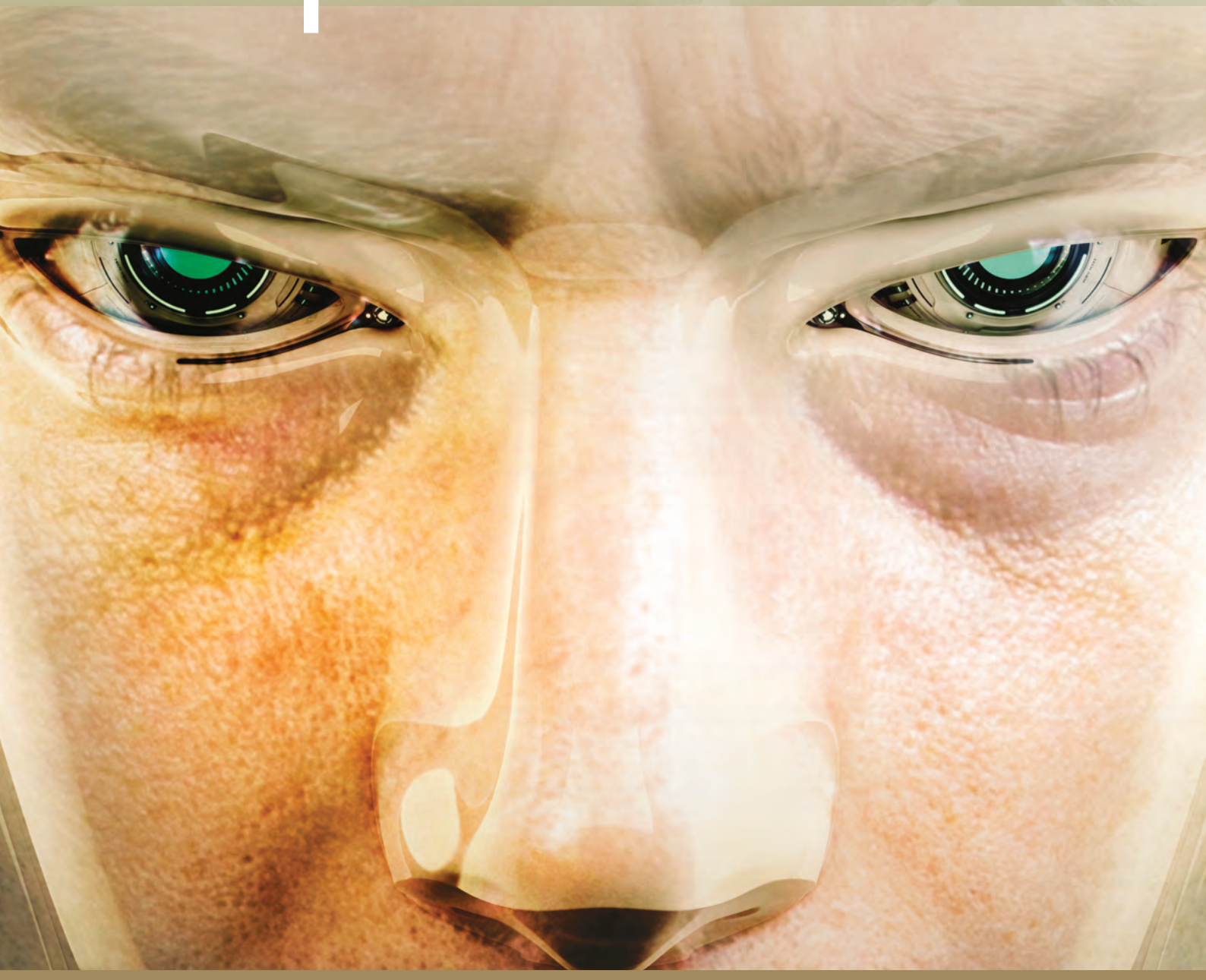
Spring 2016

for today's Christian doctor

triple helix



Christian medics in a digital world

Also: spiritual appraisal, DNA editing, ultrasound in crisis pregnancy, medicines and prayer, leprosy revisited

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Serving in Babylon

Being engaged but morally distinctive

We are now living in a post-Christian society and working in a post-Christian health service. But how are we to live in such a context? It's precisely for this kind of situation that the story of the prophet Daniel is so instructive.

When Jerusalem fell to the Babylonians in 587 BC, the nation of Judah was taken to Babylon in an exile that would last 70 years. As God's people in a foreign land that was hostile to their faith and values, they faced the challenge of living and serving as 'aliens and strangers'. There was great pressure to close ranks or to forget who they were. There was also great handwringing and lament. [1]

The Jews were forcibly displaced people – not even asylum seekers or refugees let alone economic migrants – but rather captives – prisoners of war in a country utterly different from their own in language, culture, values, religion and worldview. God's people – but made to serve in a godless empire, Babylon.

The apostle Peter also writes of 'living in Babylon' and describes God's elect (Christians) as 'strangers in the world' [2] and 'aliens'. [3] He calls his readers to 'be holy' – set apart – because they are 'a chosen people, a royal priesthood' and 'a holy nation'. [4]

The situation faced by Daniel and his friends in ancient Babylon was not dissimilar to ours as Christian doctors in twenty-first century Britain. In Babylon they were aliens, exiles, sojourners, strangers – awaiting the coming of their real kingdom when they would return to Jerusalem – just as we are waiting to be taken to our 'New Jerusalem' with Christ. [5]

In this situation of tension they faced two temptations. The first was to retreat into an escapist spiritual ghetto – to seek solace with like-minded believers and to leave the world to its own devices. The second was simply to compromise and become no different from those around them. We face similar temptations today – to withdraw into our Christian communities or simply to blend in.

So how did Daniel and his friends react? They neither withdrew nor conformed.

First they *engaged* with their alien society. The prophet Jeremiah urged the exiles, including Daniel and his friends: 'Seek the peace and prosperity of the city to which I have carried you into exile. Pray to the Lord for it, because if it prospers, you too will prosper...For I know the plans I have for you,' declares the Lord, 'plans to prosper you and not to harm you, plans to give you hope and a future.' [6]

And so Daniel worked hard and effectively within the alien Babylonian system and was rewarded with great responsibility for his integrity and commitment. [7]

There is nothing wrong with Christians getting into influential positions. In fact it enables us to do great good. We should work to the best of our abilities within the system in which we're placed, and value the good of the organisation in which we work. In doing this we not only obey the principles in Jeremiah 29, but also uphold the high view of work given to us in Genesis 2.

We are also urged to pray not only for 'all those in authority' [8] but also to be subject to them: 'to be obedient, to be ready to do whatever is good, to slander no one, to be peaceable and considerate, and to show humility to all men'. [9] We are also to serve our bosses 'with sincerity of heart and reverence for the Lord...as working for the Lord and not for men'. [10]

Second, this engagement did not mean compromise because Daniel and his friends were also called to be *morally distinctive*. They faced huge pressures to conform – partaking of the king's diet, bowing to the gold image, desisting from public prayer – but in the face of such threats they braved the ruler's wrath, the fiery furnace and the lion's den.

In the same way we are called to be faithful to God in ways that might make us unpopular with others. It's noteworthy that Paul's exhortation to 'shine like stars' [11] is in the context of doing 'everything without grumbling or arguing' so that 'you may become blameless and pure, children of God without fault in a warped and crooked generation'. And then there are steps of faithfulness where the stakes are considerably raised – where not just reputation or friendship is at stake – but something much more – our jobs, our property, our freedom, even our lives.

For much of biblical history God's people have lived as exiles and have worked in state systems. Joseph, Esther, Mordecai, Nehemiah were also 'public servants' in the great empires of Egypt, Media and Persia.

We don't know whether as Christians we will live out our days as a small remnant on these islands or whether by God's grace we will see another great revival like that of the eighteenth century which transforms our whole history and culture. It is in God's hands.

But regardless, as his people we are called both to be engaged and distinctive – both salt and light – in the world but not of the world – daring to be different whilst seeking the good of the city in which God has placed us.

Peter Saunders *is CMF Chief Executive.*

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news reviews

Days of our lives

When celebrity culture imparts wisdom

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

Soap operas can be an obsession. But alongside celebrity gossip they serve a function that morality plays occupied in earlier times. In morality plays characters wrestled with complex choices: between good and evil, right and wrong, the ways of life versus those of death. In popular culture it is often by following lives of celebrities that people work out how to deal with critical life choices.

In recent weeks stories surrounding high profile celebrities offer examples that illustrate the point. Outpourings at the death at age 69 of the rock star David Bowie occupied acres of newsprint and countless radio and television comments. Amidst many eulogies a comment by the singer's widow, Iman, stands out. 'The struggle is real,' she said, 'but so is God.'

Then, revelations that the television magician Paul Daniels, who has died from an incurable brain tumour, offered a media peg for insights about facing death. It prompted the President of the Association for Palliative Medicine, Professor Rob George, to say it is 'crucial' not to become 'preoccupied with the details of the illness rather than the details of the living'. He added, people with a terminal diagnosis can 'almost feel more alive knowing that time is precious'.[1]

We should welcome this insight even if our faith insists that more could be said. We need to be ready and prepared to speak if opportunities come our way. It may be possible to deploy a 'Faith Flag' as taught in the Saline Solution course. Likewise CS Lewis's great insight about pain is worth memorising: 'Pain insists upon being attended to. God whispers to us in our pleasures, speaks in our consciences, but shouts in our pains. It is his megaphone to rouse a deaf world.'[2]

Christians believe humans have only one life; faith here and now determines our eternal destination. The Bible is very clear and declares, 'Just as people are destined to die once, and after that to face judgment, so Christ was sacrificed once to take away the sins of many; and he will appear a second time, not to bear sin, but to bring salvation to those who are waiting for him.'[3]

In a culture that's increasingly indifferent to matters of faith, God is not without a witness. There are myriads of opportunities to speak up, if we are alert.

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Northern Ireland votes on abortion

Recognising that hard cases make bad law

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

In February, Northern Ireland Assembly Members debated some highly controversial and emotive amendments to a Justice Bill: amendments to allow for abortion for fatal fetal abnormality, rape and incest.

Unlike the rest of the UK, the Abortion Act 1967 does not extend to Northern Ireland. So most abortions are illegal, except where necessary to preserve the life of the mother, or where there is a risk of real and serious adverse effect on her physical or mental health, which is either long term or permanent.[1] The proposed amendments would have provided further, albeit narrow, exceptions to the ban.

The amendments were actually defeated, but in a fairly close run vote (by 59 votes to 40). Some Members opposed the amendments on procedural grounds, on the basis that they were being rushed through with little Assembly scrutiny. Others held more practical objections based on concerns that, although the proponents argued they would only change the law on fatal fetal abnormality and sexual crime, they would be likely to have a far wider impact. Much like in Great Britain where the term 'serious' in the Abortion Act 1967 is a sufficiently elastic term to allow unborn babies to be aborted for conditions that most people would not regard as constituting 'serious' handicap. Moreover, from a practical perspective, it is difficult to see how a law permitting abortion after rape or from sex with a family (or 'extended' family) member, could be framed.

Other Members had ethical concerns with permitting abortion for fatal fetal abnormality, on the grounds that all human life is worthy of protection and that a baby with a serious disability, however life limiting, requires no less protection and respect than any other human being nearing the end of their life. It was also argued that abortion of a baby with disability is not an 'easy answer' as it is generally a traumatic event and can have psychological effects lasting many years. Testimonies were cited from parents of children with fatal fetal abnormalities who kept their children and appreciated the few hours, days and sometimes weeks and months, that they had with their children.

A centre in Northern Ireland, Every Life Counts, provided some positive and moving stories from parents of such experiences.[2] It is well worth a visit. And, prompted by these NI debates, we have a a post on the CMF blog covering in more detail some of the dilemmas and challenges of these 'hard cases' of abortion for disability and rape.[3]

There is no denying that such amendments raise really difficult issues that must be handled with tremendous grace and sensitivity but we are thankful that, at least for now, all babies with disability are still protected by the law in Northern Ireland.

As CMF often points out, hard cases are indeed hard. However, jettisoning fundamental principles of protecting the life of individuals, especially vulnerable ones – the young, the severely disabled – is not the answer.

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Ebola: The epidemic that won't go away

New cases and stigmatised survivors

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

Regular reports in the autumn and early New Year claimed that West Africa was finally Ebola free after nearly three years, only for another case to crop up within days.[1] Now it seems that earlier fears that survivors may be prone to relapsing illness turn out to be well founded.

Research presented at the Conference on Retroviruses and Opportunistic Infections in Boston in February suggested that many survivors of the West African Ebola outbreak are suffering long term neurological, ophthalmic, reproductive and mental health sequelae to the initial illness.[2] Joint pain, retinal damage, depression and suicidal tendencies, were all found among survivors. Anecdotal reports also suggest a higher than normal risk of still birth and miscarriage among female survivors. Meanwhile, male survivors can carry live virus in their semen, so are an ongoing infection risk.

Many survivors face stigma that leaves them isolated and rejected by family and wider community. They cannot get work, people won't buy goods from their market stalls, and they often cannot get housing. Many health professionals were infected, and they now too find themselves unable to get work, especially as they struggle with the neurological consequences of the illness.[3]

There also is a huge sense of guilt for having been the source of infection that claimed the lives of friends and family. This news is therefore yet another cruel twist in a horrific trauma to have affected some of the poorest and most deprived communities in Africa.

More research is needed – but it seems that the virus is finding immunological sanctuaries in the central nervous system, the eye and reproductive organs. Furthermore, there is growing evidence that there are asymptomatic carriers who may also be vectors for viral transmission.

Finally, the most promising new treatment, ZMapp has been shown to have no significant effect, and we are some way off from knowing how effective trial vaccinations will be.

We cannot afford to forget all of those affected. Many national health workers and others from around the world, including some of our members, invested much time and energy (and all too often, their lives) in the acute phase. It now looks like we will need a much longer-term commitment to help the people of West Africa deal with the consequences of Ebola. And on the ground, it will be the churches and mission hospitals who will be supporting and caring for those living with the consequences long after the international community has moved on.

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Zika and pro-abortion activism

The rush to promote abortion as a response Zika invites serious questions

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

The post-Christian West is fond of believing itself to be a harbinger of moral progress and human betterment. But does this stand the reality test? We have recently seen a plethora of media reports reflecting the eye-watering opportunism of abortion rights activists. They are using the Zika emergency as a pretext to pressurise countries in Central and South America to change their abortion laws. And much of the media seems to be reporting this with approval.

Within days of the WHO declaring the Zika virus a global emergency, where it said the disease was tied to increased cases of microcephaly in babies, a clamour set in with the oft-repeated mantra that 'access to abortion is a matter of human rights'. A spokesman for the Office of the UN High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, put forward a wish list that includes contraception – including emergency contraception – and 'safe abortion services'.[1] The 'progressive' news site *Think Progress* was even more transparent. It asked, 'Could a mosquito-borne illness that threatens to spread across the Americas actually push countries to change their restrictive approaches to women's health care? International reproductive rights experts hope so.'[2] In other words, Let's pressurise Catholic majority countries to abolish anti-abortion laws. 'Zika is a direct consequence of ignoring science,' opined the Ottawa Citizen.[3] Other British media ran items implicitly critical of the Catholic Church for its stance.[4]

But hold on a minute. Has a link between Zika and microcephaly been proved beyond doubt? Not so claims Charles Camosy, Associate Professor of Theology and Social Ethics at Fordham University in California in an article first published in the Los Angeles Times and repeated on the ABC Religion and Ethics website.[5] He rightly points out that abortion is a very blunt instrument. Even if a connection was established, ultrasound tests would not confirm microcephaly until the third trimester.

Camosy concludes, 'Instead of arrogantly insisting that developing nations must change their laws to suit someone else's ideology, abortion proponents and the media would be better served by taking a critical look at the dark tendency here and elsewhere to turn to eugenics as a solution to Zika.'

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Paul Johnson explains the process and the benefits of spiritual appraisal

DOING A SPIRITUAL APPRAISAL

key points

- We are used to appraisals in the workplace. So why not consider building in a pattern of spiritual appraisal?
- It helps to set a regular date, like a birthday, anniversary or start of the year and to clear away possible distractions.
- There are many possible patterns; what is most important is to find what works for you.

Like many *Triple Helix* readers, I have recently undergone my annual consultant appraisal. Introduced as a contractual obligation in 2001, annual appraisals have become an important part of the yearly cycle for doctors. Although, sadly in reality appraisals often become a frustrating 'tick-box' exercise, if carried out as intended, they offer real potential for personal development and an opportunity to ensure that one continues to progress professionally and remains 'fit to practise'.

However, I have been challenged by the fact that, whereas my 'career journey' is closely monitored and actively developed through appraisal, my 'spiritual journey' has mainly been one of passive and unmeasured progress. In addition, the underpinning question 'am I fit to practise?' seems to be as important for my life as a Christian, as for my role as a consultant. Several years ago therefore, I started doing an informal annual 'spiritual appraisal'. I have very much done this as a slow-learning 'pilgrim' rather than as a sorted 'saint'. Nevertheless, I have found this a helpful tool for trying to make my spiritual development a more deliberate process, with some form of 'governance', and I commend it to you.

Principles of spiritual appraisal

Intense post-graduate medical training and busy GP or consultant practice can certainly have negative impacts on measured spiritual growth. John Ortberg's words have a recognisable resonance: 'For many of us, the danger is not that we renounce our faith. It is that we will become too distracted and rushed and pre-occupied that we will settle for a mediocre version of it'.[1]

Scripture reminds us of two important principles of spiritual transformation:

1) It is an on-going process

The journey of Christian discipleship should be one of increasingly reflecting the Trinity in our lives. As Paul reminds us: 'And we all, who with unveiled faces contemplate the Lord's glory, are being transformed into his image with ever-increasing glory, which comes from the Lord, who is the Spirit'.[2]

2) It is a proactive process

There are many reminders of this in Scripture. Examples include: 'be transformed by the renewal of your minds';[3] 'set your minds on things above, not earthly things';[4] 'clothe yourselves with compassion, kindness…';[5] 'above all else, guard your heart';[6] 'watch out that no one deceives you';[7] and 'flee the evil desires of youth and pursue righteousness'.[8]

Spiritual appraisal therefore, can facilitate our spiritual growth in several ways:

- Christian discipleship becomes something that we actively nurture and progress, rather than merely leave to chance.

- It enables us critically to evaluate our life choices and activities to ensure that we only maintain things that impact positively on spiritual growth.
- Monitoring our spiritual development actually increases our chances of enhancing it. The positive motivational effect caused by simply measuring an activity is termed the Hawthorne effect,[9 10] and is well recognised in clinical trials.

Practicalities of spiritual appraisal: when and how?

I have found it best to do the appraisal on an annual occasion. Originally it was my birthday and now New Year's Day. This makes it easier to remember and also provides a specific landmark by which to evaluate one full year of discipleship.

A spiritual appraisal clearly needs to be tailored to the individual. To date, I have conducted mine informally by myself, but I recognise the biblical principle of making oneself accountable to others and accept that this would make the process more objective.

It is really important to ring-fence protected time for this task away from ones busy schedule. Spiritual appraisal is about letting God's Spirit 'search us and know us', and through prayerful reflection letting ourselves be 'moulded by the potter'.

With regards the actual appraisal, I have found it helpful to base mine on a modification of four components of the consultant appraisal:

A prayerful evaluation of spiritual 'progress' over the previous twelve months.

Looking back over the last year, I start by asking whether I am more Christ-like now than I was this time last year. I reflect on passages of Scripture such as Galatians 5 and Colossians 3 that clearly outline the differences between the ways of the 'sinful nature', and the characteristics expected of 'God's chosen people'. Integral to my reflection is a time of confession and a reminder of the extraordinary message of forgiveness and renewal that we have as a result of the cross.

I review any 'action points' recorded during my previous year's appraisal and give thanks for those that have been fulfilled.

A careful consideration of any failings or shortfalls in spiritual development encountered during the year and an attempt to identify their root cause.

I spend time considering any patterns of behaviour that recur year after year and bring those before God. I ask him to show me if they have any root cause and spend time seeking any practical steps to avoid making the same mistakes for another year. I ask whether there are things in my life or behaviours preventing me from progressing on my journey towards Christ-likeness?

An honest reflection of every activity and commitment currently being undertaken and an assessment of their impact on the calling to become more Christ-like.

Most of us live frenetic lives swamped by numerous commitments and activities. Nathan Foster's words are timely for our generation and for us individually: 'I cannot think of a greater way to bring about genuine transformation in the spiritual life of the Church than to become a people who say no to busyness, hurry, and distraction, and willingly organise our lives in such a manner to be fully present to God and each other, living a life learning to love well...'.[11] I know that sadly I fall short of this ideal. An important part of my spiritual appraisal (and indeed my consultant one) is to try honestly to evaluate every professional and social commitment I have and also my job overall. To do this I reflect on the following questions:

- Is this activity something that is part of God's unique calling for me at this particular time in my life? (An activity, or indeed a job, that was right to do last year is not necessarily right for the following year).
- Is this activity something that is distracting me from being the person God wants me to become?
- Is this activity primarily bringing glory to God or glory to me?
- Is there a new activity that God is calling me to take on, and if so, what is this going to replace?
- Am I prioritising people over activities by being a good husband, father, and friend (this is clearly better assessed by those people)?
- Are my activities enabling me sufficient time each week for my own spiritual nurturing eg prayer, Bible study, and supportive Christian fellowship?
- Am I using my spiritual gifts as effectively as my professional skills?

There are of course many other questions one could ask, but I find these provide a helpful and fairly thorough evaluation.

A chance to re-define the priorities and primary focus for the next year and to implement radical changes if required to remain 'fit to serve'.

Finally, I re-establish my priorities for the next year and commit these to God. I write down any action points coming out of the appraisal and develop an informal 'spiritual development plan' (this sounds more grandiose than it is!). I refer to these throughout the year and use them during next year's appraisal.

Finally, it is important to emphasise two things. First, spiritual appraisal mustn't become legalistic. It is simply a tool to help with spiritual growth, rather than something that ends up preventing us enjoy the freedom and joy that Christ offers.

Second, our ultimate 'appraiser' is God himself. He already knows our strengths and our weaknesses, our successes and our failures. Our ultimate eternal 'revalidation' is achieved through his grace, rather than as a result of consecutive years of spiritual appraisals being approved by a spiritual 'responsible officer'. Paradoxically, it is this wonderful truth that spurs us on to want to put mechanisms in place in our lives to try to ensure that we are becoming more like him and are serving him better year by year.

Paul Johnson *is Professor of Paediatric Surgery, University of Oxford*

Looking back over the last year, I start by asking whether I am more Christ-like now than I was this time last year

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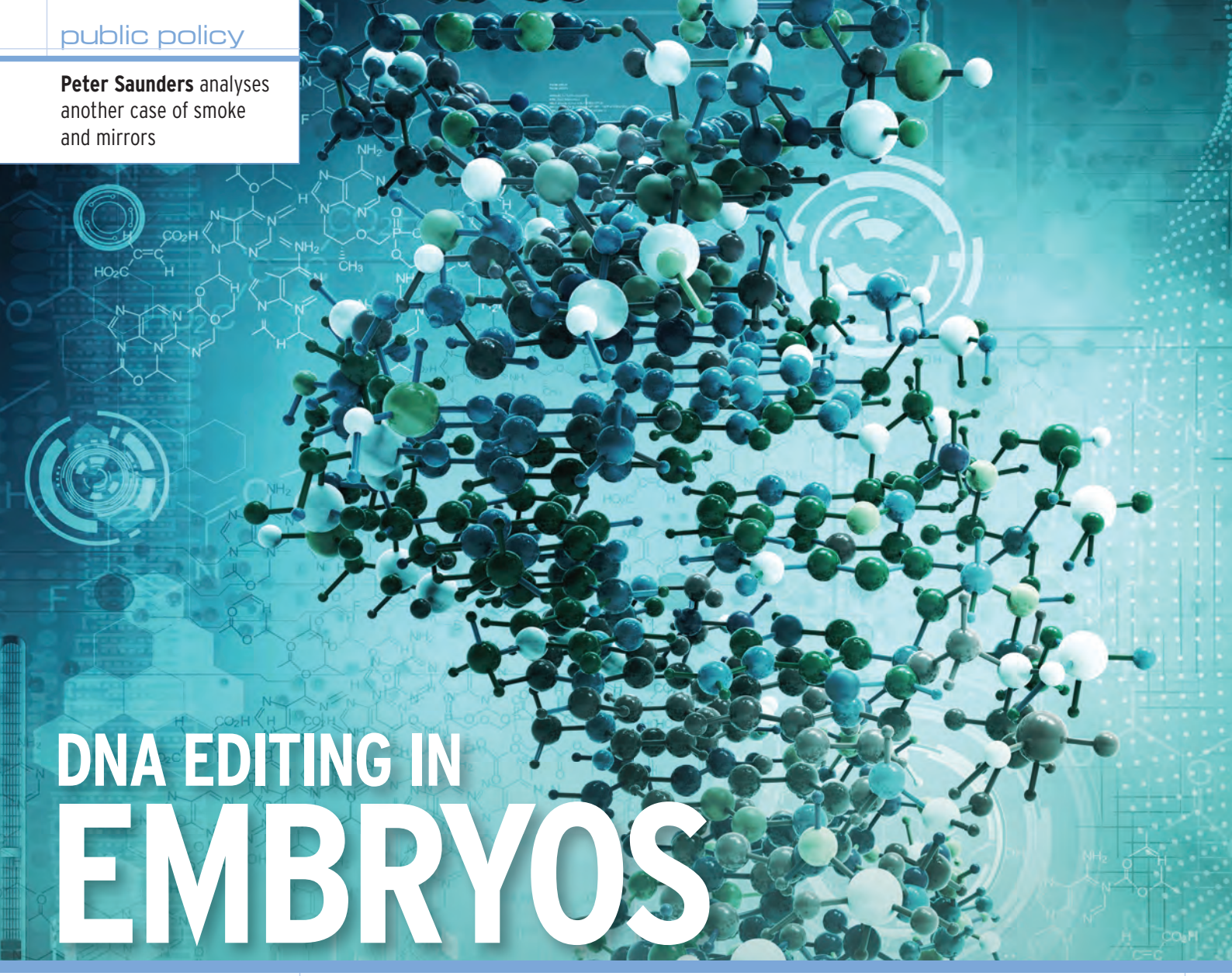
Peter Saunders analyses another case of smoke and mirrors



DNA EDITING IN EMBRYOS

key points

- The UK wants to go it alone with DNA editing in embryos (germline gene editing).
- The process has come in for huge criticism internationally.
- Genetic abnormalities which result in implantation failure (either in IVF or naturally) or miscarriage are chromosomal abnormalities, not abnormalities in single genes.
- We have no way of knowing the consequences of implementation. Here is another example where statutory authorities have failed to stand up to scientists.

Research scientist Dr Kathy Niakan, from the Francis Crick Institute in London, received the go-ahead from the fertility regulator to genetically modify human embryos on 1 February. This is the first time a country has considered the technique in embryos and approved it.[1] She expects to start the new research as early as the first quarter of this year.

Niakan wants to use a new technique called Crispr-Cas9 to 'edit' genes in day-old human embryos left over from IVF in order to discover what role they play in normal embryo development. She plans to start with a gene called Oct4, which is thought to have a critical role in embryo development, and then move onto other genes, but no doubt further requests will follow once the principle has been established.

Controversy

Although gene editing to treat some genetic diseases in *fully developed* human beings appears to have huge early promise (such as in the case of Layla Richards who was saved from terminal leukaemia in London last year[2]), gene editing in embryos (germline gene editing) has come in for huge criticism internationally and has so far only been attempted (unsuccessfully) in China.

The research is highly controversial for several reasons. First, it will result in the destruction of the embryos being studied (each will be destroyed and examined at seven days and Niakan has already used 736 in similar research in the last three years[3]).

Second, it has attracted international criticism, mainly driven by concerns about safety and unforeseen consequences. Any genetic change made in a day-old embryo will be expressed in every cell of the developing human being, including reproductive cells (sperm and egg), and will therefore, if implantation follows, be passed on down the generations.[4]

Third, scientists' claims, propagated by *The Times*[5] and the BBC,[6] that allowing GM embryos would 'give a massive boost to IVF success rates' have little evidence base and appear aimed at seducing regulators into giving a green light for what most countries already ban.

Infertility and miscarriage

Niakan has argued that her research is necessary because 'miscarriages and infertility are extremely common, but they're not very well understood' and that it 'could really lead to improvements in infertility treatment'.[7]

In fact, we already have quite a good understanding of what causes IVF failure and miscarriage and it has very little to do with anything that can fixed by Crispr-Cas9.

The average implantation rate in IVF is about 25%. Inadequate uterine receptivity is responsible for approximately two-thirds of implantation failures, whereas the embryo itself is responsible for only one-third of these failures.

Chromosomal abnormalities, rather than problems with individual genes,[8] are thought to be responsible for most *embryo-related* implantation failure and, amongst these, aneuploidy (an abnormal number of chromosomes) is the most frequent.[9,10] Chromosomal dislocations, deletions and inversions also contribute and all these abnormalities are more common in women of increased reproductive age. Aneuploidy is extremely common. At least 40-50% of blastocysts have aneuploidy,[11,12,13] along with 30% of eggs and 7% of sperm.[14]

Down syndrome is the best known form of aneuploidy and is caused by an additional 21st chromosome (trisomy 21). Edwards' syndrome and Patau's syndrome are caused by trisomy 18 and 13.

Babies with these conditions are often born alive but most other aneuploidies are lethal in utero – causing failed implantation or miscarriages.

The commonest causes of miscarriages are trisomy 16 and 22. In a 2015 study of 832 early miscarriages, 368 (44.23%) were found to be abnormal. 84.24% (310/368) of these were aneuploidies. Trisomy 16 accounted for 121 of these 310 followed by trisomy 22, and X monosomy.[15]

It may be that trisomies of chromosomes other than 13, 18, 16, 21 and 22 (there are 23 chromosomes in each egg and sperm) may also prove lethal before implantation but are less easily detected. This would be a worthwhile area of further research.

The major flaw

The key point here is that the genetic abnormalities which result in implantation failure (either in IVF or naturally) or miscarriage are *chromosomal* abnormalities, not abnormalities in single genes. But only abnormalities in *single genes* can be readily fixed with gene editing of the sort that the Crick Institute is proposing. Gene editing tools like Crispr-Cas9 do not fix chromosomal abnormalities.

This simple fact has not been made clear to the media, to decision makers or the public. In fact researchers like Niakan, who must be aware of it, seem rather to have gone out of their way to fuel the misconception that gene editing will help IVF success rates.

This, it seems to me, is both negligent and disingenuous, as the key factor that is driving the call to approve this controversial new research is the supposed benefit to infertile couples.

British scientists have form in making wild and rash promises about new treatments in order to get approval for controversial research – the hype around animal-human hybrids[16] and three parent embryos (mtDNA) are cases in point.

Few now will remember then Prime Minister Gordon Brown's empty promises in *The Guardian* newspaper on 18 May 2008 of animal-human hybrids ('cybrids') offering 'a profound opportunity to save and transform millions of lives' and his commitment to this research as 'an inherently moral endeavour that can save and improve the lives of thousands and over time millions of people'.[17]

That measure was supported in a heavily whipped vote by the then Labour government as part of the Human Fertilisation and Embryology Bill, now the HFE Act, following a high-profile media campaign by the same science journalists and research scientists. But 'cybrids' are now a farcical footnote in history. They have not worked and investors have voted with their feet.

David King, who runs the watchdog group Human Genetics Watch, remarked at the time, in words that are equally applicable today: 'The decision is very disappointing, but comes as no surprise, since the HFEA can never say no to scientists. These experiments are scientifically useless and morally very problematic. The research lobby has distorted the scientific facts in order to defuse criticism.'[18]

Conclusions

In reality, this project seems to be more about satisfying scientific curiosity about how genes work in the normal development of the human embryo with any therapeutic application a very distant dream.

Gene editing in adults and children has great therapeutic promise for treating and perhaps even preventing some genetic disease. But gene editing of the embryo (germline editing) is extremely controversial and potentially very dangerous. Scientists around the world think that we are mad in Britain to be pursuing it.

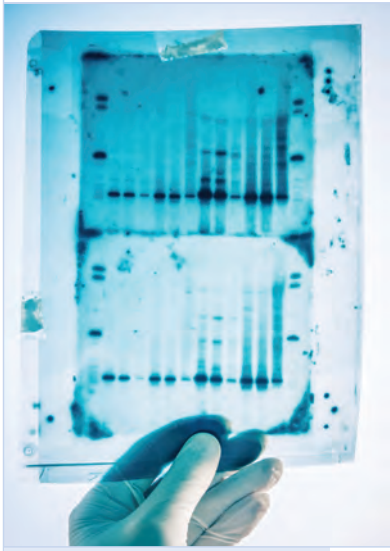
At the very least, much more work is needed in animal models before we contemplate using it on human embryos; and in particular we need to establish first in animals whether or not it is likely to have any benefit at all in preventing infertility before we start making rash promises about IVF success rates in humans.

The case for gene editing in embryos needs to be based on real facts and evidence, not false hope, hype and misleading or frankly false claims from research scientists and their irresponsible press office portals (ie the BBC and *Times*).

The HFEA does not have a great track record in carefully scrutinising new scientific developments, and appears to have capitulated too easily in the face of Niakan's specious claims about helping unfertile couples.

There might conceivably one day be a case for germline DNA editing. But this is not it.

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



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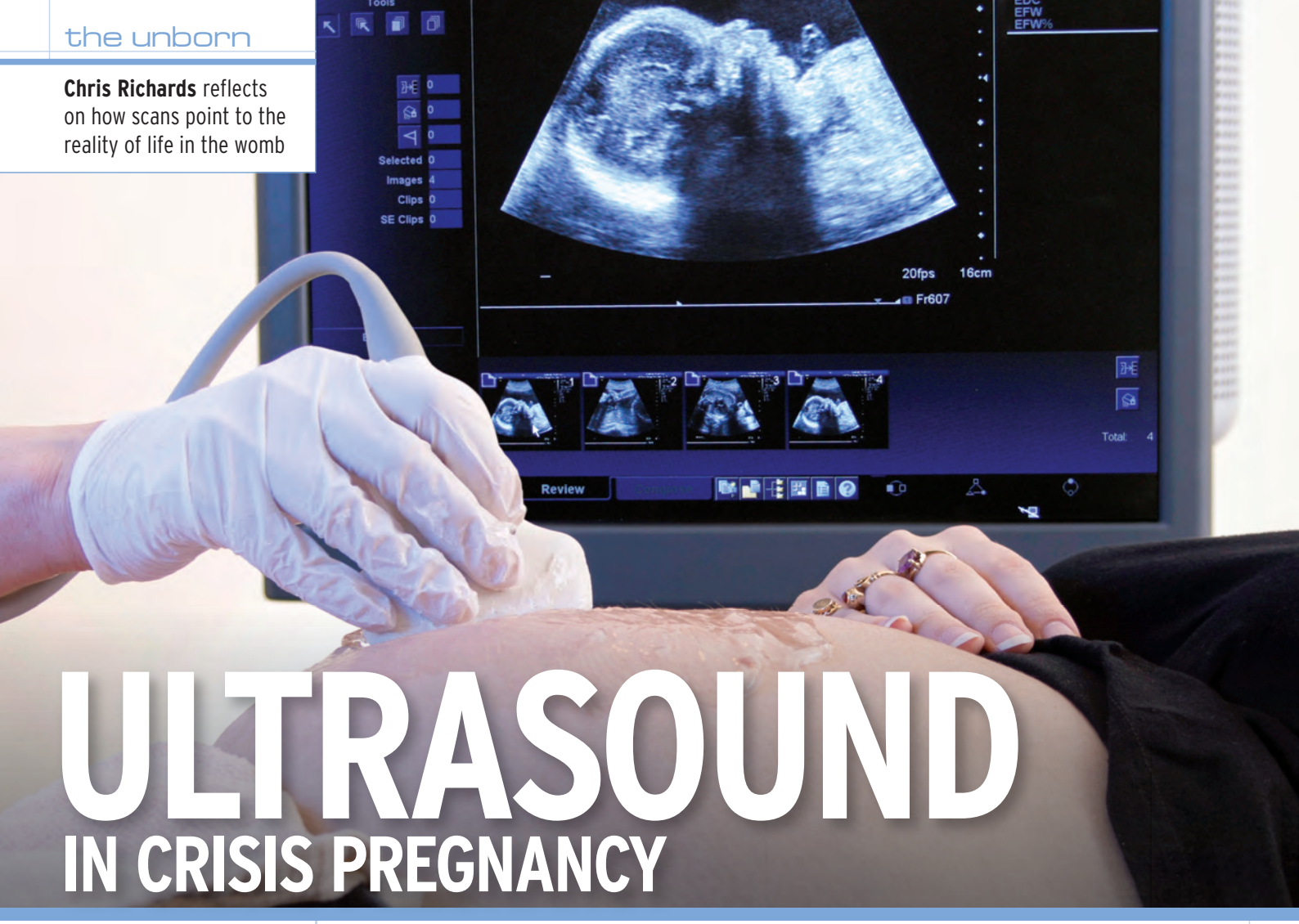
Chris Richards reflects on how scans point to the reality of life in the womb



ULTRASOUND IN CRISIS PREGNANCY

key points

- Women in early pregnancy often have little understanding of the life they are carrying in the womb.
- Often relatives and health professionals re-inforce the idea that this is not a 'real' life.
- For women considering abortion, viewing a scan can lead to a different view of the life of the tiny person they carry.

In the UK, pregnant woman are routinely offered an ultrasound scan at 11-13 weeks for dating purposes and at 18-20 weeks to detect any fetal anomalies. More recently 3-D images (and even so-called 4-D, which is animation of sequential 3-D images) have brought home the reality of life in the womb.

Pregnant women are rarely scanned before eleven weeks, unless there is a complication. For this reason women in early pregnancy often have little understanding of the development of the baby inside their womb. Sometimes relatives and health professionals reinforce the idea that the developing baby is not yet a life. This perception will influence women considering having an abortion towards going ahead with the procedure, since they do not realise the nature of what is at stake.

Yet from the very early days of pregnancy an ultrasound scan bears witness to new life. A heart beat can be seen from three weeks and five or six days after fertilisation (yes, the 'timetable' is that precise) and independent movement from six weeks after fertilisation. Through ultrasound we have the immeasurable privilege of seeing what the psalmist described as the baby being 'intricately woven' in the 'secret' place of the mother's womb.[2]

Although no longer routinely required in RCOG recommendation,[3] most women requesting an abortion are given an ultrasound scan prior to the procedure to check on gestation and for anomalies. The RCOG recommend[4] that women who do have a scan are offered the opportunity to see the scan images if they wish. In practice this is not always done, perhaps for fear of influencing their decision. Our local hospital had a policy of not showing a scan of twins to abortion-minded women, because so often the recognition of 'a special pregnancy' turned the mother's decision in favour of preserving life. This reveals something of the pro-abortion mindset of those providing abortion services.

Since 2008, our pregnancy centre (Tyneside Pregnancy Advice Centre) in Newcastle upon Tyne, has been offering an ultrasound scan to women facing unplanned pregnancy. A service such as this is widely available in the US, but our centre remains, to our knowledge, the only pregnancy advice centre in the UK to offer ultrasound. There are plans for two further centres in Salisbury and Sheffield and the potential, we believe, for many more. As Baroness Cox said when she officially opened our centre, '*So often in these circumstances, women are told that there is only a blob of tissue in their womb. The scan will help them realise that there is a little life inside of them. I hope this will be the first of many such services around the country.*'

Approximately 100 women with unplanned pregnancy attend our centre each year. About a third of these are referred by their GP; the rest self-refer having heard about us through word of mouth or the internet. Women who attend are initially

One woman's story

Susan lived alone with her 18 month-old son and was pregnant by a new partner She had a history of drug and alcohol abuse and suffered domestic violence in the past. We were able to offer her time to talk about her situation, discuss the process of abortion, fetal development and other issues such as her financial and housing problems. Susan felt pressured into having an abortion by family and friends but also thought it was the best option for her and her son. She was keen for a scan which showed a nine-week baby with a heartbeat and limb movement. Susan was overwhelmed to see how developed the baby was and was very focused on how the baby was moving its feet. She felt this made it 'more human' and she wouldn't be able to have an abortion after knowing that it was a 'real baby'.

A scanner's perspective

It is very powerful to see the effect a scan can have on a woman. We can sit and talk about a baby's development for hours but nothing has the same impact on people as seeing their own baby through ultrasound – especially when the heart beat and movement can be seen so early on.

US Scene

Centres describe very high rates of a woman keeping her pregnancy following an ultrasound scan.[3] Heartbeat International report the number of pregnancy centres using ultrasound to have grown from 500 to 1,500 in the last ten years. Focus on the Family's Option Ultrasound Program estimates that around 358,000 babies and mothers have been saved from abortion through the impact of ultrasound.[5]

offered a consultation with one of our advisors who is able to provide information on issues relating to pregnancy, parenting, adoption and abortion. During the consultation women are helped to discuss the circumstances of their pregnancy, explore their concerns, and consider the moral, emotional and spiritual implications of pregnancy and abortion. Our centre offers ongoing care and support for women, their partners and families. During a first appointment the opportunity for an ultrasound scan is offered, either immediately after the consultation or some days later, according to preference and availability. Some 80-90% of women who attend the centre choose to have a scan.

The scan is not intended to detect fetal abnormalities nor be used as a medical service for those with pregnancy complications such as threatened miscarriage; each woman signs a form to acknowledge the limitation of the scan (we have established referral routes with local early pregnancy assessment centres for women whose scans appear abnormal). During the scan the scanner shows the woman the developing baby as well confirming viability (presence of a heartbeat), location within the womb (to exclude an ectopic) and gestational age. Though our machine has the technical capacity, we do not provide 3-D scans. Though they may produce striking images in late pregnancy, early 3-D scans are less easy to interpret than 2-D scans, which clearly show the baby's outline and heartbeat.

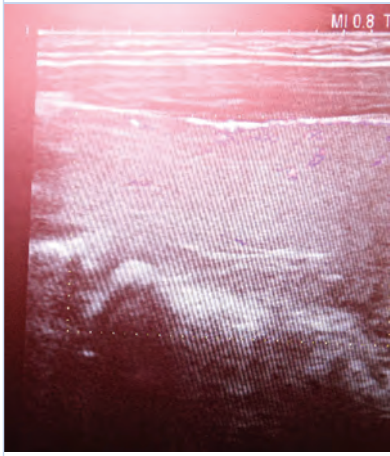
There are a number of practical challenges to setting up the service. Staff members need to be trained in early pregnancy ultrasound scanning, which includes a two-day course, supervision of 150 scans and external assessment. For this purpose we offer early scans to local volunteers, which has turned out to be very popular and an unintended, but very effective way of advertising the service. Those who perform the scans need not have a radiographic training; our current scanners are a medical physicist, an occupational therapist and a dietician. Scanning skills are assessed on a regular basis by a qualified radiographer. The ultrasound service now needs to be approved by the Care Quality Commission (CQC), a process which we found straightforward but somewhat time-consuming. Our staff needs to be covered by professional indemnity, for which we pay a total annual bill of over £2,000 for those scanning and around £500 for all our advisors.

The provision of an ultrasound service has been criticised by some who consider that showing a scan to a woman facing unplanned pregnancy could amount to emotional manipulation. We have found this to be an objection amongst both Christians and non-Christians, by those who favour reflective only, non-directive counselling. In response we would point out that every woman attending our centre chooses whether she has a scan or not, and that we are simply showing a truth in images – the presence of independent life that may be denied by those around her. As Christians, we serve the Lord God of truth. We understand that, though the truth may disturb, ultimately it will be of benefit.

Whilst there has been occasional opposition from those who are pro-abortion, particularly from within sexual health services, we are grateful that the centre's good reputation has gradually been established amongst health professionals and the general public. Feedback from those using the service has been positive, with women reporting that their views are respected and they do not feel judged or pressured.

What has been the response of abortion-minded women to a scan? More extensive data is available from the US in terms of the impact of ultrasound scanning in unplanned pregnancy. Through our service we have only limited means of quantifying the response, but we can confirm that the impact of an early scan is often profound, as illustrated in the case study. Whilst we do not know the outcome in the majority of cases, we are aware of many women on Tyneside who have decided to continue with their pregnancy following their visit to our centre. We would be pleased to help anyone interested in setting up a similar service in their area.

***Chris Richards** is director of Tyneside Pregnancy Advice Centre and a consultant paediatrician.*



So often in these circumstances, women are told that there is only a blob of tissue in their womb. The scan will help them realise that there is a little life inside them. I hope this will be the first of many such services around the country.

(Baroness Cox)

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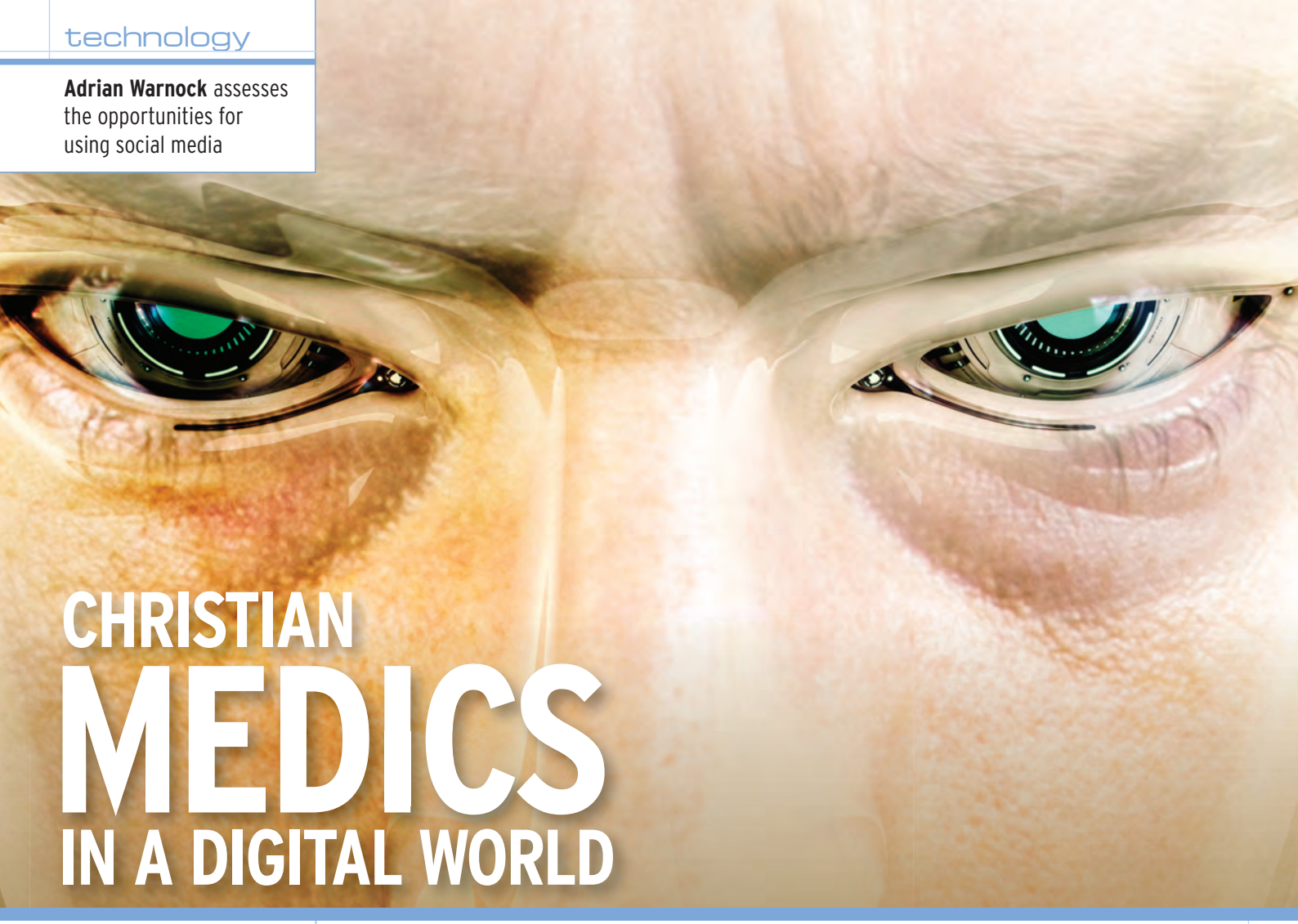
Adrian Warnock assesses the opportunities for using social media



CHRISTIAN MEDICS IN A DIGITAL WORLD

key points

- This is an age of unprecedented technological and social change.
- It presents Christians with enormous opportunities to share the gospel, but there are traps for the unwary.
- The Bible has an abundance of wisdom on how to approach the task.

My grandfather is in his nineties. He is old enough enough to remember a horse and cart delivering his milk. During his lifetime, here is just a sample of the technological advances he has seen:

- Widespread car use
- The Jet Airliner
- TV
- Video recorders
- Microwave ovens
- The Walkman
- MP3 players / iPods
- Mobile phones
- Computers
- Smartphones
- The Internet
- eShopping

There has never been a time in human history that has seen a more rapid change in our technological tools. If we can afford an airfare, we can all now move quickly around the world. For almost no cost we can communicate instantly with potentially millions or even billions of people. No wonder many Christians believe these advances were predicted in biblical prophecy with these words: '*Many shall run to and fro, and knowledge shall increase.*'[1]

The average medic today has no memory of *Index Medicus*. Those of us over 40 will remember the laborious task of going through each year's volume to find references to journal articles on the subject we were researching. Now we can just search an online PubMed resource, or even simply *Google Scholar*.

But perhaps the most remarkable advance in the history of human technology is the way social media can turn anyone into a one-person media organisation. This ability truly is as revolutionary as the printing press. Arguably the Reformation would never have happened if someone hadn't published Luther's *95 Theses* and the books that spread the new Protestant theology.

There is no question that reputations can be made and lost online. An amateur sitting in their bedroom can appear to be as authoritative as a world expert. This is truly a double-edged sword as many medics will know all too well. Patients will often come to see their doctors with dangerous 'knowledge' about their condition gathered online. But how should we respond to social media as Christian medics? Popular Christian preacher and author, John Piper states two common responses. One says:

These media tend to shorten attention spans, weaken discursive reasoning, lure people away from Scripture and prayer, disembody relationships, feed the fires of narcissism, cater to the craving for attention, fill the world with drivel, shrink the soul's capacity for greatness, and make us second-handers who comment on life when we ought to be living it. So boycott them and write books (not blogs) about the problem.

Many people choose to reject any involvement in the online conversation because of those reasons. But Piper himself continues to explain a different perspective:

The other response says: Yes, there is truth in all of that, but instead of boycotting, try to fill these media with as much provocative, reasonable, Bible-saturated,

prayerful, relational, Christ-exalting, truth-driven, serious, creative pointers to true greatness as you can.[2]

There is no doubt that the Internet, and social media in particular can be a massive time waster, rivalled only by TV. It allows pornography into our homes, a massive subject I won't address here. Nor will I explore the reasons why Facebook is apparently mentioned in a third of all British divorce cases.[3] Even simply browsing Facebook or Twitter, or googling can have addictive tendencies, as we spend hours looking for those little rewards of finding an interesting tweet, blog post, or Facebook share. It's wise to switch off the phone screen and perhaps listen to an audio book before trying to sleep. On the more positive side, we have better access to Christian resources than at any time in the last 2,000 years. We have a fantastic opportunity to study God's Word even in a snatched lunch break. And yet, perhaps because of the limitless potential for distraction, we are the most biblically illiterate generation for centuries.

The Internet allows us to do both good and bad things more easily. I am sure that the apostle Paul's response would be simple, and encompassed by his motto, 'by all means I might save some.'[4] So what principles can guide our online lives as Christian medics, and in particular our use of the Internet for evangelism?

1. Join the conversation

Whilst many of us are very busy, if we choose never to engage online we miss an opportunity to strengthen our relationships, particularly with those who live miles away from us, and to influence people positively for Jesus.

2. Understand the online world we are entering

People are much more honest and open online than they are face to face. If you are used only to having deep and open conversations with people who are also Christians, be prepared for a shock when you begin to engage online. You will find remarkable hostility towards Christianity is very common.

3. Write in a way that is understandable to readers

Too often we have a 'Christian Mind' that we only exercise on a Sunday and when we are with our Christian friends. We talk in a language that we all understand, and make assumptions in what we say. When we go online it is vital to remember that anyone can read what we write. So we should assume nothing, and explain everything we are trying to say.

4. Don't think anonymity will protect you

The GMC is very clear, 'If you identify yourself as a doctor in publicly accessible social media, you should also identify yourself by name' and warns that anonymity can often be breached.[5] So always post under your own name.

5. Beware of how we come across to others

It is all too easy inadvertently to come across to outsiders like superior 'know-it-alls' who reject those who are different from us. In contrast, we should consciously demonstrate that we are in fact broken learners who are on the same journey as others, who are not perfect but forgiven. It is incumbent on those who love the doctrines of grace to demonstrate grace, towards others, not condemnation and angry rejection.

6. Be bold AND winsome

There is a form of communication online that to quote Proverbs, 'invites a beating.' We can communicate truth clearly, but graciously. We must demonstrate that we actually care about the lost and want them to be saved. This will be shown by how we draw people into what we are saying rather than aggressively condemn others.

7. Learn to really listen

All too often we see conversations about our faith as an opportunity for a data dump where we share our opinions with others and then depart. That is sometimes called 'hit and run' evangelism. But we should aim as much to understand what others believe, as to share what we believe.

8. Don't say too much

Proverbs warns us, 'When words are many, transgression is not lacking, but whoever restrains his lips is prudent.'[6] We need to be careful not to share excessively. Before you publish that post ask yourself, is it really necessary and helpful for me to write this?

9. Don't say too little

We must remember that words have great potential for good, and so do not be too shy to write. 'Anxiety in a man's heart weighs him down, but a good word makes him glad.'[7] 'To make an apt answer is a joy to a man, and a word in season, how good it is!'[8]

10. Don't feed the trolls

Proverbs has a name for trolls: 'fools'. One of the biggest challenges of our online lives is knowing when to challenge something someone else says, and when to ignore it. There are two conflicting pieces of advice shared in Proverbs.[9] We have to learn the wisdom of when to apply each:

Answer not a fool according to his folly, lest you be like him yourself.[10] *Answer a fool according to his folly, lest he be wise in his own eyes.*[11]

Jesus is calling each of us to play our part in the re-evangelisation of this nation, and indeed the world. For some of us that will include speaking out online. However it is important that this is carried out with respect for our readers especially those who may disagree.

Adrian Warnock *is a medical doctor with post-graduate qualifications in psychiatry and pharmaceutical medicine. He writes online regularly at* adrian-warnock.com *and is author of* Hope Reborn *and* Raised With Christ.

For almost no cost we can communicate instantly with potentially millions or even billions of people

Article based on a talk at the CMF Student Conference, February 2016. The audio and PowerPoint can be accessed here: *bit.ly/1mJA5M6*

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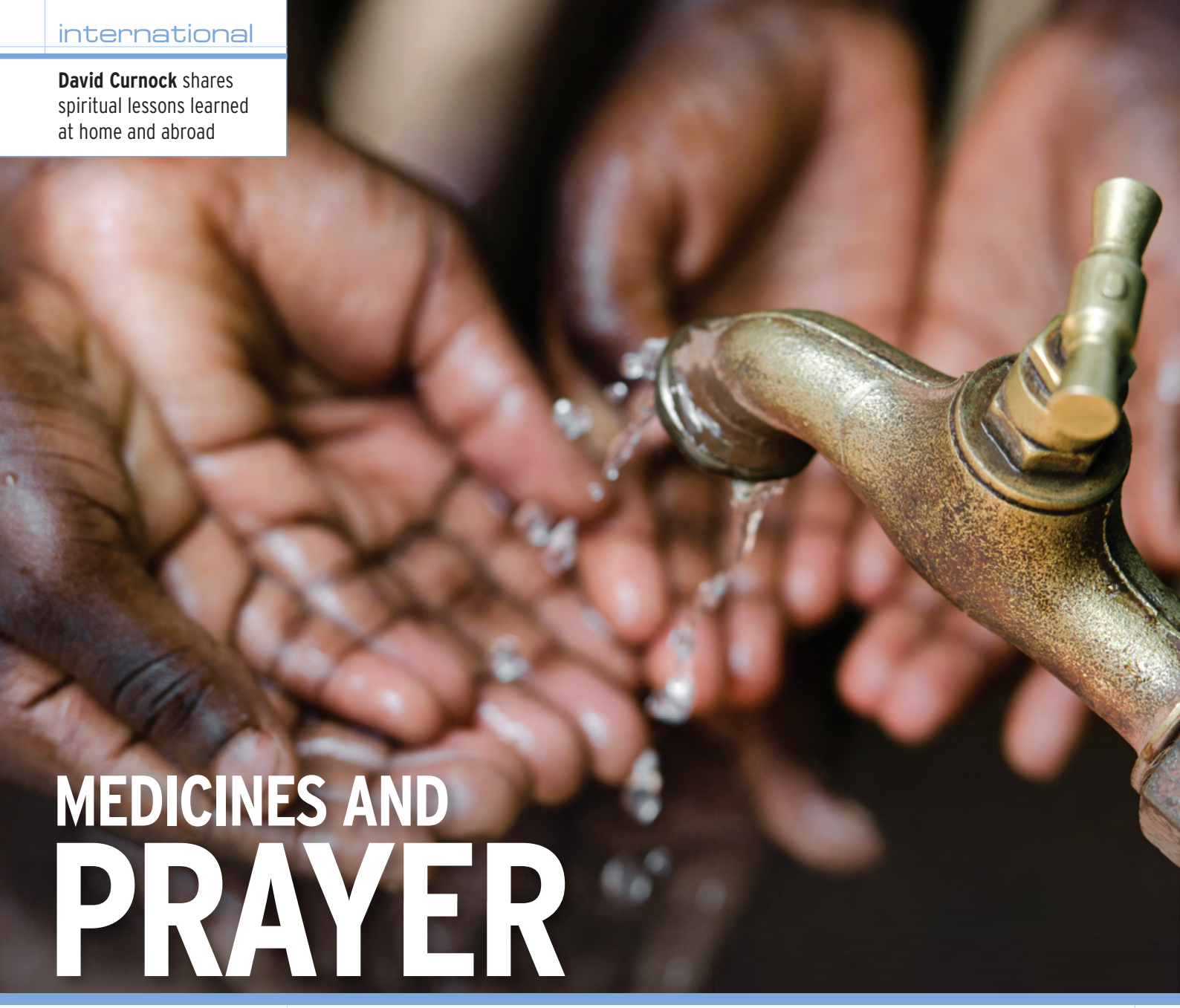
David Curnock shares spiritual lessons learned at home and abroad



MEDICINES AND PRAYER

key points

- Gospel stories of Jesus the healer contain important lessons for us.
- Prayer was a prerequisite for Jesus in his healing ministry.
- International links can open up satisfying opportunities for teaching and learning.

As a medical student I went on a six week elective to Ghana. I learned so much and enjoyed it so much that I promised myself that when I'd passed my paediatric exams I'd go back to Africa. After getting membership and two years as a registrar in Derby and London, I began to look for an overseas job in Africa. I applied to several agencies including Tearfund and Oxfam without success.

Then some time later, my wife Anne and I met a visiting Nigerian paediatrician who was setting up a Department of Paediatrics and Child Health at a new teaching hospital in Benin City, central Nigeria. He needed staff. There weren't enough Nigerian paediatricians being trained at that time. I applied and got the job and from 1977–1979 we lived and worked in Nigeria.

On returning to the UK I completed my paediatric training as a senior registrar in Derby and Nottingham. In the 1990s our hospital established a link, through the Tropical Health Education Trust (THET), with a hospital and Health Institute at Jimma in Ethiopia, 230km southwest of Addis Ababa. Doctors and nurses and other health workers from Nottingham visited Jimma and some of their staff came to Nottingham. For two weeks most years I was teaching and learning in Jimma. Anne came with me and volunteered in a mission run by sisters from Mother Teresa's order. Again we learned much in very difficult circumstances.

> Jesus teaches us that healing of the mind may be the key to healing of the body in some patients

When we retired in 2006 we felt sure we should be involved in mission work abroad – short term postings rather than long term, because we were both responsible for elderly parents. We volunteered with two mission agencies, Crosslinks (Anglican) and International Teams (inter-denominational). Crosslinks sent us to Berega in Tanzania. IT sent us to work in Stara Zagora, Bulgaria, doing outreach work with Roma, gypsy, children and families.

We spend two months each year teaching and encouraging in Berega, and five weeks each year in Stara Zagora. The pattern means that we have nine months of grandparent time here in the UK: it seems to us a good work–life balance.

In all our work we have been inspired by the Gospel accounts of Jesus healing people. Take for example Luke's account of the raising of Jairus' daughter.[1] Why does Jesus tell the parents to give her something to eat? Surely it was because Jesus knew her blood sugar would be very low. Jesus could have miraculously increased her blood sugar but he chose instead to use normal physiology, designed of course by God the Father as creator. Isn't that a lovely example of Jesus working through the created order?

In Nigeria there was a Bible School. I was often asked to see students when they were ill, sometimes very ill, with malaria. In the 1970s malaria in West Africa was fully sensitive to chloroquine. So I would say to the student that he or she needed to take chloroquine and if they were vomiting they would also need a dextrose drip. 'Oh no,' students would say, 'I don't need chloroquine and I don't need the dextrose drip. I believe in prayer!'

In these cases it was very helpful to repeat the story of Jesus and Jairus' daughter to help them see that Jesus used common sense therapeutic measures when they were appropriate. The Lord made chloroquine. He made the sugar and the water in the dextrose drip. And *of course* we should also pray for wholeness and healing as the children of our loving heavenly father. And so the students agreed and recovered.

Some 23 years after we left Nigeria we revisited because our eldest daughter and her husband had been posted there by Tearfund. We went back to see our church in Benin. By then they had established a small hospital next to the church. In the Outpatients Hall there was an open window through to the pharmacy where the patients went to collect their medicines. Above the window was a large notice which read 'medicines and prayer'.

Let me take other examples from the ministry of Jesus. A leper says to Jesus, 'If you are willing, you can make me clean'.[2] Shortly after that, Jesus healed the paralytic whose friends made a hole in the roof and lowered the man on his mat to Jesus' feet.[3] *Prayer was a pre-requisite* for Jesus before exercising his healing ministry. And of course prayer is essential for us too in our practice as Christian doctors.

While I was the Clinical Director of the Neonatal Intensive Care Unit at Nottingham City Hospital, from 1982 to 1997, two local Christians came to see the senior nurse and myself. They said they believed that God was calling them to pray regularly and specifically for the babies on the Neonatal Unit.

With the help of one of the hospital chaplains these two Christian men would come to the Unit as Ward Visitors twice a week and go round the High Dependency Unit asking the parents by each incubator if they would be happy for a local church group to pray for their baby. Parents simply told them their baby's first name – nothing more and no clinical details of course. Then back at the church the small group prayed for those babies by name twice a week.

I have no scientific evidence about outcomes but it was a very fulfilling time on the Unit, *knowing* that the babies were receiving the very best of care *and* prayer. Knowing that every baby is precious both to the parents and to God – that each little life is of inestimable value to God. Knowing this enables Christian nurses and doctors to continue working in these difficult situations.

In that same account in Luke 5 about the cleansing of the man with leprosy, we read, 'Filled with compassion, Jesus reached out his hand and *touched* the man'. To the Jews every person with leprosy was unclean. Touching someone with leprosy would make you unclean. Jesus knew of course the vital importance of touch in caring for people and healing them and he reached out to touch the man. I'm sure we all know the intrinsic importance of touching the patient: we cannot examine the patient properly without touch. The patient instinctively feels that touch is important in the healing process. The same is true of prayer ministry for wholeness and healing.

Then in Luke 5:17–26 Jesus heals a paralytic. The onlookers are indignant when he says, 'Friend, your sins are forgiven'. Sin and suffering were closely connected in the Jewish mind.

Jesus was warm and reassuring to him, and saying in effect: 'God is not angry with you. It's all right.' Rather like speaking to a frightened child in the dark. The condemnation and the burden of estrangement from God, was rolled away from the man's heart. He was released. Patients may be weary to the point of being wheelchair dependent. Jesus teaches us that healing of the mind may be the key to healing of the body in some patients.

Today, recognise that a patient may bring illness upon themselves – for instance by smoking or by drinking heavily. We know that illnesses can be result from the harm others cause: like the radiation released by badly constructed nuclear reactors at Chernobyl.

Finally, we can sometimes think to ourselves, 'Whatever I can do is so small in the big picture of the coming of the kingdom'. But think about Jesus' ministry. Most of his ministry took place in an area of less than six square miles, with a total population estimated around five or six thousand people. Yet Jesus' ministry in that small area changed the world. So we too, in the places where we live and in the hospitals and clinics where we work, can be empowered by His Holy Spirit to be part of his great plan and purpose.

David Curnock *is based in Bramcote, Nottingham. Based on a talk given at the CMF Breakfast, RCPCH Annual Meeting in Birmingham.*

The Lord made chloroquine. He made the sugar and the water in the dextrose drip. And of course we should also pray for wholeness and healing as the children of our loving heavenly Father.

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Alice Gerth reflects on opportunities church life offers junior doctors

SERVING AND FLOURISHING IN CHURCH LIFE

key points

- Starting as a Junior Doctor presents unique challenges.
- An F1 can offer a lot to church life, but of necessity it will be different from what 'regulars' do.
- There are great opportunities for ministry among students.
- 'Menial' tasks can be hugely rewarding.

Changeover is a big day for all doctors. For many, starting as an F1 brings a unique set of challenges: new city, new job, new church, new friends. Looking back on this experience, I found settling into a new church was the hardest. Not because they were unfriendly, but because, to put it briefly, I have 'commitment issues'.

I work at least one weekend in four (on a good rota). The other weekends are spent trying to keep in touch with school and university friends now scattered across the country. Weekdays are often no easier. When I can make home group, it usually requires eating dinner in the car en route.

As I come to the end of my F1 year, I want to redirect the energy I've been spending – making friends and adapting to working life, into church. Having graduated the year before, student work was a natural option. I could still relate to the student experience, but at the same time I have some life experience to share. My question was whether the church would want me given my crazy rota (next year I will be working in A&E and neurosurgery – both notoriously busy jobs). This means I am unable to guarantee my presence at every student group.

I am blessed to belong to a church family that has a large medical population, used to shift workers, so

> The professional world demands our time, and pressures us to make career and money our idols

able to embrace the challenges we bring. The process, though, has helped me to reflect on what it means to commit to a church family; what I bring as a doctor and as shift worker that those with more regular working hours don't. It's why I choose to serve in certain areas rather than others.

Why is being an active member of the church family so important? How can young medics serve when we can't make a weekly commitment? How can shift-working young medics be fruitful participants in various ministries, especially student ones?

Christ describes the church as his body. We are not designed to walk alone in our faith. Over this past year I have been exposed to so much more as a doctor than I was as a student. My consultants have supported me, whether in the difficult discussions with families, or dealing with angry patients, heart-sink patients, deaths of patients young and old. But my consultants don't point me to God. So I have found conversations with Christian doctors at church, at work and in CMF vital for my spiritual

health. They have helped me to keep a godly perspective.

I believe that to get the most from church, we need to be following Christ's example of service. I don't think anyone can dive straight into Sunday school or playing in the band every week. Initially it is important to find your feet and work out what you have time to do. During my first few months of work, I was trying hard not to fall asleep on the drive home. There was no way I was in a fit state to serve on a weeknight, let alone disciple anyone.

Not being involved in a teaching ministry felt foreign to me. Throughout university I had taught Sunday school and I was used to being a very active part of the body. This year I have discovered many more subtle ways to serve.

PRAYER: Prayer is the lifeblood of a church. I attend the monthly church prayer meetings whenever I am able. It is very encouraging to hear what is happening in the church. It's humbling to pray alongside older and wiser Christians who radiate the power of prayer. But as wonderful as corporate prayer is, you don't have to attend a meeting to pray for your church family. We are called to pray in private,[1] and what better way to serve your church family than to lift them up in prayer?

GIVING: Since graduating I now have a stable income. As such it is time to use the income God has provided to begin regular giving to my church family, following the example of Christ's generosity to us.[2] Yes, there is the student loan to pay off. But if we don't learn to give now, we won't give when we have a mortgage and children to support.

BEING ON TIME: When you can make it to church turn up early to talk to friends and greet those you have not met before. It is hard for those on welcome duty if they have no one to guide visitors to seats.

ONE-TO-ONES: If you don't have the time for more demanding ways of serving, you could volunteer to meet with a member of the church family to read the Bible and pray together.

TEA & COFFEE ROTAS/BAKING: This is not the glamorous side of church. But helpers are always needed and our duty teams are usually willing to accept people on an ad hoc basis.

ENCOURAGING YOUR CHURCH LEADERS: Paul instructed the church in Corinth to put Timothy at ease as 'he is doing the work of the Lord' and to 'help him on his way'.[3] I know how much it encourages me when patients thank me and acknowledge work I have done. This is the same for those looking after our spiritual health.

So why, given all these other opportunities, am I looking to help with the Thursday evening student group, especially as I begin F2 with an A&E job? At university, time and availability are often inverted compared to the rest of society, with more time available during the day than in the evenings. Clubs and societies meet after lectures in the evenings. A benefit of working shifts is that we have time to meet with students on weekdays. Another benefit is that we can show students that you can be involved with church once you start a busy job.

There are transition periods when we are more susceptible to spiritual attack and falling away. The obvious one is transitioning from school to university when as young adults we have to make a personal decision to identify as a Christian. I believe that the transition from university to young professional is equally dangerous and this is often overlooked. The professional world demands our time and pressures us to make career and money our idols.

The witness of young professionals when I was at university helped prepare me for this transition. Their attendance at church and student group despite being on day eight of ten, with an exam looming, was a visible reminder that Christ comes first. They were honest about the challenges and their need for prayer and fellowship. I left university with eyes open to the struggles ahead. I had mentors I knew I could talk to who I knew would be praying. Their support over the past few months has been invaluable.

We need to show students that commitment to God is more than just attending church every week. It is sacrificing time and resources to serve the people of God. I believe that leading a student Bible study pre-night shift, or after a long day at work, speaks volumes about our commitment to them and to their spiritual growth. We can add a different life experience into the leadership mix and mentor trainee medics and nurses.

A final note. Given the challenges I have outlined above, if at all possible, I would encourage medics to commit to one church (and therefore city) for your F1 & 2. This year I have lived in Oxford but commuted to Milton Keynes. In F2 I will be working at the John Radcliffe in Oxford. The one hour commute (each way) has been hard work, but the benefit of being established in one church for two years and not having a commute for F2 far outweighs the cost.

This year I have learnt the joy of quiet service behind the front line where often only God can see. However, as I start F2, I look forward to the challenge of a regular commitment and I pray that despite missing a few sessions I can make a positive contribution to the student team (God willing).

***Alice Gerth** is an F2 based in Oxford.*

Shift-working young medics can be fruitful participants in various ministries, especially student ones

references

1. Matthew 6:6
2. 2 Corinthians 8:9
3. 1 Corinthians 16: 10-12

Ruth Butlin reviews the challenges involved in fighting leprosy today

LEPROSY REVISITED

key points

- Because leprosy progresses very slowly there is a paucity of data. Individuals often prematurely give up treatment and health professionals are often tempted to move on to seemingly more pressing issues.
- Although leprosy may be an 'idle' disease health professionals should not be idle about confronting it and helping sufferers rebuild their lives.
- Jesus' command to care for the leper has never been rescinded. In God's new creation, leprosy – along with all sickness and suffering – will be no more.

The leprosy bacterium is a lazy micro-organism, not in any hurry to grow or multiply or mutate. It takes about a fortnight to proceed from one cell division to the next, and only manages that when embedded in a living cell of another species (usually a human one). Its genome is rather degenerate, making it dependent on other cells for certain essential metabolic pathways, so one might even consider the bacterium as 'disabled'. Because of its slow growth, in humans the incubation period of leprosy runs into years. In fact because the bacterium is relatively non-toxic, it multiplies up to enormous numbers without making the host unwell (a good strategy for a parasitic organism). Even with a high bacterial load, most clinical manifestations result from host immune responses rather than from direct action of the bacteria or its products. These host responses vary between individuals (determined by genetic factors and prior exposure to other mycobacteria).

Leprosy develops slowly, the insidious onset of signs and symptoms often result in delay in presentation to health services. There seems to be no cause for alarm: a slowly-expanding non-painful non-itching skin patch or a gradual thickening of the skin with coarsening of facial features, thinning of eyebrows, lumpiness of earlobes. Sadly, it is also common to see delays in diagnosis because the health workers do not immediately recognise the signs of leprosy. Hence by the time a diagnosis is made there may be extensive spread of bacteria in the person's body and immune recognition has become established.

Leprosy epidemics progress slowly, the time scale is quite different from an epidemic of cholera or influenza. Looking at the world-wide situation, there have been waves of leprosy passing over Europe and other parts of the world, the prevalence rising and falling over centuries (unimpeded by chemotherapy or immunisation). The current global 'epidemic' has probably passed its peak (not necessarily as a result of medical interventions), the number of new cases found each year is much less that it was 20-30 years ago. However the trend has recently plateaued: it is no longer falling annually as public health experts had hoped it would. Maybe it is too soon to draw conclusions or extrapolate; predicting the future course of the public health problem is risky when the data is not wholly reliable.

One of the big problems with data on leprosy is that only for a short period (about 1985 to 2005) was it collected routinely, in a detailed consistent

format, in most countries with a large burden of disease. Before that, where there were leprosy control units or clinics people kept adding new patients' names as they were diagnosed and deducted them again only at death, so the data was on 'cumulative prevalence' (how many people in the population had ever had leprosy) then it was gradually switched to registering only 'current cases', deleting those who were 'released from treatment' – and so how long one stayed on the register depended on how long a course of treatment was recommended at that time. The slowly metabolising bacteria only slowly respond to chemotherapy, so courses of treatment have tended to be very long: when only dapsone monotherapy was available courses ranged from three years to lifelong, when multidrug therapy entered the field the shortest course was six months but some patients still had many years of treatment.

So patients with leprosy have to be very patient. They do not see any dramatic change in their signs and symptoms when taking the medicine. In fact when they are told they have 'completed treatment' they may still have the same patches or nodules or madarosis as before. It is a matter of having faith in the health worker`s claim that 'the bacteria have been killed' and 'you are not infectious now'. Over the next few months and years their patches may fade away and lumpy thickened (infiltrated) skin return to a normal appearance.

What does not disappear is the structural damage to extremities resulting from injuries to limbs or eyes affected by peripheral nerve damage: the scarring from trophic ulcers…the loss of digits…the neuropathic disintegration of bone in the ankle… the clouding of an exposed cornea unprotected by blinking. These things last a lifetime. Often the disabilities and deformities increase over time.

The WHO tells us [1] that in 2013 there were 215,656 new cases of leprosy reported in the world and amongst them 13,289 had acquired 'Grade 2 disability' before treatment. In the public health arena the proportion of Grade 2 disabled amongst new cases is significant as an indicator of 'late case detection', a health system failure to diagnose these cases earlier. But for the individuals concerned, the significance of Grade 2 disability is its permanence – often it is not only irreversible but progressive. The WHO reports that amongst the new cases 9.2% were under 15 years old at diagnosis. If the children have a similar proportion of Grade 2 disability to the adults, that means that over 1,000 more children with life-long disability due to leprosy were found, in only one year. Every year more are added.

Some of those disabled by leprosy can be helped by reconstructive surgery, such as those who have footdrop or lagophthalmos, but only if they can access one of the few specialist centres offering it. Most could benefit from teaching about self-care and provision of aids such as protective footwear, but only a fraction will have easy access to these things. There are probably at least 2-3 million people living with residual morbidity due to a past leprosy infection, and these people will be with us for many years to come.

The leprosy bacterium may be an idle creature, but we cannot afford to be idle: we must help these people along with helping people disabled by other diseases or by accidents. The surgeon Jonathan Hutchinson said (over 100 years ago) 'The problem of leprosy is not for the idle-minded. It is full of intricacy and difficulty'. [2] The fact that it is a difficult medical problem is largely the result of its being such a slow-motion disease with long-lasting effects, that any research has to be conducted over long periods of time and does not soon bear fruit, while some health workers lose patience and do not persevere with studying the disease. At the same time many leprosy-affected people, disappointed at their own slow response to treatment, give up hope of recovering from the impact of the disease.

In the face of the ongoing epidemic of disability due to leprosy, several specialist non-governmental organisations are persevering with good work. Notable among them is The Leprosy Mission International, which has just celebrated its 140th anniversary. Its aim as ever is to minister in the name of Christ to meet the needs of individuals and communities affected by leprosy, working with them towards the eradication of the disease. [3] In his instructions to his followers Jesus specifically told them to address the needs of people with leprosy-related problems, [4] and that command has not been rescinded.

Human beings whose bodies have been damaged through leprosy, can be seen as specimens of God's beautiful handiwork which have become marred. Such people still bear the stamp of God's image: their situation can be compared with that of old money. After rough handling in circulation a coin may become worn, chipped, dirty – but even a damaged coin has the same monetary value as a new one. Although the monarch's image imprinted on it has been defaced, a Coin of the Realm still holds its value.

Whereas worldly individuals may discount 'damaged goods' as worthless, and blind evolution sacrifices the weaker members for the good of the race, Christians believe people who have been damaged (by accident, disease, abuse or neglect), should not be thrown out of society, but rather should be helped towards healing of mind and body. It is a Christian's privilege to share in God's work of restoration, anticipating his New Creation where there will be no leprosy bacteria.

Ruth Butlin *works with The Leprosy Mission International which recently celebrated its 140th anniversary.*

fact box

It was Gerhard Henrik Armauer Hansen who in 1873 first described the leprosy bacillus. The expert consensus seems to be that the Bible uses 'leprosy' as an umbrella term for infectious skin disease, but this would have included sufferers from Hansen's disease.

Leprosy is mentioned over 60 times in the Bible. Healing stories about lepers appeal to the Christian imagination and have spurred missionary work among lepers.

The leprosy bacillus destroys nerve endings. When these people cannot sense touch or pain, they are at risk of injuring themselves and may be unaware of injuries. Paul Brand (1914-2003), a missionary doctor of world-renown who worked with leprosy patients, illustrated the value of sensing pain.

Human beings whose bodies have been damaged through leprosy can be seen as specimens of God's beautiful handiwork which have become marred. Such people still bear the stamp of God's image

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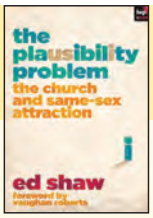
1. World Health Organisation, weekly epidemiological record, 5 September 2014
2. Quoted in 'For the elimination of leprosy', newsletter of the WHO ambassador for leprosy, published by Sasakawa Foundation
3. *www.leprosymission.org*
4. Matthew 10:8



The plausibility problem

The church and same-sex attraction
Ed Shaw

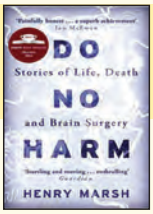
- IVP, 2015, £8.99 Pb 160, ISBN 9781783592067
- Reviewed by **Andrew Sims**, emeritus professor of psychiatry, University of Leeds

A biblically-based, and very personal, account of how a celibate same-sex attracted Christian works out how to lead his life, accepting that God has his hand on every part of it. He aims to live in fellowship with Christ and obedience to the word of God, accepting that he has to miss out on sex and marriage.

The problem with plausibility, he finds, is that most people outside the church and many inside cannot understand or accept his principled position of being exclusively same sex-attracted and yet celibate. He considers that within evangelical churches there are nine 'missteps' that make his position often incomprehensible.

He deals with each of these from a biblical perspective. Throughout he is brave, honest and personal – at times his description of his dilemma is agonising. He writes to help and encourage others who, through their Christian commitment and sexual orientation, may wish to follow the same path. He also writes for himself: to work through what he believes and how he should act.

Many of his 'missteps' give salutary advice to those of us in churches who enjoy the benefits of marriage and family but have little sensitivity for those in his position. He longs for the possibility for friendships, within the church, to become more intimate.



Do no harm

Stories of Life, Death and Brain Surgery
Henry Thomas Marsh

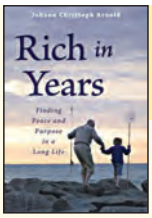
- Orion Books, 2014, £8.99 Pb 278pp, ISBN 9781780225920
- Reviewed by **B Anthony Bell**, emeritus professor of neurosurgery

Most of the 25 chapters are dramatised case reports of patients treated in a south west London's neurosurgical unit. If you have no neurological background the clinical descriptions can be intriguing, less so for the neurologically trained, but the literary style makes entertaining reading and the book can be hard to put down.

If the book was about cakes, it has plenty of guidance on ingredients and culinary techniques to bake one, the only thing missing is the reason cakes are made. Marsh observes the central nervous system's exquisite complexity, the tragedy of disease and death, the fears and emotions of human existence, but never delves deeper to grasp the hope within us.

Hugh Palmer used part of chapter one to illustrate his Easter sermon at All Souls Langham Place. Author Ian McEwan describes the book as 'Painfully honest... a superb achievement'. *The Guardian* reports 'Startling and moving... enthralling', the Spectator 'Excellent... hugely compelling', *The Telegraph* 'This is a book about wisdom and experience'. Should you read Do No Harm? Can you afford not to?

The Observer should perhaps have the last word 'Well thank God for Henry Marsh... One of the finest admissions to emerge in this phenomenal book is that of every surgeon's dilemma, which is the inability to play God'.



Rich in years

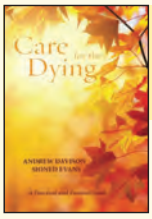
Finding peace and purpose in a long life
Johann Christoph Arnold

- Plough Publishing, 2013 £8.00 Pb 161pp, ISBN 9780874868982
- Reviewed by **Mark Cheesman**, retired consultant geriatrician

This is a good book. It's written from both heart and head, and pastorally explores growing older and dying. It's far from gloomy, with lots of practicalities and some challenges. It's written very much from a Christian standpoint, but people with no faith would find it helpful too. It's not hard going at all, and warmly invites the reader to accept the gift of older age and use it and its gifts for Christ.

The value of community and family is discussed as the most natural way of living late in life: but the author is realistic about the difficulties there can be with that. There is sensitive exploration of dealing with regrets, and with increasing disability, briefly touching on mild cognitive impairment and depression. The emphasis is on keeping faith in the presence of limitation, and refusing over-medicalisation.

It is a book about late-life mindsets and living them out: it does not go into detail with difficult disability, and perhaps glosses over a little just how difficult life can become. But we are encouraged to continue to make new friendships, to get good at intercession, to live as an encouragement, and as an example in faith and holiness. And to have faith that broken things can be fixed, peace is findable, and that 'goodbye' can be a blessing and a benediction. Great stuff.



Care for the dying

A practical & pastoral guide
Sioned Evans & Andrew Davison

- Westcott Foundation/Canterbury Press, 2014. £16.99, Pb 166pp, ISBN 9781848254701
- Reviewed by **Andrew Fergusson**, retired GP & Patron of hospice 23

Palliative care is now arguably a victim of its own success: over-medicalised and in danger of losing its commitment to a holistic approach to death and dying. This comprehensive handbook, written by a palliative care physician and a priest with experience of hospice ministry, comes from the best traditions of Anglicanism and helpfully redresses the balance.

It is intended for clergy, chaplains and hospice/hospital visitors as well as all health professionals. After introducing palliative care and a fascinating chapter on death in Christian theology, it asks provocatively: What is a good death? A necessary chapter follows on the importance of professionals looking after themselves, and there are well written sections on issues affecting the dying, communication, terminal care, and approaching the end. The medical and pastoral inputs blend seamlessly throughout.

The authors quote both CMF and Care Not Killing, 'I just want to die' and they unequivocally reject euthanasia and assisted suicide. Caring for family carers, dying children, continuing care after a death, and an Appendix with prayers for use with the dying complete the book. Overall, an amazing amount of relevant, up-to-date and practical material is packed in. Highly recommended.

The healing tradition of the new testament

Douglas Ellory Pett

- Lutterworth Press, 2015, £19.00 Pb 194pp, ISBN 9780718893873
- Reviewed by **Russ Parker**, Acorn Healing Trust

This is essentially a work of scholarship focusing on a Form Critical approach to the New Testament. At its heart lies the conviction that the original and authentic Gospel message is to be found in the Gospel of Mark and a 'sayings' document known as Q which Matthew and Luke adapted.

Pett believes that the healing stories in Mark have been changed by Matthew and Luke and as such are of an inferior quality as they represent the convictions of the developing church. It is for this reason amongst others that he maintains that it is a fallacy to believe that healing was a central part of Jesus' and the church's mission. Pett points out that Mark, unlike Matthew and Luke, does not include healing as part of the Apostolic mission, only preaching and the casting out of demons.

In this he is correct. However, to dismiss the other Synoptic writers as inferior is to pay scant attention to their alternative sources whilst failing to appreciate that Mark undoubtedly adapted his own source material.

The welcome challenge of this book is to re-examine our assumptions about the nature and practice of Christian healing. It is not so much a separate category to the proclaiming of the good news of God's saving grace as an integral element of it through which we extend our care to and for the whole person.

Growing up God's way (for boys)

Chris Richards and Liz Jones

- Evangelical Press, 2014, £7.99 Pb 76pp, ISBN 9780852349991
- Reviewed by **Pippa Peppiatt**, CMF Nurses' Student Staffworker

This is a short book, very accessible and well illustrated. It explains puberty, marriage and sex all from the perspective of being wonderfully created by God.

I read it with my twelve year old son who, although he found the style of writing young for him, still benefitted from a read 'with mum' to plug any gaps of his knowledge.

After dealing in adequate detail with the changes that happen in the body for pubescent boys, it was good that the following chapter addressed changes in the body in girls. My son informed me that sexual education at his state primary school (year five and six) separated sexes for its puberty talks, so my son appreciated learning about the changes in the opposite sex. We used the book as a springboard for discussion, and so it was really helpful. There is a companion volume for girls.

The thing I most appreciated, which distinguishes it from many other books on puberty, was the Christian, biblical context throughout; that God is the one who has ordained the different seasons in our lives, and that growing up and puberty is his idea in the first place. My son found this reassuring. And that these changes take place in readiness for future adult responsibilities, physical intimacy within marriage and the opportunity to procreate. All God designed and for his glory!

What makes us human?

And other questions about God, Jesus and human identity

Mark Meynell

- The Good Book Company, 2015, £3.99 Pb 96pp, ISBN 9781909919051
- Reviewed by **Julian Churcher**, CMF London Staffworker

The writer describes humanity in various roles such as thinker, worker, and animal, then demonstrates how inadequate is *any* self-referential approach, before turning to Scripture to unpack both how God sees us – our true state – and its remedy at the cross.

He explores our limitations and potential, and our flourishing in generous interdependence. Jesus' complete humanity and utter uniqueness are described ('the best of us'), along with what this reveals about redeemed humanity, both at the present and in the coming age. It's inspiring!

My only gripe is with the author's assertion that we were made and saved to be 'other-person centred'. For those raised to believe that others' needs should always have priority over their own – and as a result impaired from healthy self-love – this is reinforcing of pathology. At its worst this produces the compulsive giver striving for acceptance, inhibited from receiving from either God or man. The corrective, I believe, is being God-centred. Experienced son–hood of God results in what might be called other-*orientation*, arising from confidence in his care and provision for us.

The final summary 'postscript' chapter is superb, ending with a quote of Dag Hammarskjold that could sum up the book: 'I became a Christian in order to become a man.'

Finishing line

John Wyatt

- Care and Keswick Resources, 2015, Leader's pack & DVD £22.02, Study booklets 10 for £16.65, Pb 54pp, ISBN 9780905195209
- Reviewed by **Kathy Myers**, emeritus consultant in palliative medicine

Talking about death and dying remains a hard thing for many people, including Christians, to do. *Finishing Line* comprises a DVD and leader's guide to support five small group discussions. These aim to explore different aspects of death and dying 'from the perspective of the historical biblical Christian faith'.

The first topic covered is 'Euthanasia and Medically Assisted Suicide' followed by 'What does it mean to be human?', 'Can suicide ever be a Christian way to die' and two sessions on 'Dying well and faithfully'. The talks are given by Professor Wyatt and are about ten minutes long. The leader's guide contains the full transcript followed by four or five questions for further discussion, Bible passages for reflection and a closing prayer.

The material covered in this course provides a helpful framework for church groups to discuss sensitive issues related to dying. However it is not exhaustive and discussions may well raise questions that are not answered in the leader's guide. For some the material may touch on significant pastoral issues, for example those who have had a loved one who has not 'died well'. Mature leaders skilled at guiding discussions and able to recognise the need for further pastoral support will be required.

eutychus

A better story

Abortion on grounds of disability? Praise for one TV personality who having lived through the real-life anguish of having a disabled child, has publicly rejected abortion as an option in that situation. Katie Price became a mum at 23. She revealed on the ITV 'Loose Women' programme she 'probably would have aborted' her son Harvey had she known he would be born blind. Thirteen years on, however, she says she would have none of it. Bringing him up changed her opinion. 'I love Harvey so much. I would never change anything about him.' *Metro*, 2 February 2016 *bit.ly/1ShD3Vv*

Commons rejects unlimited Sunday shopping

Good news. The government's attempt to allow big stores to open on Sundays beyond the current six hours has failed. Here is an example of wrong-headed policy defeated by good parliamentary process. In opposition were the churches and the Association of Convenience stores (ACS). The government's case relied on shoddy evidence. Research cited in the case 'for' is simply reheated decade-old data. Extending hours during the Olympics did not increase overall till receipts. God instituted Sabbath rest for the best of reasons. *Telegraph* 28 February 2016 *bit.ly/1UtDdJK*

An apple a day

So now we know. Normally adults gain one or two kilos every four years in middle age, but you don't need fad diets to beat middle age spread. Just eat a handful of grapes a few times a week. Add berries, apples or cherries and plenty of vegetables. Keep the habit over two decades and in every probability you won't add to your waist – maybe even you'll get slimmer. These are the findings of three massive 24-year US studies involving 124,000 people. An elaborate research project showing what common sense probably knew all along. *Independent*, 29 January 2016 *ind.pn/1nV62T0*

Risks to IVF children

Pascal Gagneux, a San Diego-based population expert has ruffled feathers claiming children born through IVF face a potential health timebomb: a higher risk of diabetes, high blood pressure and premature death. IVF is an 'evolutionary experiment' and could pose health risks on par with junk food. He's met a chorus of opposition. For example fertility expert Professor Allan Pacey (Sheffield) concedes there is much to learn about how the female reproductive tract selects sperm for fertilisation, but claims 'a wealth of evidence' suggests IVF babies do as well as those conceived naturally. *Mail Online*, 16 February 2016 *dailym.ai/1OdzBUG*

When food prices bite

Spikes in food prices hit the poor hardest. But why do they happen? One factor is financial instruments linked to food staples such as sugar, wheat and corn. They can cause sharp fluctuations in prices of these items. Now a coalition of NGOs is calling on the EU to demand greater transparency in the way food futures are traded and curbs on price speculation. 'High and volatile food prices have had a devastating impact in poor and food dependent countries, causing increased hunger, poverty and instability,' says Global Justice Now. *Guardian*, 1 March 2016 *bit.ly/1TCzB8P*

Speaking of food, again

There is no such thing as 'healthy food', says Harry Balzer, retail analyst with the NPD Group (USA) and we need to steer people away from misuse of terminology. People are healthy, good food is nutritious, he insists. We take for granted that a kale salad is healthy and that a Big Mac with fries is not. To describe a kale salad as healthy, however, obscures what is most important: that it's packed with nutrients your body needs. But if all you ate was kale, you would become sick, he says. *Independent*, 19 February 2016 *ind.pn/1NiqIc0*

Police and mental health services overstretched

Some 40 percent of police time is taken up dealing with incidents relating to mental health problems. According to December's report by the Revolving Doors Agency it cuts across public services and adding extra pressures the police. Almost weekly there are reports of mental health services buckling under high demand and sharp budget cuts. There is increased pressure on A&Es as well, all this alongside police facing their own funding cuts. *Guardian*, 3 February 2016 *bit.ly/1JZSqQg*

New virus, new threat?

Well, not particularly new. According to the *New Scientist*, it first surfaced in Uganda in 1947 with sporadic outbreaks in Africa, Southeast Asia and Pacific island communities since. It reached Brazil in May 2015 and from there has spread to nine more countries. Containing it is an important priority for health services. 'Clinicians need to be aware that this virus is rampant in South America' and 'it's probably being under-diagnosed,' says Abraham Goorhuis of the Center for Tropical and Travel Medicine at the University of Amsterdam, the Netherlands, who diagnosed three people returning from Suriname in December. *New Scientist*, 30 December 2015 *bit.ly/1XXcVe3*

Sugar in the dock

William Wilberforce persuaded people to boycott sugar because of its association with the slave trade. Now there are calls to tax fizzy drinks and sugar-heavy snacks to improve the nation's health. Public Health England says we eat too much sugar and it makes us fat and ill. PHE offers suggestions to help achieve a new lower recommended daily intake of sugar (5% of total energy, down from 10%). It would save lives from weight-related diseases, cut tooth decay, and save the NHS £576 million a year. *NHS Choices*, 23 October 2015 *bit.ly/1i8LWkF*

Ban on junk food online ads

A public consultation is planned over proposals to ban advertisements for junk food on content streamed online aimed at children, says the Committee of Advertising Practice (CAP). Foods considered unhealthy cannot be advertised on children's television. It is proposed to extend this ban to online outlets like You Tube or ITV Hub. Growing numbers of companies are utilising online video to reach young audiences. A ban would achieve consistency. It makes little sense to ban certain ads on television where the same programmes carrying them streamed online are not. *BBC Health* 13 March 2016 *bbc.in/1UsR1UA*

RADICAL HEART SURGERY

'And if your right hand causes you to stumble, cut it off and throw it away. It is better for you to lose one part of your body than for your whole body to go into hell.'[1]

It was an unusual clinic letter from the prosthetics department. A patient at the prison where I work had been released and was so appalled at the crime he had committed that he severed his own hand. Clearly, Jesus did not want to be taken literally here, and I doubt my patient had this passage in mind when he mutilated himself. But perhaps we can relate to his awful sense of regret, and the desire to distance ourselves from something we have done or said.

The context of this verse in Jesus' Sermon on the Mount shows that amputation of an offending body part will not achieve cure. The disease is metastatic and has disseminated even from our innermost thoughts. We would need to excise right back to the heart, and then what? Are blind men cured of lust or amputees of envy?

Jesus is not addressing the pre-op ward, but outpatients. He is addressing those who have realised that self-surgery is futile and thankfully unnecessary. He is addressing the cured, those who have already consented to radical heart surgery.[2] They are renewed from the inside out, new creations, and now want to make the most of the new lease of life given to them. They want to live whole-heartedly for the Great Physician.

For reflection: What might we be called to turn away from in order to follow Jesus?

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references

1. Matthew 5:30
2. Ezekiel 36:26

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