autumn 2020

for today's Christian doctor

triple helix

COVID-19
voices from the frontline

vanquished or vindicated by the virus? servant leadership, corruption and conflict of interest, from medicine to music

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contents

God in the gaps

Perhaps one of the most significant things we can take into a future COVID peak is the importance of being present for our patients

One of my favourite pastimes is walking the mountains of Snowdonia. I spent many a day off in its breath-taking hills when I worked in Bangor. One memorable day out a friend took me scrambling up the side of Tryfan, notorious not just for its rugged crags and picture-postcard formations but also its two, three-meter high monoliths at the top – nick-named Adam and Eve. North Walian climbing etiquette dictates that those ascending Tryfan for the first time should jump between the two, a gap is little over a meter. However, the stones are perched on the cliff edge, and the exposure on one side is knee-knocking. All sorts of doubts race through the mind. What if I jump too far? Not far enough? The landing so close and yet feeling so far away. The gap getting bigger every time I catch a glance at the valley disappearing below me.

As we make our somewhat groggy retreat down the side of the first peak of the COVID-19 pandemic, maybe this affords a quiet moment to reflect on what the last few months have brought us. One of my abiding memories is of the gaps wherever you looked. Gaps in rotas and around the lunch table as the virus took a heavy toll on colleagues' health. Stories of gaps in our national PPE stock. Gaps in our clinic and hospital lists as services were cancelled and patients heeded the advice to stay at home. For me, the most striking gap was the one by the bedside – the one in the chair a patient's loved one should occupy. While this gap was hard for me to witness as a carer, it was harder for the patient who had the pain of illness compounded by separation from loved ones. To say nothing of the sheer helplessness of family having to stand back and entrust the care of their loved one to others.

One of the striking things I heard the staff on the COVID wards talking about was how the patients had become like family. Doctors and nurses learnt how to be truly present for those in their time of need. Despite the risks to their health, the fear for their families at home, the fatigue of non-stop shifts and the frustrations of the lack of PPE, they could also see and feel the absence of their patients' loved ones, knowing that, for a time, they would need to stand in that gap. And stand in the gap they did.

There have been so many good examples of how we can adapt to help people in such crises again. From names and photos on our PPE to ensuring every patient has access to a video call. Perhaps one of the most significant things we can take into a future COVID peak is the importance of being present for our patients. We now know better than ever that the road of sickness and deteriorating health is often one marked with fear and loneliness.

Our hospitals are filled with ever more advanced and sophisticated technologies, but COVID-19 has shown us that at their core, all clinical settings should be filled with care; to be a refuge for the suffering traveller. Our job is to provide and embody that care – to live it out in a way that technology will never be able to replicate, finding ways to communicate sensitively and clearly, even when we don't feel we have the words. To sit with those in distress, and not to fear the silence. We must show people that, whatever the circumstances, whatever the barriers (PPE or otherwise), whatever the protective distancing policies, they will never travel alone.

Yet, as the dust clouds have settled ever so slightly, and we now begin to have the chance to reflect on all that has happened over the last few months, I find it easy to feel somewhat guilty about missed opportunities. For the missed chances to help and support those who have suffered. For the things we could have done differently.

I am also fearful of having to show up and stand in the gaps all over again, wondering where the energy – both physical and emotional – will come from. I am thankful too that in the chaos of COVID, we were never left to work alone, in our own strength. We have a God who, from the beginning of the Bible story to the very end, longs to be with his people. From the Garden of Eden to the Tabernacle, from the Temple to the Church, we have a God whose promise to his people is '*I will be with you*'. Through the incarnation of Jesus, we have a God who, in the most incredible way imaginable, both showed up *and* stood in the gap to bring those who would trust in the promise of his salvation home to himself. So, if we need to scale the peak again, we need not fear falling into the valley below, as Jude 1:24 tells us, he will keep us from stumbling and one day will bring us to be with him – forever face to face.

Anthony Williams *is a palliative care consultant in South Wales*

This editorial originally appeared on the CMF Blogs under the same title on 29 July 2020 at *cmf.li/3jRHUyv*

news reviews

Ideology trumps evidence at the BMA?

votes on controversial issues passed, ignoring the science

Review by **Mark Pickering**
CMF Chief Executive

The British Medical Association (BMA) held its annual meeting on 15 September. Usually a four-day residential event with 600 delegates, it was reduced to one day online due to COVID. Much debate focussed on urgent COVID-related issues, but there was also a helpful open session on embedding equalities and inclusion in the light of COVID, during which I was able to remind delegates that faith is often the 'forgotten protected characteristic' of the Equality Act. We should see faith perspectives in healthcare as valuable contributions, rather than simply problems.

However, two debated motions revealed a much more concerning agenda. The first, regarding transgender issues, went significantly beyond the broad principles of ensuring dignity and respect for transgender staff and patients in the NHS. It proposed removing any medical input to legal gender transition and strengthening the ability of under 18s to access full gender transition treatment, despite the current controversy surrounding the Tavistock Clinic and concerns over children receiving life-changing treatments without sufficient safeguards and reflection. Concerns over trans rights trumping those of women's rights in access to gendered spaces (such as domestic refuges) were also brushed aside. A helpful briefing paper from the BMA ethics team was hastily withdrawn and urgently rewritten to excise certain paragraphs deemed inappropriate, although with no explanation of why. There was a distinct feeling that the only opinion deemed valid was that of full-on trans affirmation; the motion was passed in all its parts, but with an unusually high abstention rate (14-18% for each part), suggesting unease amongst many delegates.

A second motion proposed the continuation of telemedicine provision of home abortion, so-called 'pills by post' that was brought in (up to ten weeks' gestation) as an emergency measure during COVID in March. This has long been an aim of abortion lobbyists, who are using the COVID measures as a 'foot in the door' to continue them. Speakers stated the many benefits of the measures, such as reduced waiting times and even better safeguarding against domestic abuse. Powerful speeches were made against the motion by Melody Redman and Naomi Beer, highlighting evidence from leaked NHS communications in May showing deeply concerning complications, including two maternal deaths, a stillborn at 28 weeks and a near-miss at 32 weeks. However, proponents of the motion, and even the chair of the BMA ethics committee, simply dismissed this evidence as 'misleading', instead repeating the mantra from abortion providers that all is safe and well.

Priceless but penniless

Hero worship and the NHS pay rise protests

Review by **Georgie Coster**
CMF Associate Head of Nurses & Midwives

On 21 July, in a move by the government to cultivate a positive relationship with its valuable 'frontliners', the Treasury announced a pay rise for almost 900,000 public sector workers.[1] However, not everybody embraced the pay rise because the pay rise did not embrace everybody. In the NHS, the raise will only benefit dentists and senior doctors, leaving nurses, midwives, junior doctors, healthcare assistants, and many other frontline health workers excluded, not to mention those working in social care.

Many of those excluded are in the final year of a three-year Agenda for Change pay deal,[2] while junior doctors signed an agreement last year[3] after a hard-fought battle. Not at all satisfied with that reasoning, protestors filled the streets in more than 30 UK cities to express their disgust at the decision.[4]

While the fight against the virus has taken centre stage, another battle has bubbled under the surface: the fight for hero status. Who has sacrificed more during the pandemic – teachers or healthcare workers? NHS staff or care home staff? Nurses or doctors? Intensivists or GPs?

Many healthcare professionals object to being called 'heroes' because heroes volunteer. In contrast, they argue, healthcare professionals are employed to provide a service for which they have been promised an appropriate financial compensation. Calling them heroes masks the truth.

In contrast, a CMF member recently told me that '*I have never knowingly treated a COVID case. And I am not the only one who has "felt a fraud" when clapped on a Thursday by my neighbours. Particularly so when I know that many of my neighbours, and church brothers and sisters, had to either continue to work in supermarkets, public transport, care homes, or survive on furlough on 80 per cent pay, whilst struggling to pay rents, and fearing eventual redundancy... meanwhile [many doctors receiving the pay rise] have been sitting at home, still being paid for work they were not able to do because of lockdown...*'

Sometimes our colleagues work hours that are incompatible with their or their patients' safety. Some rely on foodbanks despite working full time because their wages are insufficient. Others are paid more despite doing less due to circumstances beyond their control. That does not feel just. And we should speak up – sign the petition; write the letter; go to the protest. However, we must realise that our attitude to our own work is of utmost importance and that this season of exasperation among colleagues is an opportunity for us to shine, knowing that while our earthly rewards may waver, our treasure in heaven is secure.[5]

This news review is based upon Georgie's CMF Blog at *cmf.li/3gVQIBB*

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Vaccinations

ethical challenges in the fight against infectious diseases

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

In August, Australia's ABC News reported that the Anglican and Roman Catholic Archbishops of Sydney, Glenn Davies and Anthony Fisher, had raised ethical concerns about the COVID-19 vaccine being developed by a team at Oxford University. [1] The vaccine, AZD1222, which is currently undergoing trials in South Africa and Brazil, [2] was developed using a stem cell line derived from a fetus aborted in the early 1970s. [3]

The use of fetal-derived stem cells in the development of vaccines is not new. Vaccines for rubella, rabies, hepatitis A and chickenpox, for example, were derived using a stem cell line derived from abortions in the early 1960s. [4] How should we process the fact that we may already have benefited from research facilitated by voluntary abortions? How should we evaluate the morality of accepting a vaccine whose source is ethically questionable, when to denounce it could have catastrophic effects in the context of a global pandemic?

A paper from the Vatican in 2005 offers a helpful framework for considering these questions. [5] It concludes that '*there is a grave responsibility to use alternative vaccines and to make a conscientious objection with regard to those which have moral problems*' but that where there is no alternative, the use of morally problematic vaccines may be necessary '*in order to avoid a serious risk... for the health conditions of the population as a whole*'.

There are, of course, other ethical considerations around vaccines. These range from the source of research funding, how the vaccine is being tested and the ethical history of the institution, to the question of the legitimacy of a government ordering compulsory vaccination. CMF is spending some time looking into some of these issues, whilst being aware that Christians will differ on them, and it is up to individual conscience to decide with which questions we can live.

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Coronavirus 'immunity passports'

An undesirable and unworkable response to COVID-19

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

Should people who have positive antibody tests for SARS-CoV-2 be issued with immunity certificates? With pressure on the international tourist industry, global sporting events and business travel, there is a growing economic case for using such certificates, or 'immunity passports' to bypass quarantine regulations between and within countries, returning a semblance of normality to national and international travel and business. These certificates would allow these privileges or exemptions from restrictive public health regulations because such individuals are likely to be immune to COVID-19. On the face of it, this could be an attractive idea and a way out of lockdowns within and between nations.

However, there are strong reasons for concern. [1] Four months ago, the WHO produced a scientific briefing, [2] highlighting the limits of current knowledge and the technical limitations around issuing such' certificates of immunity'. In it, they state that '*The use of such certificates may increase the risks of continued transmission*'. A report on the BBC World Service quoted Robert West, Professor of health psychology and behavioural science at University College, London as saying '*certification could create a multi-tier society, and increase levels of discrimination and inequity*' allowing a supposedly '*COVID-immune elite*' to develop. [3] Dr Briand and colleagues from the Global Infectious Hazard Preparedness Unit at the WHO presented a very comprehensive and thoughtful seminar on the issue in May 2020. [4]

There are several problems with making such 'immunity certificates' or 'passports' workable. Firstly, the scientific validity of any immunity certificate would depend on adequate evidence that the serology test was of sufficient sensitivity and specificity. It would also depend on whether the presence of antibodies reliably indicated protective immunity or reduced infectivity. Finally, it assumes that the duration of protective immunity is known and specified. At present, none of these details is fully understood.

Secondly, the official validity and applicability of such a certificate would depend on a common, international standard for laboratory accreditation and the administration system which verified the person's identity, as well as the creation or appointment of a certifying body capable of monitoring the scheme.

Finally, even if it were possible to fulfil all such conditions, there would still be the problem of justifying the expense of just carrying out the millions of tests that would be required, let alone of setting up and policing the global standards. Furthermore, it is conceivable that such 'immunity passports' would create a perverse incentive to expose oneself to infection, undermining public health efforts Most worryingly, it would exacerbate social inequalities since both access to, and the consequences of, testing may be manipulated to the benefit of the rich and powerful and the detriment of marginalised groups. [5]

At present, the promotion of 'coronavirus immunity certificates' appears to be incompatible with Christian and professional ethics.

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We share three, different stories of how Christian health professionals have been affected by the COVID-19 pandemic and what God has been doing in and through them

VOICES
FROM THE FRONTLINE - THE UK

From the end of March to the end of May, we recorded over 40 testimonies from CMF members and other Christians working in the healthcare in the UK and overseas about their experiences during the first peak of the COVID-19 pandemic. Here are three of their stories.

THE OCCUPATIONAL THERAPIST

Ruth *works as a paediatric OT in Oxfordshire*

A lot of our caseload had to shut down when lockdown started. For the kids that were physically healthy with only moderate learning difficulties, it was mostly OK. But those who were more vulnerable were put onto a special caseload managed by technical and therapy instructors, only coming to me if there was anything that I need to make a call on.

Many parents really struggled, and the children were very anxious, especially the older ones. They already deal with a lot of anxiety, fear and difficulty in their lives, so something like this caused even more worry. It was also very isolating for them – they missed school and their routines.

Early in lockdown, I got drafted across into a community therapy service working alongside the District Nurses. One thing that was quite a sobering was when we were given training in the verification of death. This is something that we never do as therapists. A District Nurse did the training. At the end of the training, you could have heard a pin drop in the department. But the District Nurse said, '*Any problems, just take the time, go outside, give us a phone call. We're all there, and we all want to help each other*'.

I believe that God sends us into situations where we can't openly say '*I'm a Christian*' or give the gospel, but we can pray. I heard what people were saying to me in person or over the phone, and I heared the anxiety in their voice. So, I would just pray. The Bible says '*The prayers of the righteous are heard by God*' so, I believe that in all the situations we were going into God had a purpose and a reason, maybe more than we'll ever know.

There were several verses on which I was reflecting and meditating during that time – Psalm 121, '*I look to the hills – where does my help come from? My help comes from the Lord, who made heaven and earth.*' And I thank God that he's given me help. I ask God for wisdom, and as it says in James 1:5 '*if anybody asks for wisdom of me, I will give it liberally and without reproach*'. There were times when I was saying to God '*I don't know, I feel like I'm out of my depth right now, but I know that you'll give me that wisdom*'. As I was driving around making home visits, I would meditate on Philippians 4 where it talks about anxiety and praying and also encouraging us to '*rejoice, and I say again rejoice. Let your gentleness be evident to all*' and I just thought – well, if I can only do one thing, then I'll go in with a gentle spirit

THE ITU NURSE

***Adi** was working in a unit for suspected COVID-19 patients*

Life was very different in ITU at that time. Mentally we were all apprehensive. It was tough to know that you might get an infection from your patient, and yet you still go and care for them.

There is a dark side to PPE. When you wear a tight mask around your face, a hat, a face shield, a gown, two pairs of gloves, and something to protect your shoes, it's tough. You have to stay in that unit for twelve and a half hours. It is physically draining. You feel hypoxic because you can't breathe normally, and you are constantly sweating. You can't even go to the loo because your patients are terribly sick. They are on maximum life support so you can't take your eyes off that monitor.

Yet, I found help in Scripture. I was reading through Matthew 8:1-4. He went down and touched a leper, and he healed him and spoke to him a few words. That was really encouraging for me. Jesus was defying the norm by caring for the sick, even though they are infectious. Jesus touched a leper, which was not acceptable at that time. We were going in and helping people in need who others feared to touch. That gave me a beautiful understanding of how we can show Christ through our work. Whatever we are doing as Christians in the healthcare professions, we can reflect him.

THE INTENSIVIST

***Audrey** is a consultant anaesthetist in ICU*

We had some fantastic conversations about God and the fact that Jesus is alive... And they came so naturally because of the bizarre circumstance that we found ourselves in

It feels like it's been a bit of a roller coaster ride with real mountaintops of fun and good things and valley dips of really awful stuff. I work in a twelve-bedded ICU, with twelve level three beds and eight level two beds. I usually work part-time, but during the COVID peak, I was in the unit full-time, as were all my colleagues. We were fortunate because we've got a big anaesthetic department, so folks who don't normally do ICU, including most of our trainees, were just drafted into ICU. I think by the first couple of weeks, we had 17 people on per shift, which made it just about manageable.

Most of us didn't know each other, especially the trainees, and then we were working in full PPE. So, we would find ourselves on shifts saying, '*Oh, hello. I'm so, and so who are you?*'. So, we would write on the front of our PPE who we were, what our training grades or professions were.

I think one of the hardest things for our whole team to cope with was that there were no relatives. There's no visiting at all in our hospital. The government gave ICUs iPads. So, we were able to send little videos to families. They weren't in real-time, but we could take a video of the patient, then send that off and they could make a little text comment back to us. And that was lovely.

But when people died, it was tough because the family couldn't be there. We held phones to dying people's ears as family members poured out their hearts. And, you know, we've had staff weeping at the bedside. Audibly weeping in the background as family members wept to their loved one that they knew that they would never see again.

I have found myself standing with nurses sobbing by the bedside, a trainee sobbing across from us and me in tears too. And normally you know my instinct would be to give everyone a hug. But you couldn't even get close enough to put your hand on their arm.

Our nursing staff have just been fantastic. I cannot praise them enough. They did far more time in PPE than we, as medical staff did. They've all worked outside of their usual areas, and they have just been amazing.

I find myself on repeated occasions, speaking to nursing and medical staff, saying, '*do you know when I read my Bible, and I hear about how Jesus lived and his sacrificial life and his selfless giving – the stuff I've seen from you guys has, has reminded me of him*'. And it's true. These are folk who haven't had any real personal experience of faith before, reminded me of what selfless giving to another person is like. And some folk have just laughed and said, '*for goodness sake, keep your Jesus out of it!*'.

But I was working most of Easter weekend, and we had some fantastic conversations about God and the fact that Jesus is alive. God is with us by his Spirit because of the resurrection of Jesus Christ. It was amazing to be able to have those conversations with people. And they came so naturally because of the bizarre circumstance that we found ourselves in.

We were praying together at seven o'clock most nights with CMF's *COVID-1900Prayer*. Several staff had timers on their phones to remind them to join us. These are folks who have never prayed before!

May the Lord keep us enthusiastic about simply chatting the gospel in the rough and tumble. And in the wonderful ability we've had to work together as a team, may we bring the truth of God's kingdom to our colleagues, patients and their families.

You can hear all our voices from the frontline podcasts on the CMF website at cmf.li/COVID19VFF or via our podcast feed at cmf.li/39WJGsC

Aaron Poppleton talks to three CMF members working in global health and mission about the impact of COVID-19 in the developing world

VOICES
FROM THE FRONTLINE - THE DEVELOPING WORLD

Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy. (Proverbs 31:8-9)

The coronavirus pandemic (COVID-19) has stretched health systems, locked down societies and claimed lives across the globe. While COVID-19 research and prevention strategies have been widely publicised within high-income nations, the limited financial, governmental stability, and healthcare resources faced by low and middle-income countries (LMICs) put them at disproportionate risk of suffering and death.

We interviewed three UK-CMF partners working overseas to explore their experiences of the COVID-19 pandemic.

NATHAN LAWRENCE

Mandritsara, Madagascar

I think God has been at work in people, helping them to trust him and remember that 'to live is Christ and to die is gain'

I work as a medical doctor at the *Hopitaly Vaovao Mahafaly* (The Good News Hospital), in northern Madagascar. We share gospel hope with the Tsimihety people of the Sofia Region, providing them with life-saving medical care as we do so.

The community impact of COVID-19

Madagascar has 12,000 confirmed COVID-19 cases (August 2020); however, there have been few recorded deaths. A strict and lengthy lockdown not only risks economic downturn and massive loss of crucial tourist revenues but even outright famine. Storing food is difficult; very few people own a fridge or freezer and so visit the market almost daily. Restrictions are variable and not well enforced or adhered to. Given the alternative, that's probably the lesser of the two evils.

Mandritsara is very remote. Our first two COVID-19 cases were confirmed in July. The local population are mainly rice farmers, meaning people are unlikely to lose their livelihood. They will, however, have more mouths to feed as family members return from towns and cities as their income evaporates. Local culture is strongly relational – this continues to (mostly) trump infection control. I've just returned from a house-warming ceremony where 50 people shared rice porridge, prayed, and sang together in the main room of one of our community health team's new houses. Social distancing was somewhat limited, with mask-wearing intermittent at best.

As COVID-19 has only just arrived in Mandritsara, it's hard to know the longer-term impact. I would not be surprised if there were a significant rise in malnutrition next year. The economic impact will be dramatic for the tourist-dependant parts of the island.

The impact of COVID-19 on your work

Travel restrictions have closed borders since March preventing home assignment and much-needed holidays. Probably even more significantly no-one's been able to get in: students, short-term doctors (medical and surgical), engineers to mend the solar panels, friends visiting, and long-termers in the UK when the pandemic struck. We expected dozens of people over the last six months – we're pretty stretched without them. The hospital itself is quiet (people are avoiding hospitals/towns wherever possible). This makes balancing the budget harder and almost certainly means there's a lot of untreated patients and fewer people hearing the gospel. That said, we have more time to share Jesus with those who are here. It's nice to go beyond just handing out a tract whilst trying to get through a rammed 40 person morning clinic.

Has there been a spiritual impact?

When COVID-19 first reached Madagascar, there was a lot of fear, especially amongst staff who'd read stories on Facebook of healthcare workers dying. I think God has been at work in people, helping them to trust him and remember that '*to live is Christ and to die is gain*'. (Philippians 1:21) Church has been cancelled, and online services are not feasible. We have a one-hour radio service each Sunday. Do pray for Malagasy brothers and sisters missing those meetings. They are a huge part of how people relate to Jesus in this highly collective society. I'm grateful for our team Bible-studies keeping me going spiritually (just finished a series in John 5-10).

How can CMF members be supporting and praying for you?

Please pray for:

- Spiritual sustainment, particularly without church
- Gospel fruit, making the most of our time with patients (despite tiredness and feeling overstretched)
- The hospital's financial stability
- Energy for hospital staff and for those on-leave and students to be able to return

Information on updates, arranging a student placement, or giving to the work of Mandritsara can be found here mandritsara.org.uk or by contacting nathan.lawrence@mandritsara.org.uk

ALISON DUDGEON

Salavan, Laos

The significant economic hardships are having a greater impact than COVID-19 itself

I am a trained nurse and midwife. My husband, Colin, and I work in Laos, a beautiful landlocked country facing many economic obstacles. Buddhism is the official religion, often mingled with animism by the native ethnic groups. I work in Salavan Province, one of the poorest in the country. Malnutrition, stunted growth, malaria, dengue, TB, and Japanese Encephalitis are all major problems and daily challenges. As the sign in our dining room says '*every day is an adventure*'.

We work for a small Swiss-French NGO called SFE Laos on a health education and community development project in the provincial hospital, five health centres and ten rural villages. My work is to reduce maternal and child mortality. The project also aims to improve health by working with communities to build toilets, water systems to provide clean running water, improved agriculture and health education.

Our ministry is based on 1 Peter 2:12, which tells us to '*live such good lives... that they may see your good deeds and glorify God*'. Our aim, with his help, has been to live our lives this way. In a place where it is difficult to share, we have seen God at work, touching people's lives.

The community impact of COVID-19

Laos has very limited resources, making communities very vulnerable. Borders are closed, with restricted entry points and a 14-day quarantine. So far, only 20 COVID-19 cases have been confirmed with no fatalities. Many Lao people working abroad or in the cities have lost their jobs and returned to their home villages. This has put extra pressure on already limited resources. Rice stocks don't typically last between harvests and foraging for food in the forest is common. We have heard that even in the cities some people are foraging along the waterways. Loss of income from tourism is making life very difficult in Laos. So far, the significant economic hardships are having a greater impact than COVID-19 itself.

The impact of COVID-19 on your work

We were advised to leave Laos in March due to the pandemic. It was a tough decision to leave our colleagues and friends behind. We have been able to maintain contact and continue to help and advise them while working remotely. It has been wonderful that social media contact has led to some conversations that wouldn't have happened under normal circumstances. As we prepare for the next phase of our project in January, we are praying for finances. We know many donors are also facing difficulties.

SFE has been active throughout the COVID-19 outbreak. We continue to provide equipment and knowledge while working with our local and national colleagues and other agencies, including the World Health Organisation, to upskill local health professionals. The Government of Laos is training medical personnel to recognise symptoms and perform tests to identify and manage individuals with COVID-19. We hope that the pandemic will positively impact healthcare provision and particularly hygiene in all aspects of life in the nation. One of our challenges has been to promote handwashing. Now this message is coming from all quarters. Irregular running water and limited sinks for staff, patients, and families had been an issue. SFE offered expertise by implementing a 'handwashing station model' to the hospital, working with staff to install twenty-four handwashing stations with water bins and soap. With temperatures of up to 40ºC, SFE also provided Terraclear water filters allowing clean drinking water for staff and patients around the hospital.

For prayer:

- That Laos will continue to have very few cases of COVID-19 and the healthcare quality will continue to improve
- Pray for the Lao people who have lost their jobs and are struggling to survive
- That our brothers and sisters will continue to grow, support and encourage each other – particular as technology is very limited
- That we know Gods leading and timing of our return to Laos

Updates and further information on the work in Laos can be found by emailing alison.dudgeon@sfe-laos.org

IAN SPILLMAN

Kisiizi, Uganda

We have been encouraged by The Blessing, reminding us that we are not isolated, but part of God's church around the world

My wife Hanna, a midwife, and I work at Church of Uganda Kisiizi Hospital in southwest Uganda. The hospital is situated in a hard-to-reach rural area serving a poor community who are mostly subsistence farmers. Our motto is '*Life in all its fullness*' (John 10:10) and a key theme is '*care for the vulnerable*'. In addition to our core work, we run a not-for-profit community health insurance scheme (more than 40,000 beneficiaries in 224 groups), a primary school including special needs children, a school of Nursing and Midwifery, a child sponsorship programme, the Kisiizi Falls tourism project to support our Good Samaritan Fund for the neediest patients and a 300kW hydro-electricity plant for the hospital and our community!

The community impact of COVID-19

We currently have a few suspected COVID-19 cases. However, while none have yet been confirmed, the secondary impact has been unprecedented. Entebbe airport and all borders have been closed since March, except for cargo. Churches, markets, shops and schools are all shut. There was a serious lockdown on public transport, and a curfew with beatings and even deaths reported relating to its enforcement. Thousands of people such as *boda-boda* (motorbike) drivers lost their source of income overnight.

The impact of COVID-19 on your work

In Kisiizi, the closure of our schools, guest house, and cancellation of tourism, electives and visits have significantly dropped our income. Patient numbers have reduced as they have been unable to get here. Supply and equipment costs have increased, sometimes dramatically, as supply lines were interrupted. We had to get special permission to drive to Kampala (a seven to eight-hour trip) to obtain supplies from the national psychiatric hospital for critical medications, including chlorpromazine and carbamazepine.

Some short-term overseas volunteers returned home early, and we were forced to send some staff home, eg primary school teachers on a 10 per cent retainer salary. We had to increase patient charges and insurance fees and for the first time ever, cut salaries by 25 per cent for all staff.

Difficulty getting to the hospital has led to late presentations. One lady with a dog bite was unable to complete her anti-rabies vaccine course and tragically died. Some patients with chronic problems such as epilepsy, diabetes, and schizophrenia could not get ongoing treatment though Kisiizi. Staff have worked very hard to do extra home visits to keep the most vulnerable supplied.

Has there been a spiritual impact?

Prior to COVID-19, Kisiizi was holding weekday staff prayers, fellowship groups and Sunday services. These provided a sense of community and family, encouraging teamwork, perspective and communication, eg '*...whatever you did for one of the least of these brothers and sisters of mine, you did for me.*' (Matthew 25:40) The absence of the student nurses affects the atmosphere and the dynamics in the hospital. Connecting digitally has helped. We have done this through a WhatsApp '*Thought for the Day*' from our Chaplain and Zoom meetings with colleagues across Uganda and overseas (Internet permitting). We have been encouraged by *The Blessing*, reminding us that we are not isolated, but part of God's church around the world. The Ugandan version is brilliant! [1]

How can CMF members be supporting and praying for you?

As we sail these uncharted waters not knowing what is ahead, we thank God that he is our anchor in the storms and is with us in the boat! We pray for wisdom in our planning and good stewardship of the limited personnel and material resources available. It's hard to know what the long term impact will be given the daily increase in cases being reported. We hope the disease is contained as we have a very vulnerable population with malnutrition, TB and HIV still prevalent. Please pray for staff morale and unity and may the joy of the Lord be our strength.

May this time of shaking up cause many prodigals to come home. Amen

More information on the work of Kisiizi and regular updates can be found at www.kisiizihospital.org.ug or by contacting us on khmedsup@gmail.com

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Alison Dudgeon *is a nurse/midwife working in Laos*
Ian Spillman *works as a doctor at Kisiizi Hospital, Uganda*

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Ella Kim, the incoming Chair of the Junior Doctors' Committee, shares a bit about herself and how God has been leading her in her career

UNITING TO SERVE JESUS IN MEDICINE

Triple Helix: ***What's your name?***
Ella Kim: My full name is Soyang Ella Kim – Some know me by my Korean name Soyang, and others know me by Ella so apologies to anyone I have confused in the past!

THx: ***Where do you live?***
EK: London

THx: ***What's your job?***
EK: I'm an ophthalmology registrar in the North Thames deanery

THx: ***How are you involved in CMF, and what does that look like?***
EK: Well, to be honest, I've been a bit of a CMF keen bean since day one of medical school and have been involved in a variety of ways over the years. I'm currently serving on the Junior Doctors' Committee and will be chairing it from October. My main roles over the past year have been organising this junior doctors conference and helping to increase our social media presence. I've also been involved in various local groups over the years and recently helped to set up a church group.

THx: ***What's the best thing about CMF for you?***
EK: Hmm... this is a tough question as there is a lot that I love about CMF. I love that the fellowship is made up of so many different but like-minded people who are all united in seeking to serve Jesus in and through medicine. I love that I've met some of my closest friends through it, and I keep meeting more wonderful, inspiring people each year. I also love that CMF's ministry encourages and helps me in practical ways to live and speak for Jesus in the medical world.

THx: ***What encourages you from day to day?***
EK: The goodness and faithfulness of God whom I meet through his word, through prayer, and through his people.

THx: ***What difference does your faith make to you as a doctor?***
EK: I think it makes a massive difference to why I do my job, who I am ultimately serving, the way I view my successes and failures, and the way I treat my patients and colleagues.

I love that the fellowship is made up of so many different but like-minded people who are all united in seeking to serve Jesus in and through medicine

THx: ***How have you grown spiritually since starting medicine?***
EK: I'm grateful that God has grown me spiritually in different ways. He's matured my understanding of what it looks like to serve him; he has helped me to trust him in any situation that I find myself in, and he gives me the ability to love people that I wouldn't naturally love. I've still got a lot of growing to do and pray that he will continue to teach me and mould me each day.

THx: ***What tip would you give to other Christian junior doctors?***
EK: Try to love and respect everyone the way Jesus does. This includes your boss, your team, patients, relatives, nurses, cleaners, porters, receptionists, ward clerks, therapists, students, rota coordinators, secretaries, and anyone else you come across. And remember that we love because Christ first loved us.

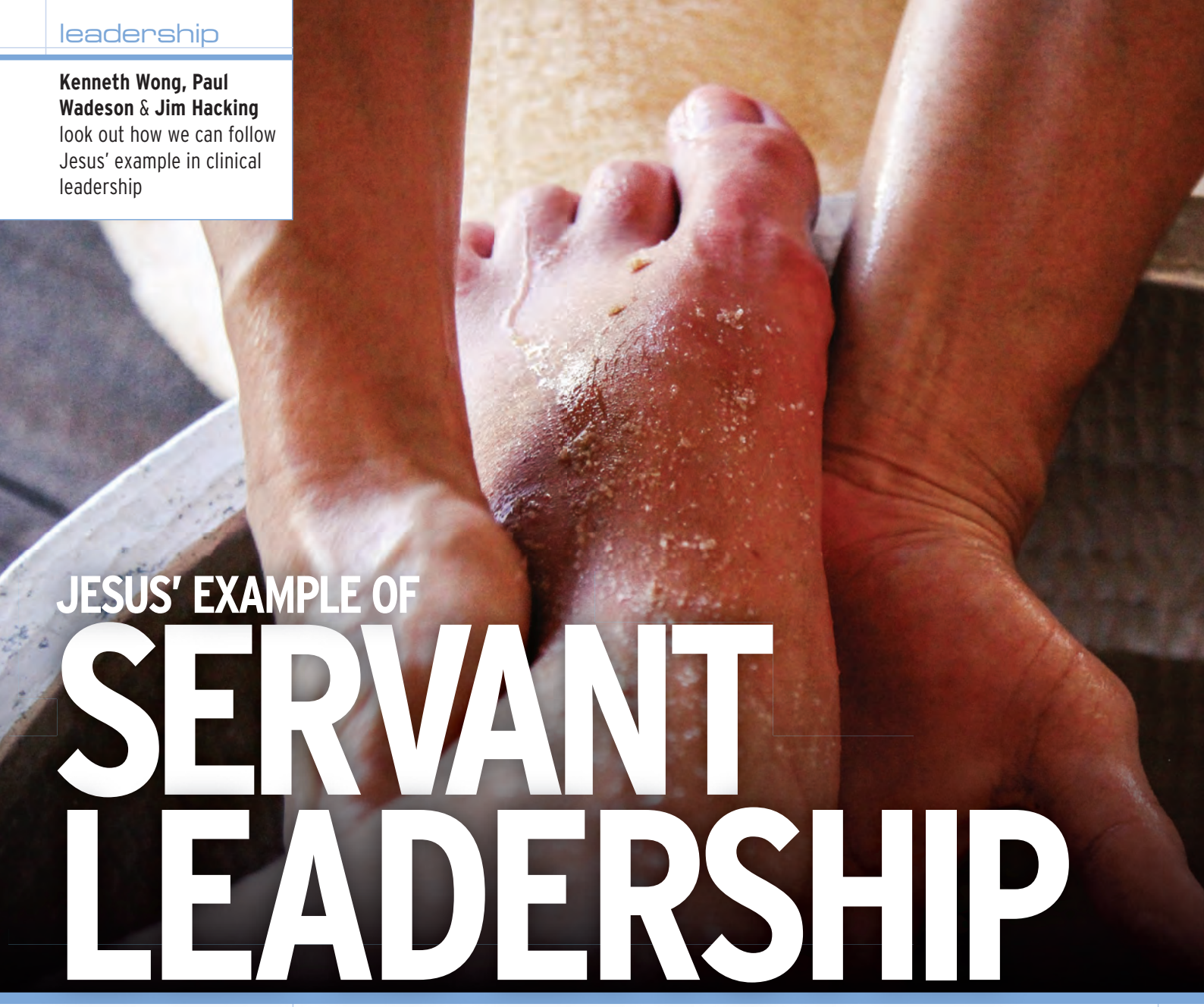
THx: ***What do you like to do outside of work?***
EK: I like to spend time with my fiancé, friends, and family. I enjoy being part of my church, keeping fit, going out for nice meals, creative projects, trying new activities, and going on adventures!

THx: ***If you weren't a doctor, what do you think you would be doing?***
EK: Maybe I'd like to be a teacher, or something very different like a medical illustrator, calligrapher, florist, seamstress, or pilates instructor.

THx: ***What's your favourite biscuit, and why?***
EK: I don't often have biscuits (because I would just eat the whole pack in one sitting), but with my sweet tooth it's difficult to say no to a Choco Leibniz or Jaffa cake (although the latter are not actually biscuits, are they!)

Ella Kim *is an Ophthalmology Trainee in London*

Kenneth Wong, Paul Wadeson & **Jim Hacking**
look out how we can follow Jesus' example in clinical leadership



JESUS' EXAMPLE OF SERVANT LEADERSHIP

key points

- Servant leadership is characterised by humility, empowerment, giving credit where credit is due, accountability, willingness to forgive, courage, and stewardship.
- Jesus demonstrated servant leadership when he humbly washed his disciples' feet and empowered them to follow his example.
- The authors encourage us to follow Jesus, as we LOVE our teams: Love with compassion, being Other-centred, being Visionary and Empowering.

'Now that I, your Lord and Teacher, have washed your feet, you also should wash one another's feet. I have set you an example that you should do as I have done for you. Very truly I tell you, no servant is greater than his master, nor is a messenger greater than the one who sent him. Now that you know these things, you will be blessed if you do them.' (John 13:14-17)

Following the Lord Jesus' example of servant leadership in this passage, let us consider the characteristics of servant leadership, which he revealed and demonstrated. The mnemonic-LOVE-may help us better remember these key features:

L for Love or compassion, which can be defined as seeing a need and lovingly doing something about it. What needs did Jesus see? The disciples' dirty feet that need washing? Their psychological need the evening when they were going to Gethsemane, so Jesus gave them a foot spa? The need for tender loving care? Might Jesus be concerned about pride which can endanger the body of Christ if the head and hands tell the heart and feet that they are not needed? Did Jesus see all those needs and perform this humble act to meet the needs lovingly? 1 Corinthians 13 tells us that love is patient and kind. It does not envy. It does not boast. It is not proud.

Practising compassionate leadership means listening with fascination to those we lead, arriving at a shared (rather than imposed) understanding of the challenges we face. It is about empathising with and caring for the team, taking action to help and support them.

How can we love and pray for our teams? Can we do more than making coffee for the team after a ward round?

O for Other-centred: Servant leadership is characterised by humility (a willingness to listen and learn from criticism). Did you notice how Jesus gave space and time to Peter? When Peter asked him those silly questions, he didn't say to Peter, '*Come on, let's just get on with it. We have to go to Gethsemane in a moment.*' Should we encourage a less hierarchical team structure so everybody can voice their opinion and be valued? After checking the understanding of

the team, we also need the courage to correct any misunderstanding and do the necessary. Jesus is an authentic leader (showing his true feelings). Servant leaders are also willing to forgive.

We see the supreme example of servant leadership when Jesus washes his disciples' feet, an act of service only a slave was supposed to do. Jesus redefined leadership as serving each other in love, meaning there was no job that was low or demeaning to do.

As part of my (Paul's) GP training, six months were spent in a busy A&E department. The supervising consultant for the department was a Christian. In our induction, he stated that his aim was always to lead from the front. I discovered he was a man of his word when on the busy shifts he would regularly be working hard alongside the juniors. There was no role in the department that he felt was too low to him. This was in contrast with another consultant in the department who would only be seen for the big trauma cases. In our workplaces would we be willing to step up and help our colleagues? It can make a big difference if we are willing to humble ourselves. I have a GP colleague who once swept the floor in the waiting room, to the patients' surprise. In what ways can you help and serve your colleagues? Would you be willing to step down to do a task 'below your pay grade' as a demonstration of servant leadership?

V for Vision: Jesus always had a long-term, big picture vision. He knew what the Father had planned and walked the path towards the Cross every day of his earthly ministry. But his disciples could not grasp it. In all four gospels, Jesus explains what is going to happen to him time and time again, but none of his followers can get their heads around it. After his death and resurrection, it took him the whole walk from Jerusalem to Emmaus to explain to Cleopas and his companion how the whole of the Hebrew Scriptures pointed to the Cross and the resurrection as God's plan for salvation. It was then that the penny finally dropped, and they rushed back to Jerusalem to tell the others.[1]

A visionary leader does not just have a vision. They take the time to share it with their team, in different ways, at different times, until the whole team grasps the big picture and can articulate it to outsiders. But often, until they see it in practice, modelled by the leader, the team can find it hard to get the vision clear in their heads. The visionary leads from the front.

Always work for the good of the whole – making sure everything the team does serves the core vision.

Servant leaders also show good stewardship, ensuring that all the resources the team uses are deployed as effectively and efficiently as possible to achieve the vision.

Do you have a clear vision for what your team is there to do, a big picture of what it can achieve?

E for Empowerment: leading by example with clear instructions and appropriate delegation. Give your team responsibility and permission to exercise it. With permission to take on responsibility is permission to innovate and change, but also to fail safely. Failure must be seen as a chance to learn and develop confidence and skills. Are we committed to helping the team develop in this manner especially when we have to stretch our comfort zones? One of the things we need to persistently pray for is wisdom to manage uncertainty and for research efforts to improve understanding.

Finally, in verse 17, Jesus said, '*Now that you know these things, you will be blessed if you do them.*' Are we able to hold our team accountable and give credit where credit is due?

What is the motivation that led Jesus to wash his disciples' feet? Verse three gave us an important clue- '*Jesus knew that the Father had put all things under his power, and that he had come from God and was returning to God.*' Jesus was motivated by this eternal hope and everlasting love (verse 1). Thanks to Jesus' death on the Cross, taking our punishment for sins which separated us from God, we also have an eternal hope. Does that motivate us to be servant leaders and love and persistently pray for our teams? May the risen Lord Jesus pour out his Holy Spirit on his followers and empower us to be servant leaders.

Let us take heed of Jesus' calling as he hold us accountable, '*Now that you know these things, you will be blessed if you do them*'. (John 13:17)

Kenneth Wong *is a Consultant Cardiologist, and Cardiology Directorate Research Lead*
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servant leadership...

Servant leadership is also demonstrated in hospitality: A friend once said to me – 'God is the great inviter'. In the Gospels we see Jesus extending radical hospitality to all, particularly the marginalised and the outcasts. Being a medical student in a large teaching hospital, I (Paul) was very aware of my low position in the food chain! I remember clearly an obstetric and gynaecology consultant taking us out for a pub lunch and how special it made us feel.

I (Ken) also remember how an Ophthalmology professor bought me dinner at a nice restaurant in Oxford when I was a medical student in the mid-1990s. Some acts of kindness are remembered for decades!

I (Paul) remember as a student once being stopped in a corridor by a consultant to introduce himself and ask about me. It has stuck with me to this day because there can sometimes be a tendency for those in authority to be aloof. There is an expression that love is spelt: T I M E. When we give our time to people, we value them.

A visionary leader does not just have a vision. They take the time to share it with their team... until the whole team grasps the big picture and can articulate it to outsiders

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Steve Fouch looks at the insidious and damaging effects of corruption and conflict of interest in healthcare

CORRUPTION
AND CONFLICT OF INTEREST

key points

- The author outlines the differences between corruption and conflict of interest in medical, midwifery and nursing practice, and the impact that they have on patient care.
- Medical corruption and conflict of interest are not just issues in developing nations but are ongoing if often hidden problems in the UK and other developed nations.
- The Bible speaks clearly about the evils of corruption and how we should live as his people.

Do not pervert justice or show partiality. Do not accept a bribe, for a bribe blinds the eyes of the wise and twists the words of the innocent. (Deuteronomy 16:19)

Whatever the origin of our calling to medicine, nursing or midwifery, one thing we would all agree, as Christians and as health professionals, is that we are required to do the best by our patients, our colleagues and the institutions for which we work. Preferably in that order of priority. We need to practice our profession with integrity, seeking the best interests of others, and above all, to honour Christ in all that we do.[1]

The real world presents us with many situations when it is not so straightforward. For instance, what should you do when a drug company offers to fund some clinical research you hope to undertake into one of their new products? Or you are granted funding from a medical equipment company to attend a conference in your capacity as part of a procurement committee? Or a relative offers gifts of food to you and your team before you have even started to care for the patient? What should we do when faced with situations which could call into question our professional integrity?

Conflict of interest

NHS England defines conflict of interest as '*A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold*.'[2]

A conflict of interest could include the provision of 'hospitality' at meetings, including continuing professional development and training, or financial support for study days by pharmaceutical companies, which may result in greater prescribing or use of particular and possibly more expensive treatments. It can also manifest in the form of favouritism – for instance giving more time to relatives, friends or members of the same faith group as oneself.[3]

Conflict of interest compromises our professional integrity. When we lack congruence between our inner, spiritual life and our outer, professional life, we are not living in God's way.[4] Small compromises can be the first steps to much more serious corruption further down the line.

The GMC[5] and NMC[6] have specific guidance on handling such conflicts, and it requires constant vigilance, transparency and honesty on our part not to compromise our integrity

Corruption

Transparency International defines corruption as 'the abuse of entrusted power for private gain'. It classifies it as either grand, political or petty depending on the amount of money and the sector where it occurs.[7]

Grand corruption occurs at a high level of government, enabling leaders to steal funds at the expense of the civic good. A recent case in Romania saw the prosecution of several senior doctors for diverting public funds to their own pockets.[8]

Political corruption occurs when senior officials (including doctors, health managers and senior nurses) distort processes and divert resources for their personal benefit. For example, demands for bribes by officials to obtain permission to set up a new healthcare programme.

Petty corruption involves everyday abuse of entrusted power by public officials (including health professionals) in their interactions with citizens who seek access to essential healthcare services, which are supposed to be provided by the government. For example, asking nurses to inform patients that a 'gift for the doctor' is necessary before the doctor will see them in a 'free' government clinic.

In many parts of the world, political corruption and petty corruption are endemic. Individually, health professionals may have high standards of integrity, but they struggle when all around them compromise theirs. It is especially problematic when salaries are low, and there is a long-established tradition of giving 'gifts' when 'doing business'.

We may, therefore, think that this is primarily a problem of the developing world or the former communist countries of Eastern Europe. However, a 2012 study by Transparency International showed that corruption was more widespread in the UK, including the NHS, than we might think.[9] For example, a recent investigation by Channel 4's *Dispatches* programme found that 59 of 195 Clinical Commissioning Groups in the UK had recorded a breach of the World Health Organization code of practice designed to support breastfeeding.[10] *The Telegraph* reported that, in 2016, pharmaceutical companies paid £116.5 million to doctors in consultancy fees, travel, hospitality and other costs. Only a third of doctors receiving such funds declared them.[11] Furthermore, an investigation by the *BMJ* in 2018 showed that a significant number of Clinical Commissioning Groups failed to declare financial support from the pharmaceutical industry.[12]

The impact

Conflict of interest and corruption are not victimless crimes. As Deuteronomy 16:9 reminds us, when bribery and corruption are practised, truth is twisted, injustice is perpetuated, and the poor suffer. The World Bank considers corruption to be a significant '*challenge to its twin goals of ending extreme poverty by 2030 and boosting shared prosperity for the poorest 40 per cent of people in developing countries*'.

Furthermore, '*reducing corruption is at the heart of the Sustainable Development Goals*[13] *and achieving the ambitious targets set for Financing for Development.*[14] *Corruption has a disproportionate impact on the poor and most vulnerable, increasing costs and reducing access to services, including health, education and justice. Think, for example, of the effect of counterfeit drugs or vaccinations on the health outcomes of children.*'[15] Empirical studies have shown that the poor pay the highest percentage of their income in bribes. For example, in Paraguay, the poor pay 12.6 per cent of their income to bribes, while high-income households pay 6.4 per cent.'[16]

The Bible is quite explicit that bribery and corruption are evil. First and foremost – corruption is contrary to God's character – '*For the Lord your God is God of gods and Lord of lords, the great God, mighty and awesome, who shows no partiality and accepts no bribes.*' (Deuteronomy 10:17).

Scripture warns us about the danger of institutions and cultures that foster corruption – '*Woe to those who make unjust laws, to those who issue oppressive decrees, to deprive the poor of their rights and withhold justice from the oppressed of my people, making widows their prey and robbing the fatherless.*' (Isaiah 10:1,2)

At the same time, corruption warps the soul and the mind – '*Extortion turns a wise man into a fool, and a bribe corrupts the heart*'. (Ecclesiastes 7:7)

Finally, truth, trust, integrity and justice suffer when people with responsibility give way to corruption – '*Do not pervert justice or show partiality. Do not accept a bribe, for a bribe blinds the eyes of the wise and twists the words of the innocent.*' (Deuteronomy 16:19)

Space here precludes a detailed exploration of how we deal with corruption and conflict of interest in practice, but there are lots of resources available. NHS England has produced some helpful, practical guidance based around common scenarios.[17] There are some useful case studies from CMF members who have faced challenges related to conflict of interest in many parts of the world that available on the CMF website.[18]

We cannot do this alone – we need to address this in community. Nobody is immune from the temptation or pressure to work with a conflict of interest or to act corruptly. Being linked in through a local CMF group or workplace fellowship is one way to do this. Discussions based around the CMF briefing paper on corruption and conflict of interest can help explore the issues faced in practice.

Steve Fouch *is CMF Head of Communications*

This article is based on a longer briefing paper, *Conflict of interest and corruption in healthcare: A paper by a working group of the Global Committee of the Christian Medical Fellowship* accessible at *cmf.li/ConInCor*

The paper was produced by a working group of the Global Committee of CMF (Martin Allaby, Ibrat Djabbarov, Jonathan Fisher, Steve Fouch, Fi McLachlan, Huw Morgan, Andrew Tomkins, Marius Ungureanu, Catriona Waitt and John Wyatt). They have been assisted by many individuals and organisations, including Transparency International, to whom the working group is extremely grateful. An interview with Marius Ungureanu about medical corruption has been released on the CMF *1st incision* podcast, available at *cmf.li/2tUKKxw* or *cmf.li/2vpE4Yv*

Case example

Based on the real experiences of Christian health professionals. See *cmf.li/CorCasestud* for more.

You are a senior surgeon working in a government hospital in a resource-poor Central Asian country. You have responsibility for advising on which company should be contracted to supply your hospital with surgical equipment and supplies. Several companies have approached you, offering to run, or pay for, professional training courses for your junior staff who are very keen to learn; there is very little Continuing Medical Education provided by the government. The companies offer high levels of training, hospitality and consultancy fees to yourself. Your colleagues advise you to accept an offer. What would you do?

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Roxana Walker shares how God walked with her on her journey from medicine to a new career

FROM MEDICINE TO MUSIC

WHY CHANGE THE KEY?

key points

- Leaving medicine is a tough choice to make after investing years in training and professional development, but for some it is the right road to walk, especially when we have given our lives and careers to God.
- The author shares her struggles with the pressures and lack of resources in General Practice, and its impact on her own mental health.
- While not wanting to encourage people to leave the profession, the author is keen to encourage those feeling trapped and unhappy to realise that there may be other, God given opportunities to discover outside of medicine.

After nearly 23 years as a doctor, I hung up my stethoscope and picked up my violin. Of course, I had been picking it up for many years, but now it has become my livelihood, rather than purely a hobby. Some people were shocked, while others, including many doctors, expressed genuine approval and understanding. So why would I give up a good career with a healthy income, a position of respect, and the sense of reward which comes from ministering to the sick and vulnerable?

Looking back, I had always found medicine difficult. After studying in Nottingham, my pre-registration House Officer year (FY1) was one of the toughest in my life. However, I then went on to Accident and Emergency, where I began to develop some confidence. I spent six months working in Cameroon and then returned to Nottingham to train as a General Practitioner. After 18 months of locum work, I joined a partnership in 2002, and within a year, I realised that I wasn't happy or settled enough to 'buy-in' to the premises. I joined another partnership, and initially, I thought I had found my job for life. However, one year in, I developed my first depressive illness, which sadly led to my leaving the practice a year later.

> I began to wonder whether this lifestyle and work pattern was sustainable

God often works through difficult times, and the following year I was offered a post with CMF as Regional Staff Worker in the East Midlands. This was one of the best jobs of my life, where I had the opportunity to explore ethical and theological issues, to teach and to spend quality time with medical students and junior doctors. When that post came to an end, I joined a Nottingham practice as a Salaried GP. The following year I got married, and in 2011 my son Joel was born. Two years later, following another episode of depression and a difficult return to work, I took a break and worked as a locum, in order to spend more time with Joel.

Shortly before Joel started school, I joined a local practice, initially as a locum, and subsequently as a salaried GP. The practice was going through turbulent times, with all but one of the partners having retired within a short space of time. Soon after I arrived, the decision was made to go into

partnership with a private company, who would take over the management of the practice.

Sadly, the stability promised by the company failed to materialise. Morale was low, and several staff left. Sometimes there was a four-week wait for a routine appointment with me. Consequently, when patients saw me, they needed far more than could be provided within a ten-minute appointment. There was always a long list of messages and phone calls, partly because patients could not get a timely appointment.

I began to wonder whether this lifestyle and work pattern was sustainable. I was already working part-time in order to stay healthy and to be present after school for my son. I adjusted my working day to manage the workload better. But I often went into work on my day off to catch up with administration, and however much time I put in, I never got on top of it. I was aware that I was bringing my stress home with me and that this was affecting my family as well as my own health.

Although some of the issues were unique to my practice, much of what I have written will be familiar to GPs across the country. Many doctors work more hours than I was working, some with the added responsibility of partnership. I knew that it would not be difficult to get a job in another practice, but that many of the pressures would be the same wherever I worked.

For three years running, I experienced an episode of depression and anxiety, resulting in time off work. On the last occasion, this happened despite taking a maintenance dose of medication. To me, this was a warning sign that there was a more fundamental issue at stake. Both my husband and my mother were experiencing significant health problems, and I knew that I needed to look after myself if I was to support them adequately. I had often felt somewhat trapped in that I was highly skilled in one field, with no opportunity to move sideways into another area. But I started to think more creatively about my options. I met two people at church who were music teachers, both of whom had moved into music from other careers. I wondered whether this was something I would be able to do. I had a degree of proficiency in the piano and violin, experience with children, and teaching skills gained while working in medicine and for CMF. I started giving a small number of lessons informally and found that I enjoyed teaching and received positive feedback.

'*Whatever you do, work at it with all your heart, as working for the Lord, not for human masters*'.[1] Early in 2018, I heard a sermon which prompted me to consider what my motivation was for staying at the practice. I realised that most of my reasons were negative rather than positive – I didn't want to let down my patients or colleagues, but I was no longer working out of a keen desire to serve God, or for a love of the job.

Discerning God's will is often a tricky thing, and I cannot say that God 'told' me to leave medical practice. But I did have a sense that God was giving me 'permission' to move on. It is easy, as medics, to feel that our duty is to serve God within medicine for all our working lives. But this is not what we sign up to. As Christians, we decide to follow Jesus, as he called his first disciples,[2] wherever that might lead. He certainly calls us to make sacrifices for him, but he also calls us to look after our families.[3] He asks us to use our gifts,[4] but most of us have been given a range of gifts which we could use. Providing medical care is not the only gift or the highest calling.

Jesus said to his disciples, '*Come to me, all you who are weary and burdened, and I will give you rest... My yoke is easy, and my burden is light.*' (Matthew 11:28) I have never found medical life easy or light, and yet Jesus calls us to live under grace, not under law.[5] For me, the opportunity to explore music teaching was a chance to step away from the burden of worry about my work, and the toll it was taking on my mental health. It was also a step of faith. I did not know whether I would find sufficient teaching work or whether I would have to locum to supplement my income. As the number of pupils increased, I could see that God was indeed opening this door for me.

We are also called to seek wisdom, '*For the Lord gives wisdom, and from his mouth come knowledge and understanding.*' (Proverbs 2:6) Each of us is a unique individual, known and loved by God. We live in a society which is full of challenges, and many of us work in high-pressure environments. We need to take time to reflect on our situation and to understand our personalities, strengths and weaknesses. Are we in a job where we can thrive, using our gifts and giving of our best? Or are we in a place which is a less good match, where every day is a struggle? If this is the case, it is worth asking ourselves what the cause of the problem is. Are there parts of the job which are particularly stressful, and can anything be done to ease that stress? Can the balance or focus of the job be changed, so that we spend more time on the things which we are good at, and which we enjoy doing? Each person's situation is different, but there are always choices which can be made.

I submitted my resignation, and a few weeks later, the decision was made to close the practice. By the time I left, three months later, I had been offered a post at a local primary school, teaching both piano and violin. Two years on, I now also have many private pupils. I am much happier, and I have not had another relapse of my illness.

In sharing my story, my intention is not to trigger a mass exodus from the medical profession! However, for anyone unhappy in their work, I would encourage them to think prayerfully about what the issues are, to seek God's wisdom and remember his grace. '*Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls.*' (Matthew 11:29)

***Roxana Walker** is a music teacher in the Midlands*

He asks us to use our gifts, but most of us have been given a range of gifts which we could use. Providing medical care is not the only gift or the highest calling

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3. Mark 7:10-13
4. Romans 12:6-8
5. Romans 6:14

Richard Scott challenges us to share the hope that we find in the gospel of Jesus as an antidote to the fear and anxiety surrounding COVID-19

VANQUISHED OR VINDICATED BY VIRUS?

key points

- COVID-19, and all the measures to combat it are creating a climate of fear and anxiety in the nation and around the world.
- The gospel is the answer to this 'Corona-fear', but we need the confidence and skills to be able to share it.
- The author shares several tools and resources from CMF that can equip us to confidently share our faith.

COVID-19 continues to dominate news headlines. Daily prime ministerial briefings may have ceased but print and TV remain devoted to this extra-ordinary microbe. Overwhelming all competitors, it has wrought terrible harm on our health and economy with hundreds of thousands infected, tens of thousands dead and many out of work and many more uncertain of the future.

The effect on our minds has been almost as severe. The mental health tsunami predicted by the Royal College of Psychiatrists is already a reality in general practice. Easing lockdown over the summer has been vital not only for the nation's finances but also for our equanimity. Save the NHS by keeping your distance has been replaced by spend money to save business. But the price has been high, with herd immunity binned early on in favour of disease avoidance, preserving life as well as livelihoods.

De rigeur on public transport and whilst shopping, masks may soon become mandatory whenever we leave the house. Social distancing and limits on meeting in groups have transformed our natural social lives, making them feel not only alien but dangerous. Ubiquitous face masks shout of danger, and barred from normal human interaction, '*keep out of my air-space*' is the unspoken rule. '*Corona-fear*', which rose rapidly and subsided more slowly is set to rise again. Society risks being vanquished by a virus.

Fear not

But not in my consulting room. The ubiquitous scriptural command *do not fear* (mentioned 365 times in the Bible), allied to *do not be anxious about anything* (Philippians 4:6a) sounds like a tall order when patients are faced with life's usual challenges, let alone a pandemic. Paul's words were penned in prison, his life menaced by man. Yet, while our enemy may be invisible, his advice remains spot-on. '*Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds.*' (Philippians 4:6-7) We have the antidote to Corona-fear. Faithful prayer, even through the valley of the shadow of death, [1] and peace will be yours.

The antidote is all very well; but how to get the message for the moment across? Entering general practice, I had one major advantage. Returning spiritually dry from medical mission in the mid-nineties, with faith intact but responsibility for

sharing it unkindled, I not only lacked intention but know-how. God dealt with the first through the Alpha Course.[2] I was stunned to realise that the imperative to tell others about Christ had somehow passed me by. So, I tested the water in what was to be my new mission field as a trainee doctor. I made a deal with the Lord; give me a partnership in a poor seaside town. It took him three weeks to answer that prayer and tell me to 'go for it'.

Intentionality *in situ*, my know-how grew on-the-job. Heroin addicts were my introduction to medical outreach. The cycle they commonly went through was as follows: leave prison, spend their £46 allowance on drugs, rob a supermarket badly, get re-arrested. The addicts were hopeless and Western medicine helpless. So it was that I set up Alpha and drug addict evenings as a new approach to break the cycle. One man was saved after nine prison stretches, becoming our church bass guitarist. Almost all received the message kindly, though many would reject it and die young. With time unpredictably short, I moved on to alcoholics, the depressed, anxious and angry; anyone with a spiritual angle to their illness.

A church mission to Kent in 1999 also proved pivotal for me. Joining a team in Chatham, I learnt to share my faith with people outside of the practice setting. Further UK missions led to doors opening for evangelism in rural Maasailand, Kenya and the genesis of Evangelistic Medical Missions Abroad.[3] EMMA enables a range of health care professionals to share their skills and faith in short-term mission settings. Indeed, our largest ever team of 22 returned from Sierra Leone just prior to lockdown.

Training reduces fear

Kick-started by Nicky Gumbel's *Alpha* course, my journey has stemmed mostly from what I've learnt in the field, boosted by some formal training en route. Theory and practice may be our staple diet as clinicians, yet Christian health professionals are often reluctant to apply this tested formula to spiritual health. '*I'm not trained, it's fraught with danger, not my job...*' Pre-Alpha, this was my position. Now, with eyes opened and in a changed world, I can recommend some training to put your minds at rest and deliver on what our Christian DNA tells us will hugely benefit our patients and colleagues. I'll wager it becomes the most exciting thing you'll ever do at work. Here's what CMF offers:

'**Saline Solution**'[4] originated in America in the nineties. Tried and tested, CMF were early adopters, appreciating the goal of producing appropriately salty Christian medics. With 28 UK trainers, 30 courses took place in just the last five years. Currently flourishing on-line, Saline has been Zoomed abroad most recently to Romania and South Korea. I co-led a Saline course in my practice 15 years ago and was delighted that 40 health professionals from East Kent really valued the gentle teaching. Making the case for science and faith, delegates learn to take a spiritual history and drop in faith flags, leading to the gospel. Formally set-up, it allows for personal stories with detailed feedback another strength. Mixed courses (for diverse health professionals) and a range of timings add flexibility. If you have never undergone any outreach training, Saline is an excellent place to begin.

Saline graduates who fancy something more in-depth and academic may opt next for CMF's in-house '**Confident Christianity**'.[5] Honed since 1989, with input from both past and present CMF CEOs, it's *raison d'etre* is that faith-sharing can be a struggle and that confidence is required to present the gospel accurately. Majoring on the 5 Rs (check them out), communications skills and dialogue, it leans heavily on Paul's strategy in Athens.[6] The course is currently under reconstruction to bring it up to date. Recommended whole-heartedly.

Unashamedly, the third option is mine. '**Outreach in Outpatients**' was trialled last year with CMF's Evangelism and Apologetics Track.[7] It is a medical version of my established evangelism training course for churches. The course is stuffed full of stories from general practice and mission. It is highly interactive and though aimed at medics, it is suitable for all Christian health professionals.

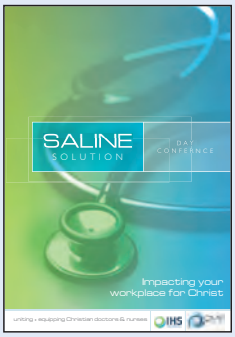
It is based around a series of questions. WHY reach out at work in the face of considerable personal and professional barriers? WHAT are the General Medical Council and Nursing and Midwifery Council regulations? WHAT is the Gospel and WHEN and HOW can we best share it? Emphasising stories, we practise giving testimony (I share mine at least weekly at work). The course naturally overlaps with the previous two, eg emphasising reason and debate, but uniquely stresses the need to take risks for the gospel and finishes with tips from the mission field. The course is stuffed full of stories from general practice and mission, is highly inter-active and though aimed at medics, is suitable for all Christian health professionals.

Vindicated, not afraid

Three options, but one goal: a workforce on fire for Christ and enabled to share his Good News. But why now? For months I resisted writing this article. Exhausted health workers have enough on their plate; there seemed no need for an additional burden to be laid upon them! However, as Corona smoulders with mini-lockdowns and second or even third waves appearing inevitable, the timing seems right. COVID-19 has awakened a spiritual hunger in the nation. Alpha has tripled on-line. Virtual church services are extending their reach beyond their usual congregations. More people admit to praying now than ever before. On YouTube The *UK Blessing* worship song[8] has had nearly four million views since it premiered on 3 May 2020.

The wind is blowing in our direction. Vanquished by a virus? Most certainly not! A desperate society is open to Jesus. This pandemic vindicates Christian outreach. Let's go for it!

Richard Scott *is a GP-evangelist in Margate and CMF's Evangelism Associate*



Saline Solution
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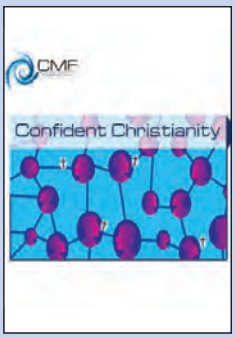

Confident Christianity
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Outreach to Outpatients
Contact: Richard Scott
richard.scott@cmf.org.uk

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3. *uk-emma.org*
4. *cmf.li/Saline*
5. *cmf.li/Cchristianity*
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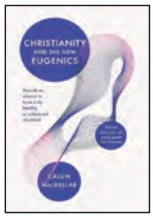


Christianity and The New Eugenics:
Should We Choose to Have only Healthy or Enhanced Children?
Calum MacKellar

- IVP 2020 ,224pp, £12.199, ISBN: 9781783599134,
- Reviewed by **Trevor Stammers**, Reader in Bioethics at St Mary's University and Director of the Centre for Bioethics and Emerging Technologies

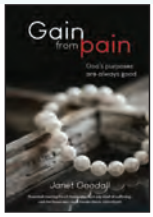
Most Christians will have no idea of the history of eugenics, aside from vague associations with the Third Reich. They will certainly not have any awareness of how deeply embedded the ideology of the new eugenicists is within the NHS and indeed, most other Western healthcare systems. Hence, this book that aims to examine the past to learn lessons for the present will be a total eye-opener to many readers.

It first examines the rise of eugenics in Nazi Germany but also charts the course of the practice in the UK and US. Frances Galton, Dean William Inge, Winston Churchill, Arthur Balfour, Neville Chamberlain, Glanville Williams, Francis Crick, Julian Huxley and Robert Edwards all feature in the gallery of shame which MacKellar unveils. In the US, many Bible-believing Christians were also swept up in the eugenics movement at the start of the 20th century. 'In fact, the Nazi government '*.... looked to the USA for favourable results of sterilization policies, which were portrayed as being both feasible and humane*' (p22).

The second and largest chapter explores the Christian perspective on eugenics. The biblical theology of creation is briefly considered followed by an in-depth discussion of what it means to be created in the 'image of God'. Other themes in this chapter include procreation and its meaning, eugenics and human equality, discrimination and the disabled, and questions about eugenic selection and the instrumentalization of children. A prominent theme throughout is that of unconditional love. '*...if parents set preconditions and do not accept their child for the mere sake of his or her existence... the child will always be aware that his or her very life was related to the selection procedure and associated preconditions, instead of being appreciated for the mere fact of existing.*' (p74)

The final main chapter explores ten different methods of eugenic selection ranging from the selection of sexual partners to cloning, infanticide and germline editing. Along the way, many other areas of beginning of life ethics, such as child and embryo adoption, saviour siblings and designer children, are critically evaluated from a Christian perspective.

With lists for further reading, an excellent glossary and both a general index and an index of scriptural references, this book is an excellent summary of where the new eugenics currently stands and how it has embedded itself within Western healthcare.



Gain from Pain
God's purposes are always good
Janet Goodall

- Gilead Book Publishing, 2020, £8.85, ISBN: 9781999722456
- Reviewed by **Ruth Butlin**, a retired medical missionary and member of the Triple Helix Committee

At only 173 pages divided into 17 short chapters, this is an easy read. But, as each chapter ends with suggestions for further reading (both Bible passages and other books), it could lead on to wider study.

A small book with a large message spelt out in its subtitle 'God's purposes are always good'. It reassures us that, in distressing circumstances, we can by the Holy Spirit's help learn to trust in God's long-term creative purposes.

There are no startling new theological insights, but rather a distillation of a lifetime's thought on the subject informed by the author's professional experience as a Paediatrician who sees '*(her) patient is the whole family, not just the sick child*' (chapter 5).

It is a book for Christians, full of anecdotes of people who have suffered in different ways; an eclectic mixture of people - from the Bible, from more recent history and from our own generation. Many of those whose experience is described have left us a precious legacy (a hymn or some prose or an example, or even an institution) which might aid us in our own struggles with pain. Each anecdote is presented in the context of scriptural truth, with a focus on the redemptive suffering of the incarnate Christ.

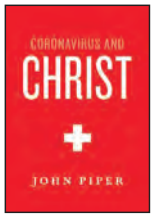
Speaking of personal calamities, the author writes, '*When the agony is raw, there will be little comfort in a well-intentioned comment that "God can bring great good from it", though people of faith learn by experience to trust this truth, even in the dark*' (from chapter 15).

Christianity and the Coronavirus: Four reviews

Where is God in a Coronavirus World?

John C Lennox

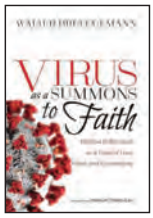
- The Good Book Company, 2020, £2.54, 63pp, ISBN: 9781784985691



Coronavirus and Christ

John Piper

- Desiring God, 2020, £4.99, 112pp, ISBN: 9781433573590

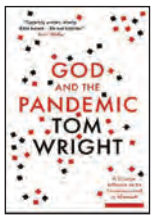


Virus as a Summons to Faith

Biblical Reflections in a Time of Loss, Grief, and Uncertainty

Walter Bruggeman

- Paternoster Press, £4.99, 92pp, ISBN: 9781788932011



God and the Pandemic

A Christian Reflection on the Coronavirus and its Aftermath

Tom Wright

- SPCK, £6.99, 88pp, ISBN: 9780281085118
- All four reviews by **Steve Fouch**, CMF Head of Communication

An Eastender's Tale

Dr Peter Armon

- feedaread.com, £7.98, 2017, 367pp, ISBN: 9781786979919
- Reviewed by **Vicky Lavy**, a former CMF Head of International Ministries

When there is nothing else to do, an author's instinct is to write. For four leading Christian writers and theologians, the COVID-19 pandemic has been fertile territory to write books to reassure, challenge, inspire and warn the church.

Piper and Lennox's books were first to appear back in March and are close kin. Starting with the rapidly unfolding crisis caused by the novel coronavirus, both authors seek to understand the nature of suffering, death and disaster and from these move towards a positive Christian message of hope and salvation. That they take different journeys to get there is primarily to do with their starting points. Lennox, as a scientific polymath, looks at the evidence from creation and human philosophy before leading us to Christ as revealed in Scripture. Piper, as a pastor starts with Scripture and what it says about the nature of creation and humanity. Both books end with encouragement and hope, and each is a good, short(ish) evangelistic tract to share with colleagues.

Bruggeman, as befits an Old Testament theologian, looks at the Hebrew Scriptures and how they understand God's purposes and agency during times of disaster and suffering. Drawing on the Psalms, the historical books (especially 1 and 2 Kings), Proverbs, Ecclesiastes and, of course, Job, he warns of the pitfalls of a simplistic reading of suffering and disaster. Get the bigger picture of what God is doing before jumping to conclusions.

Wright starts at the same point with which Bruggeman concludes, before taking us on a different journey. Wright argues that Scripture teaches us to face calamity with lament – for the loss, pain and disruption of the pandemic, but also for our complicity in the sins that have added to that suffering. But we cannot stay there, and he shows us that Scripture always asks the question 'what' rather than 'why'. What do we do in response is the crucial question to address, rather than why God allowed this. The Bible also answers the question of 'why' with a 'who'. As Job 38-40 shows us, the why questions have no answer save in the person of our Creator and Saviour. He also warns against jumping to the simplistic conclusion that COVID-19 is a sign of the end-times by putting it into the historical context of the epidemics and global pandemics of the past.

While all four books touch on the history of pandemics, Wright, as a scholar of ancient history, explores how the early church responded to the wide-ranging epidemics of the first few centuries of its history. Christianity was birthed in such crises and has grown throughout them. We can gain great wisdom and insight from how the early Church Fathers and others (such as Martin Luther) responded to parallel crises in their days.

Four very different books, each appealing to different audiences and with differing but complementary messages, all are worth reading and sharing widely during the time of COVID.

East End boy makes good. The first doctor in his family, Peter served God as a gynaecologist in the UK, Malawi, Tanzania, Israel, Spain and Gibraltar. Friends will smile at his winsome gems that remind us of his cheerful self-effacing nature: '*I had red and curly hair, rabbit teeth and ugly NHS wire glasses – Altogether I was not a handsome lad and got made fun of, but wouldn't call it bullying*'.

Billy Graham's Harringay Crusades started his lifetime habit of reading the Bible morning and evening. But he was not a complete goody-goody, and once swapped his dad's valuable stamp collection for a bicycle.

We are taken on a journey from East Ham Grammar with homework done to Radio Luxembourg, via Charing Cross Medical School to becoming a gynaecologist. His first date with his future wife, Carol, where she is an hour late reminds us of those days before mobile phones.

We learn of his time in the 1970s and at KCMC Tanzania that he calls the Golden Years, and at Queen Elizabeth Hospital Blantyre in the 80s. Back in the UK, Peter, Carol, and their three boys save money by buying a house in Newcastle with another Christian family who only had girls. All went well until the fire…

If you knew Peter, who served as CMF's 'Overseas Secretary' back in the late noughties, you must get this. Regardless, his story is still a gem; a glimpse into the life of a servant of God.

eutychus

Lockdown fuels alcohol sales

One area of the US economy seems to have thrived during the COVID-19 lockdown there – home delivery sales of alcohol. Many state governments opened the doorway for bars and 'liquor stores' to sell their wares via 'mail order' during the spring and summer. A 24 per cent surge in sales (and 27 per cent for spirits) showed the economic wisdom of this move. The health consequences have yet to come home to roost – but the signs are not good. 15 million Americans have alcohol abuse problems and there has been a 20 per cent rise in alcohol consumption since the '90s. *NPR* 11 September 2020 *n.pr/3mKsP3d*

Vaccine factories can be bad for your health

At least if you live in the vicinity of the Zhonghu Lanzhou biological pharmaceutical factory in Gansu province, China. In July and August 2019 an outbreak of brucellosis affecting thousands of people in the city of Lanzhou was traced back to the factory. While producing Brucella vaccines for animal use, the factory used expired disinfectants and sanitisers, meaning not all bacteria were eradicated from the waste gas. This contaminated waste gas formed aerosols that held the Brucella bacteria, leaking into the air and spread to the city by the wind. The irony is hard to miss. *CNN* 17 September 2020 *cnn.it/2RPhBfm*

Hand sanitiser and child exploitation

While we're on the topic of sanitisers, the high demand for alcohol-based hand disinfecting gels has fuelled a massive increase in sugar cane production. Most of this industry is in countries where there is a high to very high risk of forced child labour, especially where lockdown has closed schools. And it's not just the hand sanitiser industry - the increased demand for PPE has increased the acute risk that the poorest could be pushed into forced labour in the manufacture of drugs and equipment to fight COVID-19, according to the UN. While no hard data has yet been forthcoming, there is growing concern that forms of modern slavery have thrived in the pandemic. There is a hidden cost to maintaining safety and fighting coronavirus to which we must be alert. *Thompson Reuters* 16 September 2020 *tmsnrt.rs/3ciDbCw*

Wildfires posing growing health threat

Forest fires have raged from Australia to Brazil to the US West Coast and Siberia over the course of 2020, bringing with them gases, particulates and synthetic toxins as the fires burn through suburbs, towns, and cities. Previous wildfires have been associated with significant increases in brain, heart, and lung damage in local populations. But with the sheer number and scale of the fires this year, it is hard to know how widespread that damage will be. 3,000 miles from the West Coast states, Washington DC has already seen the particulates in the high atmosphere dim the sun and drop temperatures. We may be picking up the consequences for years to come across the globe. *National Geographic* 15 September 2020 *on.natgeo.com/3j5kNzm*

Drink a little java for the sake of your stomach

Well, your bowel actually. More precisely, drinking one or more cups of your favourite coffee increases your chances of surviving colonic cancer, according to a recent study. And it is dose dependent – a cup of coffee a day increases survival by eleven percent – four cups increase that to 36 per cent. However, I suspect for those of us who imbibe the hot, black stimulant each morning as we stumble half-awake into the kitchen, warding off the worst of colonic cancer is probably not our primary motivator. *New York Times* 22 September 2020 *nyti.ms/2ZZJ6Y3*

Plus ça change...

For over a century the use of bacteriophages to treat infections has roused the interest of clinicians and researchers alike. As antibiotic resistance becomes a major health hazard, the interest in the clinical application of these viruses that selectively attack bacteria has once again grown. It is also now being explored as a means to replacing antibiotics as growth promoters in cattle in developing countries. Indeed, if the WHO ever approves human phage therapy, it could have a significant impact on controlling bacterial infectious diseases in the developing world. God, in his infinite wisdom has placed the solutions to our self-made problems within our reach, if we have the wisdom and courage to use them aright. *The Guardian* 21 September 2020 *bit.ly/2EmuKtd*

From the ridiculous...

US pastor John MacArthur of Grace Church, LA, has stated that he is willing to go to gaol and start a prison ministry if authorities take him to task for repeatedly breaking COVID-19 restrictions on indoor gatherings. MacArthur has repeatedly argued that Jesus commanded the church to meet, and State authorities are subject to his authority, not over it. While this is undoubtedly true, other churches have found ways of meeting and ministering that do not put vulnerable members of the congregation at risk of coronavirus. One wonders where the greater faithfulness to Christ is to be found? *Premier Christian News* 18 September 2020 *bit.ly/300DigZ*

To the sublime

In contrast, a recent UK study has found that 72 per cent of religious adults helped the vulnerable with shopping during lockdown, compared with 46 per cent of the general population. While that gap narrowed as lockdown went on, and while many argued that Christ's teaching led Christians to be more generous, it is also true that churches provided one of the few channels for coordinating effective local volunteering, whether in foodbanks, shopping services or other forms of support. Whatever the reasons, it reminds us that in responding to the strictures of lockdown in this manner, the Christian faith is always outworked in love for God and neighbour. *Premier Christian News* 22 September 2020 *bit.ly/3kF6wdf*

Jeffrey Stephenson looks at how the biblical account of the return from exile speaks to our experiences post COVID-19 lockdown

RETURN FROM EXILE

'Because of the Lord's great love, we are not consumed, for his compassions never fail. They are new every morning; great is your faithfulness.' (Lamentations 3:22-23)

The Book of Lamentations is a series of laments for the destruction of Jerusalem in 586 BC. This event triggered the exile in Babylon for the people of God. Yet these verses sound a note of hope amid despair and trust in the goodness and faithfulness of God whatever may lie ahead.

I once heard exile defined as being '*not at home and not in control*.' As I reflect on the last few months, the experience of COVID-19 has felt something like that. While most of us have remained physically 'at home' in our usual surroundings, nevertheless the familiar structures and routines of life have been disjointed and even demolished. It can feel like we've lost control, subject to government edicts, banished from corporate worship, and all the while dreading the lurking threat of an unseen menace.

But exile can be a time of refining and spiritual growth. As familiar and comforting props are swept away, we are thrown back onto a dependence on God alone. Encountering his love, we realise that we will not be consumed or destroyed because he is faithful and compassionate, and he will never allow us to face a trial without providing the means to endure it (1 Corinthians 10:13).

We have emerged from many of the restrictions, returning from exile if you will, but this can be a risky time. When the Israelites came out from exile and slavery in Egypt, they faced the dangers of the desert and hostile nations

Many of the threats persist, especially the gnawing uncertainties that can so easily wear us down. But God met the Israelites at Sinai, adopting them as his people. We can be sure that God has these times in his hands, and he will bring great blessing out of them. Indeed, he already has. He is always at work; his kingdom always advancing.

Whenever we feel 'not at home and not in control', let us look for signs of his love, his compassion, his mercies. They are all around us. And they are fresh every morning. And be assured, we will not be consumed. When we take our eyes off the things that are happening around us and look to him ,when we are determined to trust in his goodness and the truth of his word, then the God of hope will fill us with joy and peace, and we will abound in hope (Romans 15:13).

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