CMF Prayer Summit, January 2015.*

We need to remind ourselves that… we are being called to union and communion with one another, and with the suffering Christ himself

Rick Thomas highlights an often-overlooked problem

ALCOHOL'S HIDDEN ICEBERG

key points

- Fetal Alcohol Spectrum Disorders (FASD) describes a range of disorders caused by the toxic effects of alcohol on the developing fetus.
- Due to the complex assessment needed to recognise FASD, affected children may be misdiagnosed with ADHD, ASD, attachment or behavioural disorders, and given inappropriate treatment.
- Over 2% of the UK population may already be affected by FASD, a figure set to rise further if current trends continue.
- It is essential to increase training, awareness and support to help address this problem.

Imagine. You and your partner are experienced foster carers. The boy presently in your care is six years old and has been with you for four years. You never met the birth mother and have little information about the boy's early life. He is struggling at school, falling behind his peers, and is sometimes aggressive towards them. He appears happiest when playing on his own. The school's Special Educational Needs Coordinator (SENCO) suggests he might have 'autistic tendencies' and refers him to Child and Adolescent Mental Health Services (CAMHS) for assessment. He is offered psychotherapy for possible depression but after two sessions the therapist says he has been misdiagnosed and refers him back to his GP. Appointments with a paediatrician, educational psychologist, speech and language therapist and child psychiatrist all follow over the next twelve months. Numerous assessments are undertaken but consensus is lacking. Your social worker begins to ask probing questions about the state of your marriage and you start to feel your care is coming under suspicion. You confide in your Health Visitor, who trawls through records of postnatal home visits and spots a recurring comment – that the birth mother 'appeared to have been drinking'. Could this be relevant?

Fetal Alcohol Spectrum Disorders (FASD) describes a range of disorders caused by the toxic effects of alcohol on the developing fetus. At the severe end of that spectrum are those with Fetal Alcohol Syndrome (FAS), a condition characterised by stunted growth, abnormal facial features and permanent brain damage that results in impaired intellectual function alongside a range of other neurological, psychological, social and behavioural disorders. The characteristic facial features of FAS (shorter palpebral fissures, smaller nose, flatter philtrum and thinner upper lip) are often not present in other forms of FASD, but the invisible, permanent neurodevelopmental effects will be expressed in all, to varying degrees – a lifelong disorder requiring lifelong support.

Incidence

Although 'full-blown' FAS is not common, it appears to be on the rise, increasing 37% between 2009 and 2013. FAS is thought to affect about 1% of live births in the UK – about 7,000 per annum. However, the number of children with FASD could be two to five times that number – they are alcohol's 'hidden iceberg'.

Diagnosis

When facial features are obviously present, then the diagnosis of FAS is straightforward. Less severe forms are harder to pick up – analysis of facial photography and full neurological screening will be needed. Cognitive, sensory, communication and memory functions are all affected. FASD shares a number of features with ADHD and ASD from which it must be distinguished (and with which it can co-exist), as it must from other pregnancy-related conditions like neglect, prematurity, (other) drug effects and certain genetic disorders such as Fragile X.

Successful diagnosis therefore requires a multidisciplinary assessment of a kind currently available in very few centres in the UK. For lack of such

expertise, affected children may be misdiagnosed with ADHD, ASD, attachment or behavioural disorders, and given inappropriate treatment.

A correct diagnosis not only confirms the cause but gives some idea of what to expect, and directs towards appropriate areas of treatment. Early diagnosis will also reduce the likelihood of having another child with FASD by up to 80%.

Awareness and prevention

Other arguments aside, the sheer cost of lifetime care for affected children and adults means that resources must be put into raising awareness amongst health workers, educators and the public at large.

Prohibiting advertisements selling the message that alcohol is necessary for fun would be a step forward. Better labelling of alcoholic products, with clearer warning symbols, would also be helpful. Public health and safety campaigns could be used to promote awareness of the risks of drinking during pregnancy. It is impossible to say what is a 'safe' level of drinking during pregnancy – risk is variable – but what can safely be said is that 'no alcohol' means 'no risk'. One simple step towards quantifying risk prevalence would be to include a record of alcohol consumption as a routine part of antenatal care (using standardised questionnaires such as Audit-C, T-ACE or TWEAK).

Guidance

Clear and consistent guidance must come from the Chief Medical Officer, Department of Health and NICE, and from the BMA, GMC and RCOG, saying that the only advice to women who are, or who are trying to become pregnant is that they should avoid alcohol completely. Presently, some official guidance suggests it is safe to drink one or two units, once or twice a week when pregnant. How many units of alcohol there are in a glass of wine, for example, is in any case difficult to be sure about, such is the variety of alcohol strengths and wineglass sizes. Just two 250ml glasses of 13% alcohol wine would contain 6.5 units of alcohol – officially a 'binge'!

Treatment and support

Treatment is about tailoring the environmental, psychological and medical support to each individual, 'scaffolding' what they cannot do for themselves, and encouraging what they can. Understanding what they can and can't do avoids inappropriate blame being heaped on children, or their parents/carers.

Educating educators is no less important; less severely affected children may well be first 'recognised' by play leaders or teachers. Inevitably, many of these children are fostered or adopted, often before signs of FASD come to light. Information, support and advocacy for parents and carers are essential. There are a number of volunteer organisations in the UK doing excellent work in this area (eg FASD Network in the North East and Yorkshire; FASD Trust, based in Oxfordshire), but there is a limit to what they can do. Statutory measures are needed.

The role of government

The UK has the unenviable reputation of being Europe's number one nation for binge-drinking. Over 2% of the UK population may already be affected by FASD, a figure set to rise further if current trends continue. A concerted and sustained effort is needed, similar to the push to curb smoking over the last two decades. But as yet there is little evidence of political will.

Dr Raja Mukherjee, Consultant Psychiatrist and one of the few FASD specialists in UK, considers a nationwide prevalence study to be the priority. National statistics will be needed to persuade the government to direct significant resources to training, assessment and treatment.

What next?

Many of these recommendations could be achieved relatively quickly. Looking further forward, it is essential to train specialists, build diagnostic capacity and develop 'hubs' around the UK where the necessary neurodevelopmental assessments can be carried out, strategies for care supervised, and training for local practitioners given. The current postcode lottery must end.

Providing appropriate training for, sharing information between, and integrating the actions of the medical, educational, social care and criminal justice agencies, all of whom are involved with these children and their families/carers, represents an enormous challenge. Multiplying the number of voluntary community-based support groups for parents and carers, whilst avoiding unhelpful duplication or competition, is also vital.

Our part?

As practising health professionals, we could:

- Raise our own levels of awareness
- Display advice posters and literature (*www.nofas-uk.org*)
- Integrate enquiry into alcohol consumption as a routine part of antenatal care
- Encourage local support groups for parents and carers (*www.fasdtrust.co.uk*)
- Encourage local commissioning bodies to consider funding prevalence studies
- Request unambiguous guidance from BMA, GMC and Royal Colleges
- Invite MPs to support better labelling , funding for compensation and for national prevalence studies

Many of those currently working in this field are Christians, motivated by the same compassion and regard for the value of all human life that energises Christians involved in the care of other vulnerable people. They face significant obstacles – vested interests, public attitudes, scarce funding. They are the champions of a previously hidden group of children, who will require lifelong support, and they will value our encouragement and prayers.

Rick Thomas *is CMF Public Policy Researcher.*

The UK has the unenviable reputation of being Europe's number one nation for binge-drinking. Over 2% of the UK population may already be affected by FASD

letters

2.00005-parent embryos

The media sound-bite of 'Three-parent embryos' is misleading and should not be encouraged by CMF (News Reviews, Spring 2015, p5). Mitochondrial DNA constitutes roughly 0.005% of the total and its 37 genes (~0.15% of the total) are principally concerned with the integrity of the respiratory (energy producing) chain, so the analogy that mitochondrial donation is essentially a case of 'changing the batteries' is a good one.

On average we have 25% of our DNA in common with each grandparent, 12.5% with each great-grandparent, and so on – so we have numerous genetic parents. We also each have ~200 completely novel DNA variants (which occasionally cause very serious genetic disease) that are not present in either biological parent. The CMF promotes the mantra 'unnecessary, unsafe and unethical' in relation to this new technology for preventing devastating and untreatable mitochondrial disease, stating dogmatically that it is 'bad science'. 'Safety' is, of course, absolutely paramount – we can all agree – but is in fact the only serious ethical issue.

Novel approaches to help prevent heart rending experiences and dilemmas common to affected families are undoubtedly necessary if we have any compassion and seek to advance medicine. Concerns about the 'slippery slope' – where it might all lead – are perfectly valid, highlight the responsible use of any new technique, and flag the need for regulation. Unfortunately, as with IVF (which is here to stay), it may be many years before a full assessment of the safety can be completed, together with an evaluation of how such individuals will 'feel' about the treatment.

Alternative legal solutions are indeed available, namely adoption or IVF with egg donation, but these are often unacceptable, and the latter introduces a far greater degree of genetic uncertainty (from the donated gamete) compared to non-mutated mitochondria. In fact, the legal option for many couples is prenatal diagnosis with a view to termination of pregnancy.

The transmission of donated genetic material to the next generation is a novel ethical issue but will occur only through female lineage, and will hopefully provide reproductive confidence in the context of a tragic family history. We are witnesses to the beginning of a very new era of medical science; as Christians we should engage with it and seek to steer a safe passage through rather than condemn and dismiss potentially beneficial developments.

Peter Turnpenny *and* ***Alan Fryer***
Consultant Clinical Geneticists in Exeter and Liverpool

Author's reply

My 400 word News Review[1] in the Spring 2015 edition of *Triple Helix* could not possibly do justice to the detail in the articles[2,3] and official submissions[4,5,6,7,8,9] that CMF has published on the subject of 'therapeutic mitochondrial donation' over the past five years. However, even allowing for the simplification inevitably inherent in summarising, I consider that the description of 'unnecessary, unsafe and unethical' fits these therapies well.

The astronomer Johannes Kepler described science as 'thinking God's thoughts after him'. If fallen human beings are 'flawed masterpieces', as Professor John Wyatt has argued, then the best science and technology is that which aims to restore the human masterpiece in accordance with the artist's original intention rather that attempting to design something new. We are certainly not opposed to beneficial scientific advances but there is a difference between faithful restoration on the one hand and 'enhancement' on the other.

The technologies in question, *pronuclear transfer* (PNT) and *maternal spindle transfer* (MST), do not involve simply the delicate and precise extraction and replacement of mitochondria containing diseased DNA – 'replacement of batteries' is a specious euphemism for what really is happening.

The whole nucleus is rather extracted and replaced with another, either before (MST) or after (PNT) fertilisation. Or, to put it another way, the entire cytoplasm along with its mitochondria and all other organelles is stripped from its nuclear connections and combined with another nucleus – more Picasso than Michelangelo.

Aside from the fact that any new genetic defects thus created will be passed on down the germline, only to be discovered in subsequent generations when it is too late to extract them from the human genome, the techniques have not yet been adequately tested in non-human primates.

Drs Turnpenny and Fryer see no 'serious ethical issue' other than safety but this will be primarily because they do not object to embryo research per se, taking a gradualist view of the moral status of life before birth, which I do not share. But aside from that I contend that the risky and invasive harvesting of the necessary large number of human eggs from women, and the identity confusion of genealogically confused progeny are also 'serious' ethical issues.

I have recently reviewed thirteen possible approaches to mitochondrial disease of which 'mitochondrial donation' is just one.[10] My conclusion is that although gene editing fits best with the restoration model (if it can be done as safely in humans as in mice), adoption (of embryo, baby or child) or choosing to care for a baby with special needs resonate most with the redemptive Father heart of God.

Peter Saunders
CMF Chief Executive

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10. Saunders P. Thirteen 'solutions' to mitochondrial disease assessed. *CMF Blogs*, 24 May 2015 *bit.ly/1LGOvsg*

Their name is today:
Reclaiming childhood in a hostile world
Johann Christoph Arnold

- Plough, 2014, £9.24, Pb 189pp, ISBN 9780874866308
- Reviewed by **Sarah Germain**, a former hospital doctor and former CMF Junior Doctors' Committee chairman.

In a world where many pressures seek to deny children a happy and healthy childhood, Arnold aims to write a 'hopeful book about childhood'. He challenges parents and teachers to transform the way society is treating children. He starts by explaining why the world needs children, and challenges our Western society to value them as many other societies do. He then goes on to look at areas where children face pressure and danger.

Arnold's style is warm, yet challenging, drawing on the experience of many parents and educators, with thought-provoking examples. He warns against rigid testing in schools at an early age; pushing children to succeed and achieve; the many dangers of technology and materialism; and prescribing drugs for 'normal childhood traits'. He goes on to discuss the positive ways we can influence children to be 'what we want the world to be like'.

As a parent, I was struck by many of his suggestions, including ensuring our words and actions are in line with our ideals, valuing time and attention over material things, and encouraging perseverance and pride in achievement. It is a shame more of a Christian worldview wasn't included, apart from the chapter on 'discovering reverence'. His theology of the 'purity and innocence' of children is also problematic. This aside, it is an easy, yet thought-provoking read for any parents, teachers or carers of children.

Growing up to be a child
Peter Sidebotham

- Westbow Press, 2014, £9.14, Pb 174pp, ISBN 9781490840673
- Reviewed by **Andrew Tomkins**, Emeritus Professor of International Child Health at University College London.

This is a 'must' for all parents! Whereas many Christian authors emphasise the need to engage in thoughtful reading and interpretation of Scripture, Jesus said that 'Unless you change and become like little children, you will never enter the kingdom of heaven'. Whatever did he mean?

Peter Sidebotham, a widely respected paediatrician with expertise in child development, provides rich insight into the stages of early childhood that all parents will have experienced and probably been puzzled or exasperated by. He shows how appropriate and inappropriate parenting can explain dysfunctional attitudes as adults, including a brief section on physical punishment. Brave man! He describes the relevance of understanding, attachment, self-awareness, awareness of others, and communication of a child towards a parent and gives new insights into the many scriptures which describe how, and why, we can relate to God as adults.

This book also helps us understand why adults vary with regard to emotion, empathy and enquiry. But the author goes much further by explaining how we can all develop a greater understanding of God's love, power and purpose for us if we come with dependency, affection and wonder – just some of those precious phases of our development which often became displaced by adult arrogance and self-importance.

Prayer: *Experiencing awe and intimacy with God*
Timothy Keller

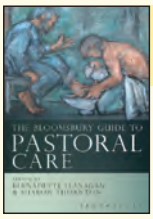
- Hodder & Stoughton, 2014, £16.99, Hb 321pp, ISBN 97814444750157. Available as an ebook.
- Reviewed by **John Martin**, CMF Head of Communications.

There is a paucity of quality books on prayer. Even good ones rarely strike an adequate balance between the theological, experimental and methodological. Tim Keller has succeeded in striking the needed balance between all three, hence a stand-out work.

Evangelicals often look to Catholic and Orthodox authors for material on prayer. It's one of my beefs that so many seem unaware of the huge and rich body of prayer resources available from our own tradition. Keller garners a huge panoply of Reformed and evangelical wisdom from down the ages. Over 350 references invite the reader to quarry further.

Keller's starting point is the prayers of the Bible. In the Lord's Prayer, he says, the Christian has all the necessary resources for theology and the practice of prayer; he demonstrates this with a succinct commentary on its two subsections and six clauses.

He moves to the practice of prayer, with a master class from the three 'greatest of the older writers on prayer', Augustine, Luther and Calvin. He draws wisdom on the most common problem we all face with prayer – the seeming silence of God. Finally he offers resources for daily prayer, including explanation of how the Anglican divine Thomas Cranmer pioneered daily prayer for lay people. Buy it to read. Buy a second copy for your minister.



The Bloomsbury guide to pastoral care
Edited by Bernadette Flanagan and Sharon Thornton

- Bloomsbury Continuum, 2014, £35.00, Hb 240pp, ISBN 9781441125170
- Reviewed by **Russ Parker**, director of Acorn Christian Healing Foundation.

This book consists of a collection of essays addressing a wide range of issues affecting the practice of pastoral care in a world of rapidly changing social contexts. The subject matter embraces such diverse issues as asylum seekers, cults and sects, male violence against women and cyberbullying. As such the book offers an insight into disciplines and experiences that may fall outside the remit of many of its readers.

The book is divided into two basic sections covering European trends and themes and their North American equivalents. A most helpful chapter is the one entitled 'pastoral care today' by Kevin Egan, who helpfully explores the differences to be understood between pastoral care and pastoral counselling. He charts the increasing secularisation within the disciplines of the pastoral world and examines the role still remaining for the traditional care from the church pastor and the boundaries such secularisation now entails.

The book is informative for those encountering new arenas of concern and the extensive book recommendations will enable such readers to grow in their knowledge of their new fields of enquiry. However, as most pastoral carers work within their fields of expertise this book can only serve as a discussion starter.

eutychus

'Wellness': a new Gnosticism

Gnosticism was early Christianity's deadliest rival. Gnostics claimed 'secret knowledge' and insisted that slavish adherence to their beliefs or rituals guaranteed eternal happiness. Eutychus can't help noticing resemblance between Gnostic attitudes and prescriptions of a new breed of 'wellness' bloggers. Belle Gibson, a 23-year-old Australian, claimed she beat brain cancer by cutting gluten and sugar. Her health app, downloaded 300,000 times, made serious money. Miss Gibson now admits she never had cancer and clearly knows little about nutrition. The internet is a happy hunting ground for quackery. Too many put uncritical faith in self-styled wellness gurus. *Guardian*, 22 April 2015 *bit.ly/1HuV3Fw*

Health as a global lens

Health, says Human Rights Watch (HRW) World Report 2015, is a 'lens' through which it's possible to observe 'compelling and disturbing themes' in a troubled world. In an editorial reproduced in *The Lancet*, HRW's Executive Director, Kenneth Roth says, 'The world has not seen this much tumult in a generation...it can seem as if the world is unravelling'. He continues: 'when one delves deeper, there is a hidden story that often does not make the headlines. That story is the health dimension of human rights.' *Lancet*, 7 February 2015:481 *bit.ly/1LW2mJL*

Home care businesses 'fragile'

News that Saga has given its Allied Healthcare business a balance sheet value of 'nil' and put it up for sale following a loss of £220m, raises questions about the viability of the home and domiciliary sector. Most firms are tied to borough council contracts. The UK Homecare Association (UKHCA) says only one in seven councils pays at least the hourly rate of £15.74 which it reckons necessary to cover costs and make a profit of 47p an hour. *Guardian*, 19 May 2015 *bit.ly/1FlRdwH*

'Gay cake' row: bakers lose case

Ashers Baking Co from Antrim, Northern Ireland have lost their case, having been taken to court for refusing to supply a cake with a slogan supporting same-sex marriage. The case brought by a gay rights activist had the support of the Equality Commission for Northern Ireland. The judge insisted the business was not above discrimination law. The firm said they were 'extremely disappointed' and may appeal. 'The ruling suggests that all business owners will have to be willing to promote any cause or campaign, no matter how much they disagree with it,' the firm said. *BBC News*, 19 May 2015 *bbc.in/1JWuZIW*

Social care crisis costs

Age UK claims 2.43 million bed days were lost to the NHS between June 2010 and March 2015 as people wait too long for social care. It says the cost of keeping these people in hospital is a staggering £669 million. Most of the people concerned are over 65. Numbers of patients kept in hospital unnecessarily because social care was unavailable increased by 19% between 2013/14 and 2014/15. Some 44% more patients were waiting for homecare compared to the previous year; 32.8% more patients were awaiting a nursing home place. *Age UK*, 16 June 2015 *bit.ly/1BlYSg2*

Dying without dignity

Bad publicity surrounding the Liverpool Care Pathway caused its abandonment. So is care for dying patients better? We wonder. A new report, *Dying Without Dignity*, documents 265 complaints over poor end of life care over the past four years. No less than half were upheld. It documents many instances of poor communication, poor pain management and inadequate out-of-hours services – all matters that surely can be put right. Pro-euthanasia activists are sure to cite this report to boost their case, but should expedience be allowed to win over compassionate care? *Parliamentary and Health Service Ombudsman*, 20 May 2015 *bit.ly/1HtV3HF*

E-cigarette restrictions in Wales

Opinion is divided over risks associated with e-cigarettes. Even so, Wales will ban their use in enclosed spaces under a new public order law that will come into force in 2017 (date to be announced). The ban will encompass restaurants, pubs, offices as well as lorries and taxis. Sellers will have to join a register for retailers of tobacco and e-cigarettes, a measure that aims to discourage sales to under-18s. It will be an offence to hand over tobacco and e-cigarettes to children. Tattoo parlours will also need licences. *BBC News*, 9 June 2015 *bbc.in/1GnFsYh*

Fines 'affect care'

Is fining NHS trusts an effective way to motivate them to achieve performance targets? Some 51 trusts were fined a total of £92m in 2015. Top of the list was King's College Hospital NHS Trust (paid £8.4m in fines). Julie Wood, director of NHS Clinical Commissioners, which represents local managers, defended the system. Fines are 'about withholding money when a trust has failed to deliver against a statutory mandatory performance standard'. Chris Hopson, chief executive of NHS Providers, commented: fines were 'ultimately reducing providers' ability to hire staff and fund service improvements'. *BBC News*, 9 June 2015 *bbc.in/1Gwsdq7*

Smoking still kills

The government's five-year strategy to restrict tobacco use comes to an end in 2015, but anti-smoking organisations have launched a push for a renewed national plan. They want an annual levy on tobacco companies to fund mass media campaigns and stop smoking services. The report *Smoking Still Kills* was welcomed by Royal College of Physicians (RCP) president Professor Jane Dacre who called it 'a comprehensive blueprint for a smokefree society... smoking is still our biggest killer.' RCP reports that passive smoking causes over 150,000 cases of illness in children every year. *RCP news release*, 10 June 2015 *bit.ly/1JKc6EH*

Mother cannot use dead daughter's eggs

The High Court has ruled that a 59-year-old mother cannot use her dead daughter's eggs so she can give birth to a grandchild. In a case believed to be the first of its kind, a judge ruled there was insufficient evidence that the 23-year-old woman wanted her eggs used in this way. While she consented to her eggs being stored for use after her death, she did not fill in a separate form to show how she wished her eggs to be used. *BBC News*, 15 June 2015 *bbc.in/1FWqBk2*

Using people's 'heart language' always makes a difference, writes **Ruth Eardley**

MESSAGE RECEIVED AND UNDERSTOOD

It was an ordinary working day but my friend was wearing a gorgeous sari in red and gold. 'I don't get many thank you cards' she confided, 'but I do get a lot of hugs'. She is a GP in an area of Leicester where there is a large Asian community and she speaks four ('or five – if you count Urdu') Asian languages – besides flawless English.

The hugs are from old ladies who speak only their mother tongue. They hail from the Punjab and the Gujarat, from Pakistan and Bangladesh. Some have lived most of their lives in Leicester but have never mastered Received Pronunciation let alone a 'propah Lestah' accent and a glottal stop. They usually bring a daughter-in-law or grandchild to the surgery to translate. How wonderful to get an appointment with my friend – they can attend in privacy and alone; they can express themselves and understand the questions; there is true communication and not so much compliance as concordance.

'What do the old men do?' I asked. 'Oh, they still see me,' she smiled. 'They shake my hand for a long time and their eyes fill with tears. But no hugs!'

By a happy coincidence, Leicester is associated with William Carey who loved the people of India and learned their dialects. He 'translated the Scriptures in part into thirty-four languages, with six whole Bibles and twenty-three New Testaments'.[1]

We know that there is perfect, loving and joyful communication within the Trinity and that God communicated with the world through his son Jesus – the Word.[2] Like those grateful patients, we should thank God for communicating with us in a way we can comprehend.

Down the road from Leicester is Lutterworth where John Wycliffe was rector in the fourteenth century. With others, he translated the Bible from Latin into English – a dangerous enterprise in those days. How avidly the scripturally-impoverished populace welcomed the word of God in their own tongue! Wycliffe Bible Translators bear his name. WBT declares that 'history documents the Bible's profound impact on individuals and societies. Its impact is greatest when written in the "heart language" of a people.'[3]

Thank God for John Wycliffe and for William Carey. Thank God for William Tyndale (who later translated the Bible into English from the original languages) and Bible translators today.

Do you have the Bible in your heart language? Read it and be thankful.

***Ruth Eardley** is a GP based in Leicester.*

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3. *www.wycliffe.org.uk/wycliffe/about/bibletranslation.html*

CMF UPCOMING EVENTS

AUGUST

10-14 STUDENT SUMMER CAMP
Moor Monkton, near York

SEPTEMBER

5 CAREERS DAY CONFERENCE
CMF, London

OCTOBER

10 MIDLANDS DAY CONFERENCE
The Welcome Centre, Coventry

16-18 NORTHERN CONFERENCE
Craiglands Hotel, Ilkley

23-25 IRISH CONFERENCE
Durrow, County Laois

26-28 RETIREES' CONFERENCE
King's Park Conference Centre, Northampton

NOVEMBER

6-8 SCOTLAND CONFERENCE
Abernethy Centre, Inverness-shire

7 LONDON & SOUTH EAST DAY CONFERENCE
CMF, London

13-15 NATIONAL JUNIOR DOCTORS' CONFERENCE
Hothorpe Hall, Leicestershire