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HUMAN BEINGS: WHY BODIES MATTER

why care about physical health?

does God heal today?

responding to disability

nucleus

the student journal of the christian medical fellowship

plus: power, puberty blockers, time management, Helen Roseveare, dieting, Leeds

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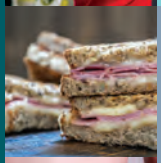


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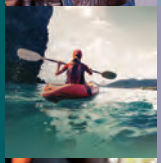
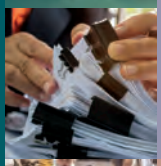

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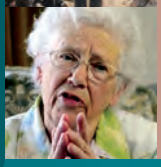

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Editorial

the editor is dead – long live the editor!

Zack Millar is *Nucleus* Student Editor and a medical student in Cambridge

Well, not so much 'dead' as having his burden shared. *#hellomynameis* Zack Millar and it is my immense privilege and delight to be starting as the Student Editor of *Nucleus*. I will be working alongside Laurence Crutchlow and the editorial team to maintain the high production value and quality articles you have (hopefully) come to expect!

The real beauty of *Nucleus* is the amount of student involvement; many of the articles you read in this and every issue are written by you, the student body of CMF. It seems somewhat felicitous then for a student to be part of its production – a step closer to the aim of producing a journal 'by students, for students'.

To that end, allow me to use my first editorial as a platform for a shameless plug! It truly is a joy for us to receive student submissions, so why not write something yourself? Perhaps your last published work was in the primary school rag, and the thought of writing an article for the world to see fills you with horror. You could start by reviewing a film or a book. Or maybe you have already established yourself as a prolific wordsmith, your style honed and perfected over the years. Could this be another outlet for your talents?

In this edition of *Nucleus*, the focus is physical health. Why should we bother devoting an issue to it when our spiritual health is what actually matters? Rebecca Horton shows us the importance of our bodies as exemplified by Jesus (page 4). Many have to deal with disability on a daily basis and it can be difficult to know how to respond appropriately as a Christian. Steve Sturman leads us through both an individual and clinical approach (page 8). In the spiritual domain, faith healing has long been the subject of controversy. Andrew Fergusson presents a review of healing miracles whilst laying down a challenge for all of us.

Finally, I share my recent personal experience of dieting along with some of the snares I faced along the way.

As for our regular features, James Adams explains to us the concept of social justice and inspires us to personal action in *essentials*. In *mythbusters*, Julie Maxwell deals with many of the myths surrounding transgender in children. Leo Hacking helps us *be prepared* to survive the turmoil we may face in our foundation years. John Greenall writes about the power we gain as leaders and how best to use it. We also have a plethora of reports and reviews on everything from Helen Roseveare to PT Barnum, travel from Romania to Leeds, and from the centuries old Daniel Fast to our modern-day mobile phones!

it truly is a joy for us to receive student submissions, so why not write something yourself?

I hope we all will benefit from thinking about this issue of physical health together. It has motivated me to finish my diet, and maybe a few of you will be spurred to action too. And on a related note, I especially hope my editorship will keep *Nucleus* in peak physical health. Every blessing for the months ahead! ▪

should Christians care about physical health?

Rebecca Horton considers the value of human bodies

Rebecca Horton is a final year medical student at UEA

the debate: why is this contentious?

'Practising medicine is simply a means to bring salvation to people's souls.'

This statement immediately feels incorrect, outrageous even... but how do we know that? What is our rationale for healing bodies that will die anyway and be resurrected? What if Jesus' healing ministry was all about drawing crowds in? If we could get alongside people in a different way, would we? How much does the physical body matter? What is the absolute value of healthcare today?

These initial thoughts are not too far removed from the 'original' mission paradigm. 'You're not strictly speaking a missionary'[1] was the attitude when medical work was first proposed as a part of global mission. This was perhaps due to an extrapolation of the dichotomy believed to exist between body and soul: a concept that is partially true[2] but does not mean that man is wholly dichotomous and can be separated into a physical and spiritual form. To put it plainly, we are neither ensouled bodies or embodied souls: but whole people who are greater than the sum of these parts. This understanding is important. If mankind was regarded as a soul that needed saving with the body almost irrelevant, there would indeed be no absolute reason to practise medicine other than to gain entry to preach the gospel or as some way of demonstrating God's love.

The whole story of the Bible affords dignity, respect and honour to physical human bodies. This begins in Genesis, continues throughout the Old Testament, is made abundantly clear in Jesus's ministry and is revealed fully in biblical descriptions of the new heaven and new earth. It is indeed true that healthcare *can* be a means of demonstrating God's love and through this some may be brought to faith. But this is not where all the value lies. The Bible gives compelling reasons to treat physical humans with the utmost care and dignity: the eternal, physical nature of human beings is at the core of this. Considering the Bible as the true story of the entire world[3] explains to us what we instinctively know: physical health matters.

created: physically

'The Lord God formed a man from the dust of the ground and breathed into his nostrils the breath of life, and the man became a living being.' (Genesis 2:7)

Although created for a different purpose to animals, man is of the same continuum, made in unity with the physical universe. Physical human bodies are made of the dust of the earth, heavenly bodies from heavenly material.[4] Each have their own glory. Man is not, therefore, simply a spiritual being trapped in an earthly body. The created 'living being'[5] is a unified body, soul, mind and spirit and this is also the pattern for the resurrection,[6] where we will be fully resurrected with our mortal bodies becoming immortal as well as our souls.

God asserts the importance of his physical creation (*'and it was very good'*, [Genesis 1:31]) and gives man special responsibility over it, known as the Creation Mandate. *'God blessed them and said to them, "be fruitful and increase in number; fill the earth and subdue it. Rule over the fish in the sea and the birds in the sky and over every living creature that moves on the ground."'* (Genesis 1:28) Man is distinguished from the rest of creation by his relationship with God, but not to the exclusion of his physical body. Man is described as a 'living being': encompassing body, mind, soul and spirit into one seamless being. The stewardship commanded over the earth extends to stewardship over the bodies of ourselves and others. In caring for bodies, we also play an important part in God's restoration; the coming of the new (perfect!) creation.

The story continues when physical brokenness enters with the fall.[7] Critically, this mandate to care for the earth is not revoked. A new day is promised when evil will be defeated, and the world restored, but in the meantime man and woman are to continue their role of stewardship. The later promises of

re-creation are not a contradiction to the importance of caring for the physical world now, but rather encourage us to work to restore broken physical bodies as we play a part in foreshadowing God's restoration. The promised re-establishment of peace (in Hebrew, *shalom*) refers to wholeness and reiterates the creation of man as mind, body, soul and spirit, beautifully intertwined. Neither the story of creation, nor the promise for restoration of God's people, present an argument for humans being merely embodied souls.

The hygiene and cleansing parts of the Law[8] primarily demonstrate God's holiness, and the holiness of his people as a nation set apart. But they also protect (and certainly do not jeopardise) their physical health. God does not command practices that harm physical health, but he protects the bodies he's made. He shows his concern for physical needs through providing food for his wandering nation in the desert,[9] so his people can be sure he will provide for them. A wonderful example of God's personal, holistic care is found in 1 Kings 19. Elijah is distraught, he '*came to a broom bush, sat down under it and then prayed that he might die*' (1 Kings 19:4). The Lord reacts with gentleness and first cares for Elijah's physical needs by providing sleep, bread and water before meeting his emotional and spiritual concerns.

God did not 'give up' on his physical creation after the fall, and indeed is still sustaining it. The mandate in creation that we too should care for the physical beings of this world still stands.

Jesus healed: physically

'Which is easier: to say to this paralysed man, "Your sins are forgiven", or to say, "Get up, take your mat and walk"? But I want you to know that the Son of Man has authority on earth to forgive sins.' So he said to the man, 'I tell you, get up, take your mat and go home.' (Mark 2:9-11)

1. not just to draw the crowds

Healing forms a huge part of Jesus' ministry. Although he is clear that heavenly matters are paramount,[10] we 'do not have a high priest who is unable to feel sympathy for our weaknesses'. (Hebrews 4:15) Jesus himself has a physical human body. As he heals the woman who is bleeding,[11] weeps with Lazarus's sisters[12] and gives back the sight to the blind man,[13] Jesus demonstrates that his healing is out of love, not simply to draw crowds to hear his name. His tears for Lazarus proclaim that suffering and death matter. Caring for the physical health needs of others is an outpouring of godly love. More than that: it is part of the restoration promised, as we get a glimpse of this heavenly restoration in Christ's ministry.

2. command to care physically

Whether or not the miraculous healings seen in Acts are to be expected today is widely debated.[14] But the command to care for those who suffer, and specifically for their physical health needs, is not a matter of debate. Our attitudes towards the physical needs of others reflect our attitude towards God. If we tell people the gospel without attending to their suffering, can we really claim to love them? '*For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was ill and you looked after me, I was in prison and you came to visit me*' (Matthew 25:35-36). Christ loves and cares for the physical needs of his people so much, that when we care for them, it is as though we are caring for him personally.

3. inwardly groan for physical restoration

Christ attending to both spiritual and physical needs is demonstrated in the story of the paralysed man.[15] We're not told why this man was paralysed, or even much about him. Jesus attended to his spiritual needs first, making it clear that our sin is more serious than our physical sufferings now. Jesus *first* forgives his sins. But, as Jesus also cares about this man's physical suffering, he then tells him to *get up and walk*. He came to bring us into relationship with God. But this doesn't mean that he thinks our physical suffering is unimportant. We should also consider what this doesn't say about healing. First, we know

from the rest of Scripture that physical sickness is not always a result of *individual* sin[16] that will disappear when sins are forgiven. Physical healing is not promised to everyone who comes to faith,[17] nor is it only given to people who have come to faith: natural and supernatural healing can happen to saints and sinners alike. Additionally, the Bible demonstrates that physical healing can happen miraculously, but it is not *guaranteed* before heaven.

That longing for final healing is captured by Paul as he 'groan(s) inwardly', awaiting '*redemption of our bodies*.'[18] Healing is promised in the new creation where there will be '*no more death or mourning or crying or pain, for the old order of things has passed away*'. Sickness and death will no longer be the order of the day. Although in God's grace we see a foreshadowing of this healing now, a correct theology will help keep us from stumbling when we do not always see the healing that we groan for on this earth.

4. incarnation demonstrates dignity

Finally, Jesus being himself fully human proclaims the importance of physical bodies. In Jesus's incarnation, God bestows his own glory on the human body and this alone is enough to tell us that all human bodies should be treated with honour, respect and dignity.

we will be recreated: physically

'*Though the doors were locked, Jesus came and stood among them and said, "Peace be with you!" Then he said to Thomas, "Put your finger here, see my hands. Reach out your hand and put it in my side. Stop doubting and believe." Thomas said to him "My Lord and my God!"*' (John 20:26-28)

Far from being a reason to ignore our physical bodies, Jesus's resurrection in human form is an *endorsement* of the physical body, the 'final yes' to the pinnacle of his creation.[19] If physical matter was just to be done away with in the new creation, something we would no longer see, then the argument for its value is lessened. '*But Christ has indeed been raised from the dead, the firstfruits of those who have fallen asleep*' (1 Corinthians 15:20) and we will also have physical resurrection bodies.

As God asserted that the physical body was 'very good' at creation, he now demonstrates that it is good enough for the new creation. Our physical bodies will '*be changed – in a flash, in the twinkling of an eye, at the last trumpet. For the trumpet will sound, the dead will be raised imperishable*' (1 Corinthians 15:52) with a physical new creation.

concluding thoughts: how does this affect us practically?

How we consider the human form has implications for us as doctors and nurses. The Bible, throughout its story, affords a great deal of dignity and respect for the human form. Yes, the eternal souls of mankind deserve the deepest outpouring of our hearts. But this eternal significance of our souls *does not* diminish the respect our bodies deserve. Indeed, we were created whole, redeemed whole in Christ, and will be restored whole on that final day. In all these states physical matter plays a part. It is easy to dismiss the human body when what we see daily is its weakness. We yearn for the time when 'the new is here' (2 Corinthians 5:17). Let's rejoice in the beauty of wholeness. Let's delight when we see a glimpse of restoration now. And let's look forward to when the physical world is made new, asserting now the utmost respect for the human body, knowing that God himself has indeed given it the 'final yes'.[20] ■

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a biblical approach to disability

Steve Sturman explores our care for disabled people

Steve Sturman is a consultant in rehabilitation and neurology in Birmingham, and CMF's new Associate Head of Graduate Ministries

We seem to have come a long way in our view of disability. Disability is a 'protected characteristic' under the Equality Act 2010. A person with a disability can legally expect to have equal access to employment and services. And yet today, many people with disability feel disempowered, vulnerable and even abused in our society. In reality, equal access to employment, transport, leisure and even healthcare facilities is a myth. Repeatedly in my practice, patients tell me 'We've had to fight for everything we've got' as they struggle to adjust to the 'new normal' of life with chronic impairments. Some described the experience of leaving acute care and returning to the community with new disabilities as like 'falling off a cliff edge'. They found the brutal reality of life-changing impairments was combined with the discovery that support and services were often paper-thin or non-existent. For all the fine sentiments about caring for people with disability, society is failing. Furthermore, if we look beyond the horizon of our own domain, we see an ocean of suffering worldwide where the disabling effects of disease are feared and loathed. How should a Christian respond? What is the biblical view of disability? Is there a Christian distinctive and does it matter?

what does the Bible say?

Fundamental to biblical theology is the understanding that we as humans are made in the image of God.[1] Human beings are beautiful, creative, passionate, ingenious and energetic – made to inhabit and subdue the world. But all is not right. The image of God is marred by sin, allowing death and decay to enter. We find ourselves sitting in hospitals and clinics the world over, pondering and struggling with the consequences. But equally fundamental to the biblical narrative is the knowledge that the God we worship is committed to restoration.[2] It was not meant to be this way and he has determined that ultimately, by his own sacrificial giving, perfection will be restored and 'sorrow and sighing will flee away'.[3] The Christian clinician therefore has a world view that asserts that there is an ultimate hope. All this suffering is not in vain. It is not the end of the story. This hope gives resilience and endurance – a key factor in being able to care for people with disability, day after day without being overwhelmed with despair.

This hope is rooted in present reality and not 'make believe' or artificially triumphalist. When impacted with grief for his friend Lazarus's premature death, Jesus wept.[4] We have a God who intimately knows the pain of abuse, loss and suffering. Ironically, the Old Testament law that seems to discriminate against any form of disability in the priesthood[5] is in fact there to emphasise that the One who was to come would indeed be perfect, but would then give up that perfection by taking on the pain, grief and physical consequences of our sinful state.[6] But what did this actually look like as Jesus met people with disability, and how might that affect our attitudes today?

what did Jesus do?

Repeatedly, Jesus had compassion on men and women who were made in God's image yet suffering with broken bodies. In contrast, healthcare systems today seem to have become self-seeking and populated by clinicians who see patients as 'getting in the way of them doing their job'. That may be stereotypical, but Christian clinicians should be different, with the spirit of Christ's compassion at their core.

Jesus never exploited people with disability. There was no media show around those that were healed. 'Keep it quiet' he said on many occasions.[7] Jesus never used people with disability to gain credibility. How different to the attitude I sometimes cherish – to obtain fame and recognition for my work with the marginalised, even in Christian circles. True Christlike service seeks no recognition or reward at the expense of those suffering with disability.

Restoring autonomy and control to those who had lost it was central to his ministry. How many times did he ask the person with obvious rehabilitation needs 'What do you want me to do?'[8] Jesus models servanthood. He takes away the power gradient, making no assumptions about perceived needs. The person is central.

Jesus was, and is, the ultimate advocate. Blind Bartimaeus is being silenced as an embarrassment until Jesus asks that he be brought to him.[9] Ultimately that spirit of advocacy takes Jesus to the cross. A Christian clinician cannot sit idly by and watch a vulnerable fellow human be treated unfairly, simply because they have no voice, or mobility or access to social media. The spirit of Jesus's advocacy drives the Christian clinician to push the boundaries for access to services and vocation.

a Christian clinician cannot sit idly by and watch a vulnerable fellow human be treated unfairly

Note too, that Jesus separates guilt from disability. 'Neither this man sinned nor his parents', he once said, indicating that disability is part of a bigger picture.[10] He soundly rules out the primitive notion that 'the disabled are cursed'. That attitude powerfully devalues the person with disability, virtually mandating neglect or disinterest. But Jesus says this is not the case. The Christian clinician does not struggle with judgmentalism towards the person with disability.

But Jesus makes the inextricable link between our fall from grace as humans and suffering, and so makes the declaration that forgiveness is an integral part of healing.[11] A Christian clinician will always know that the deepest human need is not restoration of the body, but restoration of peace with God and so will be praying for that special grace for those they treat.

This is the nature of a Christlike attitude to disability, derived not just from a cognitive apprehension of the character of Christ, but because we have 'the mind of Christ.'[12]

when I am in the eye of the storm

However, for the individual coping with the acute realisation of loss of ability there is a different perspective. One might expect to see a range of reactions. Guilt, either real or imagined, can be framed by questions such as, 'Is it my fault?', 'Is God angry with me?', 'If only I hadn't…'. Fear might emerge around what the future holds, coupled with grief for the loss of what was, or might have been. Shame and loss of self-esteem might be expected, particularly in relation to personal care issues such as incontinence. Coupled with this may be anxiety about acceptability – 'Will I still be loved?' – and vulnerability with the loss of power. Small wonder then that people predicting their response to being disabled might fearfully say 'I would never want to live like that.'

The surprising thing, however, is that in practice these reactions are not usually those immediately seen. They seem only to be brought out as trust is built with the clinician. Such trust is generated by the qualities that we have already mentioned and that Jesus modelled. This investment of trust carries huge responsibility, which the Christian clinician carries with the fear of God before their eyes, knowing he is intensely on the side of the vulnerable. Furthermore, those looking in from the outside may see things very differently from the person dealing with disability.

The so called 'disability paradox' describes the phenomenon that many people with serious disabilities report that they experience a good or excellent quality of life, when to most external observers they seem to live an undesirable existence. In one study, more than half of a group of interviewees with moderate or severe disabilities reported 'excellent' or 'good quality of life'.[13] In another national survey from Australia, 40% of people with profound or severe activity limitation regarded their health status as 'excellent', 'very good' or 'good'.[14] Analysis of the factors behind this suggests that a person's impairments and their perceived health are not directly related.[15] In practice, this means that the likelihood of

'meaningful recovery' from the patient's point of view should not be judged on the simple measure of the severity of a person's impairments; the context is all important.

Another strand of thought in the rehab literature is the tension between 'restoration', that is getting back to 'normal', and 'transformation', that is working with the 'new normal'. In practice most people start with the goal of complete restoration but make a journey towards transformation with time. A biblical metaphor has even been used to illustrate this idea, that failure to get back to normal may not be second best.[16]

There is also growing interest in so called post-traumatic growth, a controversial observation that positive psychological effects can be seen following trauma. That there seems to be such a phenomenon is clear, but understanding what it really is, and how it comes about is still open to question.

But what does the Christian clinician make of these counter-intuitive processes? First, they resonate with biblical thinking that an individual is more than just a perfect physical being. There is a bigger narrative at work in each of our lives than the pursuit of physical perfection and prosperity. People have intrinsic value. Outcomes can be unexpected and don't just depend on 'getting back to normal'.

Second, these processes impact care planning. Frontline clinicians may see only hopelessness and loss in the acute setting. This may wrongly lead to early conclusions about the futility of treatment. Raising awareness of the range of long-term outcomes is important, and whilst not a purely Christian view, it is an important part of advocacy for the vulnerable, which our Lord expects of us.

disability and clinical practice

Seeing a patient as 'incurable', or their situation as 'hopeless', profoundly affects clinical practice. For example, the management of disability is simply not seen as the core business of acute medicine. Team members may not be interested in tackling complex needs, and junior doctors cannot be blamed – rarely does disability management figure in examinations. Who has ever heard of an OSCE long case looking at neurogenic bowel management? That is someone else's job. Repeated meaningless entries in the notes like 'Awaiting rehab' are evidence of the disconnect. Does anyone appreciate what other team members are actually doing? Or is there a hint of arrogance that such things are secondary? Team relationships are understandably not warmed by this and patients suffer. This is not the image of Christ.

Negative attitudes toward disability also pervade the upper atmosphere of healthcare planning. Enablement and care services are easy to neglect and slash. People with disability have only limited resources to fight their corner.

The Christian clinician, however, sees the person in the 'eye of the storm' as absolutely worthy of equal esteem. It is hard to see how Christians cannot speak up and tackle these deep-rooted distortions in clinical practice, once we understand Jesus's values.

what now?

It is remarkable that the Gospels give us so much information about how Jesus dealt with people with disability. Surely this is there for a reason? Despite all our best efforts, secular human beings still struggle with disability in themselves and others. Jesus models a different way, in which he invested his body and blood. As disciples, we should follow him. ▪

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does God heal miraculously today?

Andrew Fergusson gives a biblical and medical review of healing miracles, and prayer for healing

Old Testament

Miracles in the OT are comparatively rare and are mainly confined to times of deliverance. Most are miracles of nature, provision, preservation, or are a revelation of God's will. The most numerous are of judgment. There are only eight healing miracles,[1] three of which involve raising the dead.[2]

New Testament

By contrast, healings appear on almost every page of the Gospels. There are 25 healings of individuals by Jesus and 16 descriptions of him healing large groups. The Gospels and The Book of Acts also describe 18 healings by the apostles and other disciples.[3]

20th century

After 1,900 years of almost total silence, the Charismatic Renewal Movement (of the 1960s onwards) revived interest in prayer for healing. Controversial claims were made and re-examined. By the new millennium, most churches had settled down into one of two agreed positions.

Some leaned towards the cessationist position –

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that once the canon of Scripture was closed by the end of the first century, God did not need any further accounts of himself and so supernatural gifts and activities ceased. Proponents added that in any case we now have the 'miracles' of modern medicine and the NHS. The other extreme tended towards the 'Blessed are they that expect nothing for they shall never be disappointed' position. We see no miracles because we don't expect them and therefore don't pray for them.

Let's explore this continuing controversy by considering two key words in the debate.

what do we mean by 'miracle'?

A large part of our problem is that we use the word 'miracle' very casually. Every brand new parent is awestruck by the miracle of childbirth, but it is a very natural phenomenon. Early risers will be amazed by the miracle of a beautiful new dawn, but one has happened every day for a long time now!

Any dictionary will help us decide the right use of the word for this debate. Mine defines miracle as:

1. An event contrary to the laws of nature and attributed to a supernatural cause.
2. Any amazing or wonderful event.
3. A marvellous example of something: *a miracle of engineering.*[4]

We need to stay with the first definition. Years ago, Dr Peter May analysed the characteristics of Christ's miracles of healing and found:[5]

- The conditions were not symptoms but obvious examples of gross physical disease
- At that time they were incurable and most remain so today
- Jesus almost never used physical means
- The cures were immediate
- Restoration was complete and therefore unarguable
- There were no recorded relapses
- Miracles regularly elicited faith

Applying this biblical gold standard to contemporary claims of miracles, and with the wealth of technology and medical documentation we have today, scientifically trained doctors will be sceptical of frequent modern miracles.

why are there inappropriate claims for miracles of healing?

Leaving aside the few fraudsters and charlatans, well-meaning lay people may sincerely believe a miracle has happened, but a quick review can usually suggest alternative medical explanations:[6]

- Was the original diagnosis wrong?
- Spontaneous remissions do occur – was this one?
- Were the symptoms psychosomatic?
- Have there been simple misunderstandings?
- Have there been exaggerations and half-truths?

So, from an evidence-based consideration of the word 'miracle', let us now turn to the second key word.

a large part of our problem is that we use the word 'miracle' very casually

what do we mean by 'healing'?

Most people wanting prayer for healing are actually looking for a cure – for the relief of distressing symptoms, for their cancer treatment to be completely effective etc. Luke, the physician, was the only Gospel writer to record a passage that shows the difference between cure and healing:

'Now on his way to Jerusalem, Jesus travelled along the border between Samaria and Galilee. As he was going into a village, ten men who had leprosy met him. They stood at a distance and called out in a loud voice, "Jesus, Master, have pity on us!" When he saw them, he said, "Go, show yourselves to the priests." And as they went, they were cleansed.

One of them, when he saw he was healed, came back, praising God in a loud voice. He threw himself at Jesus' feet and thanked him – and he was a Samaritan. Jesus asked, "Were not all ten cleansed? Where are the other nine? Has no one returned to give praise to God except this foreigner?" Then he said to him, "Rise and go; your faith has made you well."'

(Luke 17:11-19)

healing is much wider than cure. The word is linked with 'whole' and with 'holy'. It is about us as body, mind and spirit

Ten men were cured of leprosy (though the original Greek word applies to a range of disorders affecting the skin and does not necessarily signify the bacillary disease itself). Jesus miraculously removed their physical pathology and their signs and symptoms. Luke uses the word 'cleansed' – cured.

But leprosy then, as often now, did not just affect the physical body. To protect against the transmission of infection the sufferer was removed from family, friends, synagogue, and work. There were clear psychological, social and spiritual consequences of the skin stigma. Nine of the ten only received the physical, psychological and social benefits, and rushed off after the priest's confirmation to celebrate. Only one came back (a Samaritan) to worship and thank Jesus; only he fully realised the spiritual benefit; only he was truly healed.

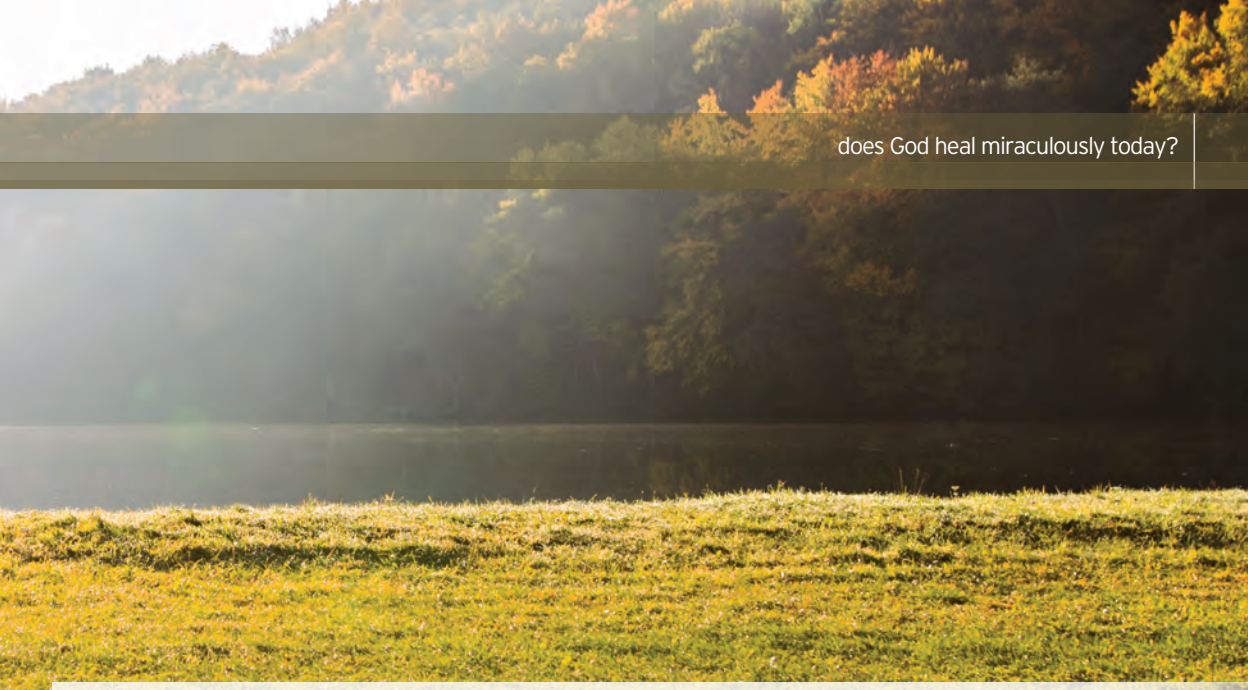
This 'nine cured; one healed' narrative shows us that healing is much wider than cure. The word is linked with 'whole' and with 'holy'. It is about us as body, mind and spirit.

does God answer prayer for healing?

Yes, of course he does. God always answers prayer! Sometimes he quickly gives us the green light of 'Yes'; sometimes the unwelcome but useful red light of 'No'; but often the frustrating amber light of 'Wait'.

In the 1980s, I worked in a Christian mission practice in south-east London, where some of our patients were believers and where most others expected occasional spiritual inputs. Praying with patients is of course very different now, but over those ten years I probably prayed with a patient on average about once a week, and briefly for almost every patient as they entered or left the consulting room.

Later, I chaired for five years the Acorn Christian Healing Foundation and regularly participated in healing services, doctor alongside Anglican clergyman. At the end of the services, any who



wished were invited to come to us with a one sentence summary of their request. We would usually anoint their forehead symbolically with oil, and pray very simple brief prayers.

In both these contexts, I think I can honestly say that when we heard follow-up God had always done something. It was usually in the 'healing' area of holistic benefit, but sometimes physical benefits in the 'cure' domain followed. People got better quicker than we would have expected, treated cancers did not recur over the years. Now of course those people had also received medical treatment and there was no need to invoke the supernatural to explain developments, but I firmly believe that 'more things are wrought by prayer than this world dreams of.'[7]

should Christian health professionals pray for healing?

In our church lives, yes we should be prepared to offer prayer. Very few will say no. Prayer in a professional context is a very different matter, requiring a clear change of role, fully informed consent and confidentiality.

'Is anyone among you in trouble? Let them pray. Is anyone happy? Let them sing songs of praise. Is anyone among you sick? Let them call the elders of the church to pray over them and anoint them with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise them up. If they have sinned, they will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous person is powerful and effective.'

(James 5:13-16)

James gives us helpful guidance

Prayer for healing is available for all:

- It should always be patient-centred
- It should always be practised responsibly
- It may involve symbols
- It is associated with faith
- It is associated with the forgiveness of sin

So, whatever you think on the subject of miraculous healing today, it is always worth praying! ▪

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essentials: the life sandwich

James Adams considers the social and spiritual determinants of health

James Adams is a final year medical student in Manchester

I'm a big fan of sandwiches. Whenever I fancy a snack, I open my fridge, grab my nice olive spread, maybe some breaded ham, mature cheddar and a bit of rocket, and I pull it all together into a rather successful sandwich in under two minutes.

There's a brilliant video of a man who tries to make a sandwich from scratch. He grows his own grain and lettuce, milks a cow to make his butter, extracts his salt from the sea and so forth. The process takes him six months. It takes me just two minutes!

You see the ability to make a sandwich isn't predominantly down to your culinary abilities, but instead the ingredients you were given to start with.

Now imagine the sandwich represents what the world would consider to be a 'successful life'. I've been given all the ingredients I might need, straight to hand. I was brought up in a loving family; I've never experienced abuse; I've always been cared for and built up by those around me, and as such I am reasonably confident. I've been given a stable home and parents who instilled key values in me, but also taught me the importance of boundaries. I had a great education and was shown the value of hard work. My parents protected my health, never smoked around me, and ensured I ate healthy meals. I've been given the best possible start in life. All those ingredients I need to make my successful 'life sandwich' were handed to me on a plate.

Now flip that on its head and think about some of the people society loves to judge. For example, John was brought up in a home where he was abused, resulting in rock bottom self-esteem. He never ate decent meals, so his health suffered. John saw that mum and dad never worked so didn't see the need to try hard at school. He got some bad marks and was branded thick, so he started to believe it was true. Mum battled with anger problems and addiction, which regularly came out at home and so drink, drugs and lashing-out were part of normal life for him. All his life, people have let him down, and he's learnt that trusting people leads to pain.

Why don't people like John make successful 'life sandwiches'? Is it because they're lazy, or thick, or they don't want to change? Unfortunately, this is what a lot of people believe.

No – it's because they've not been given the same ingredients to make their sandwich. They've had to start from scratch. If you sat a sandwich-making OSCE and were given nothing, whereas your colleague was given all the ingredients they could possibly need, and you were judged by the same criteria – wouldn't you be outraged?

the ability to make a sandwich isn't predominantly down to your culinary abilities, but instead the ingredients you were given to start with

One of the most common themes in the Bible is serving the poor and vulnerable. Some argue that Scripture dedicates more word time to it than other important themes such as giving, leadership, heaven and hell and even prayer! Clearly, this is a topic that is on God's heart. We would never see prayer as an optional part of being a Christian, just for those who are 'called to it', so why is social justice just for those who 'have that calling'? It seems to me that Scripture suggests serving the vulnerable should be a priority for us all. But where do we start?

The GMC tells us we should care for patients holistically, but what does that mean for patients like John? It means we must learn not just to put plasters over superficial problems, but as Christian medics we should learn to look at the broader picture.

During my intercalated year, I set up a charity called Number 11. Our focus is on creating a family and a home, where we address many of the social determinants which dictate the health of our clients. We work to support clients with issues around homelessness, addiction, battles with mental health, benefits and employment, low skill levels, bereavement and more. Ultimately, we focus on the underlying causes of our client's situation, whether it's abuse, relationship breakdown, isolation or poor self-esteem.

we need to bring individuals from chaos, isolation and brokenness to stability, relationship and healing – what the NHS really needs is the church!

Eating together, laughing together, playing stupid games and informal workshops, whether they be based on music, art, creative writing or sewing, all have just as much, if not more of an impact than the counselling sessions or employment workshops we run. Why? Because it's not just programmes and services which change people's lives, it's relationship.

The thing we hear most from clients isn't that they are grateful for support in beating addiction, gaining accommodation or finding employment. The thing we hear most is that they are grateful for being given a family.

The years invested setting up Number 11 contained some of the toughest times of my life (managing a building renovation and trying to bring in £350,000 alongside year four OSCEs is something I hope never to repeat) – but I'm convinced through many of the incredible stories of transformation we have seen that this is work we absolutely need to be doing.

As Christian medics, we are in such a privileged position. We understand not just medicine, and the social determinants of health, but also have an understanding of God's heart for each one of our patients. His desire is for them to be loved, and to become part of the family that we know as the church. We have an incredible opportunity to combine our head knowledge, with what is in our heart and spirit.

Soon, you are likely to be working in the NHS and focussed on delivering a service. For many of our vulnerable patients, the service will never be enough, and we'll just be putting temporary plasters over the problems again and again. We need innovative ways of addressing the causal issues. We need to bring individuals from chaos, isolation and brokenness to stability, relationship and healing – what the NHS really needs is the church!

And so, we are left with the question where do we fit in? What's your idea? What can you do? Whilst the answer to that will vary between us, the Bible is clear in its instruction for us all to serve the most vulnerable. Let's not leave it to someone else. ▪

questions for reflection

- Think of a vulnerable patient you have seen. What difficulties did they have accessing NHS services?
- Should the NHS itself be dealing with isolation or unemployment?
- How might Christians working in the NHS help with some of these issues, while still providing a clinical service, and avoiding personal burnout?
- What role could your church play in supporting patients like those described here?

just ask
time management

Abigail Randall is a GP in East London and medical school link for Bart's and the London Medical School.

Help! I have so much to learn and the exams and deadlines just keep coming; how do I keep my cool and keep up my Christian faith?

I love this question – it's not just about effective time management (and who doesn't struggle with this?), but also about walking with the Lord when time is short.

It's so important to create boundaries around our spiritual lives: there will always be multiple demands on our time. Right now that might be studying and exams – in the future there will be paid work, family pressures, concern for friends, responsibilities at church, the list goes on. Let's not allow these pressures (in Jesus's words, '*the worries of this life*' [Mark 4:19]) to erode our relationship with him.

Make daily Bible reading and prayer a priority. Pray about your studies. Pray for discernment to cover the most helpful material, for energy, for God's help in working hard and focusing. 'Cast all your anxiety on him because he cares for you.' (1 Peter 5:7).

Pray also for spiritual growth and for opportunities to serve him during this busy season. James says that '...the testing of your faith produces perseverance. Let perseverance finish its work so that you may be mature and complete, not lacking anything.' (James 1:3-4). Hold onto this broader perspective – yes, there may be tons of medical facts and procedures to learn, but don't miss out on the opportunity to become spiritually 'mature and complete'. Nurture your walk with the Lord through busy times.

Think about how you use Sundays. Consider keeping one day a week clear of studying. Use it for refreshment and a chance to focus on God who has created and designed rest for our good. Be wise about CU and church midweek activities. Decide what you are committed to and follow through.

In terms of studying, prioritise. List the areas you need to cover. Convert this into a realistic schedule based on the time you have available and try to stick to it. Don't get bogged down – if you have spent four weeks trying to get your head round ECGs, it might be worth moving onto something else for a while. Vary your approach, be it with online questions, looking at a textbook, rehearsing OSCE routines, group chats, and so on.

Keep good habits: go to bed on time, eat well, take breaks, do exercise.

Focus on the important stuff, not small print. There are key conditions – learn about these. If you're having trouble seeing the wood for the trees, talk to someone else (perhaps an older student or graduate) and make a list together of the most valuable things to spend your time on.

Step back and wonder. Drink in the beauty of what you're learning! Thank God for the way he has made the human body, created science, and for the many amazing medical discoveries.

The student years are a key opportunity to get into good habits for the rest of your life. The workload will change, but is unlikely to lessen as life moves on – if you're able to keep Jesus central now, this will stand you in good stead for the future. ▪

If you have a burning question, why not email us: *nucleus@cmf.org.uk*. The best question each issue wins free student membership for a year.

leadership : leadership & power

John Greenall considers the gift, privilege and responsibility of power

Sitting down to write an article on power, I must admit my thoughts drifted to the Marvel franchise and films like them. My favourite superpower? No, not X-ray vision ? I'd like to fly.

But seriously, have you attended a lecture on power? Or heard a sermon on the topic? I didn't think so. Power is 'the ability to make something of the world'. Power isn't 'out there' but 'in here'; and in the world of medicine we are told we have lots of it. We can prescribe powerful drugs; we can influence someone's decision making; we 'control' conversations to break bad news; we hold the keys to restricted investigations. And we learn a lot; indeed, it was a medic, Sir Francis Bacon, who first coined the phrase 'Knowledge is Power'. We might not be superheroes, but as medics we are sometimes made to feel like it.

power as a gift

This isn't an entirely erroneous view. God delegated power to humanity by commanding us to be fruitful; to multiply, subdue, and have dominion over the earth.[1] In this sense, we can view power as a gift from God to be exercised wisely in our work and in our leadership.

Andy Crouch in his excellent article *It's Time to Talk about Power*,[2] says '[Power] *is a gift – the gift of a Giver who is the supreme model of power used to bless and serve. Power is not given to benefit those who hold it. It is given for the flourishing of individuals, peoples, and the cosmos itself. Power's right use is especially important for the flourishing of the vulnerable, the members of the human family who most need others to use power well to survive and thrive: the young, the aged, the sick, and the dispossessed. Power is not the opposite of*

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servanthood. Rather, servanthood, ensuring the flourishing of others, is the very purpose of power.'

In leadership, we will recognise that power means privilege and when we exercise power well we build currency. Patients trust our decisions. Nurses trust our reliability. Colleagues trust our integrity. Building that currency means we are given trust and space to work. This is a privilege and a gift to be exercised with care.

power distorted

And yet the fall of man is a reality; when unchecked, power can be abused. You will see this as you progress through your training. In my department you will encounter victims of domestic and sexual abuse, which at their heart are abuses of power. You'll encounter patients who you feel are manipulative, and you'll have perhaps already seen 'tugs-of-war' between departments or even between consultants on your placement. Power is abused all around us in healthcare, and we have a front row seat to see it play out.

But we need to look within as well. As medics we can be proud because of the power we yield, tempted to look down on those with less knowledge, be it someone in our tutor group or a friend studying another subject. We can also misuse power. Examples of this abound in the world of healthcare: researchers falsifying clinical trial data to suit their agenda or to gain financially. And power can be abused when it is *not* used to serve others. As James, the half-brother of Jesus writes, *'If anyone, then, knows the good they ought to do and doesn't do it, it is sin for them.'* (James 4:17) Doctors are the first to speak out for their own welfare, when they could use that power to speak for others, both their healthcare colleagues and patients, especially the unborn, the elderly and other vulnerable patient groups. Unfortunately, Christians are not immune. There is the potential, and often an almost inevitable temptation for those in Christian leadership to abuse and misuse power in CUs, CMF groups, university societies, churches and on the wards.

Jesus and power

Jesus confronts the issues of power when two of his closest disciples ask him a question in Mark 10:35-38: *'Then James and John, the sons of Zebedee, came to him. "Teacher," they said, "we want you to do for us whatever we ask." "What do you want me to do for you?" he asked. They replied, "Let one of us sit at your right and the other at your left in your glory." "You don't know what you are asking," Jesus said. "Can you drink the cup I drink or be baptised with the baptism I am baptised with?"'*

power is the ability to make something of the world

The disciples want power. And yet they soon realise that Jesus demands something different.

Jesus said to them, 'The kings of the Gentiles lord it over them; and those who exercise authority over them call themselves Benefactors. But you are not to be like that. Instead, the greatest among you should be like the youngest, and the one who rules like the one who serves.' (Luke 22:25-26). He calls them to be servants.

Throughout his earthly ministry, Jesus displays his power by spending it on others. He trades his reputation for our shame. He makes himself low to bring us high. Rather than be consumed by power, he demonstrates power through serving others.

Perhaps referring to Jesus washing his disciples' feet[3] the Apostle Paul writes:

'In your relationships with one another, have the same mindset as Christ Jesus: who, being in very nature God, did not consider equality with God something to be used to his own advantage; rather, he made himself nothing by taking the very

nature of a servant, being made in human likeness.' (Philippians 2:5-7)

so how do I steward power?

Whilst we are to seek to imitate Christ, we are not Christ, and so we are all vulnerable to abusing power. We need to cultivate honest, accountable relationships with others where we can confess our pride, our misuse of power and our inaction when faced with the powerlessness of others.

Second, we need to be ready to share the good news with those who feel powerless. We can share that Jesus himself walked in their shoes. He knows what it means to be humiliated, shamed, rejected and abandoned, and he can minister to people's pain. We may have a front row seat to abuses of power, but we can interrupt the drama with the good news of Jesus to a hurting world.

> we might not be superheroes, but we are sometimes made to feel like it

Third, we need to be ready to be prophetic voices in our land. We are called not to fear power – be it political, professional, cultural or social – more than we fear God. We are called to speak out against the abuse of authority. Making a stand for the powerless will inevitably challenge individuals or structures who have power. May we choose boldness and courage over bashfulness and comfort in those moments, as we live and speak for Jesus in medicine, starting as students as we mean to go on.

leadership and power

It is a tremendous privilege to be invested with genuine power, and as a good gift from God, exercising power effectively is the key to leadership. Even though students often feel so powerless, we need to be aware of the scope of power; however subtle our power may be. And we need to develop the skills to use power well.

questions for reflection

1. In what areas of life do you wield power?
2. What temptations do you succumb to – pride, misuse of power, not using your power or even all three?
3. What steps might you take to be accountable for the power you have?
4. What does 'emptying yourself of the benefits of power' look like to you?
5. How might you prophetically speak out for those who have no power with the truth of the gospel?

When we grasp the Christian world view that power is a gift, we don't earn it! We will steward it for the good of God's world rather than use it for our own benefit, regardless of its effect on others. Instead of hoarding power and making it work 'for us', we will follow Christ's example by humbly spending it on others. The Christian apologist Francis Schaeffer warned Christian leaders, '*If we have the world's mentality of wanting the foremost place, we are not qualified for Christian leadership.*' True power is multiplied when image-bearers of the all-powerful God empty themselves of the benefits of their power and spread these benefits to others.

As medical students you aren't going to gain a superpower, but you will be invested with significant power through your status, knowledge and opportunities. As Uncle Ben in *Spiderman* says, 'with great power, comes great responsibility'. What will you do with it? Will you hoard it or spend it? As John Stott said, '*Leaders have power, but power is safe only in the hands of those who humble themselves to serve.*' [4] ■

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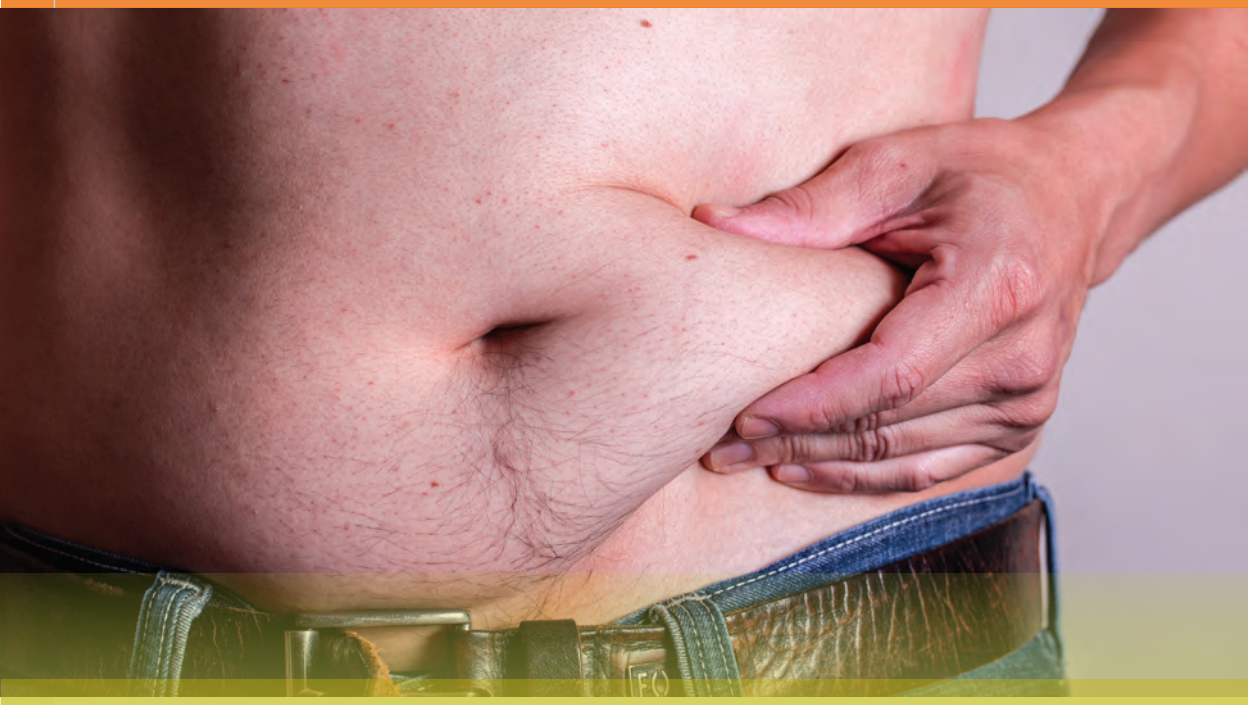
distinctives: diet options

we look at two different views on diets



opinion 1
battling the bulge

Zack Millar shares how he shaped his dieting

Zack Millar is *Nucleus* editor and a clinical medical student in Cambridge

Last August, I was tipping the scales with a BMI of 30: obese. I was dreadfully unfit, and any exercise I attempted gave me shin splints and chest tightness. My parents were similarly afflicted and as a family we had undertaken diet after diet to try and rectify the situation, each promising so much and delivering so little.

I finally decided enough was enough and I looked to an online company[1] for help. Their product is simple: a wide variety of high-protein, high-fibre and low-carb foods that keep you feeling full whilst also hugely restricting your calorie intake to 600-800kcal per day. It sounded too good to be true, but I considered it worth a try.

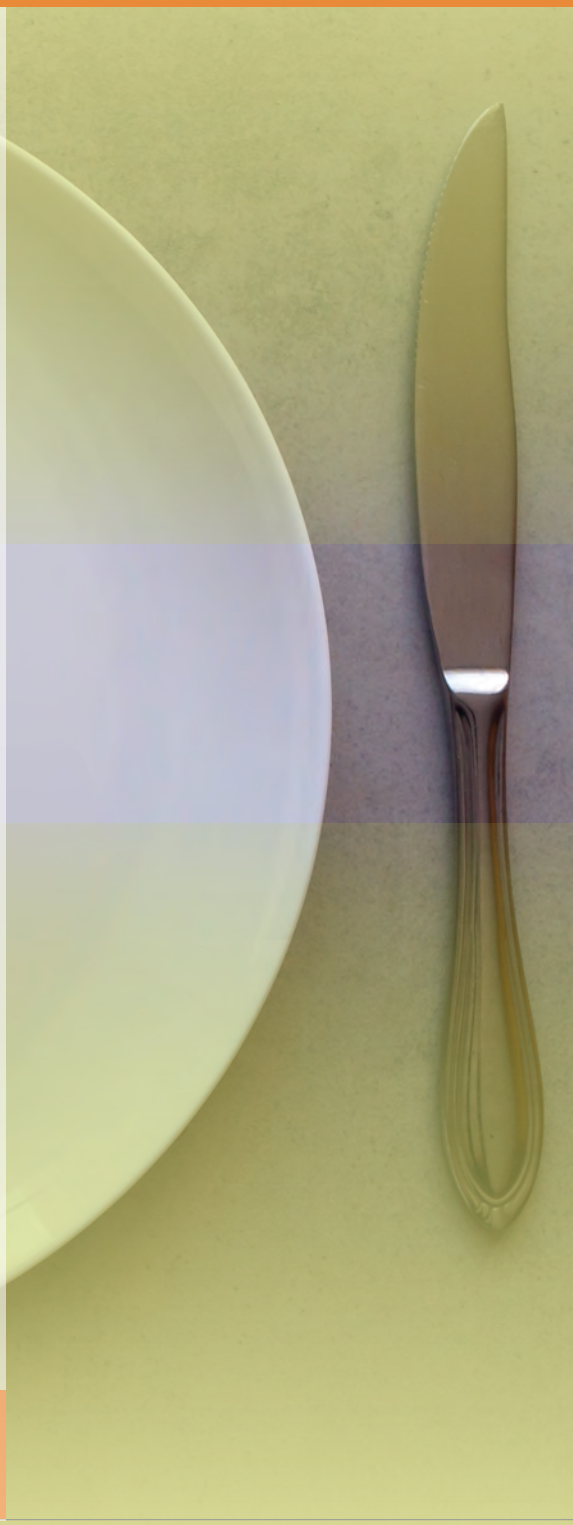
The first few days were fairly miserable, as my body adjusted to ketosis, but after that it was plain sailing, even on so few carbs! In the space of three months, I lost 13kg and dropped two clothes sizes. I took up running and the wonderfully pretentious sport of fencing, and my fitness slowly began to improve as well. By doubling fluid intake (to protect my kidneys) and consuming extra calories for exercise, my super-low-carb diet proved a safe option.

Before starting my diet, it was important to question my motivation. Many people find themselves obsessing over looks, but God is clear about what he values: *'People look at the outward appearance, but the Lord looks at the heart'* (1 Samuel 16:7). I felt a different temptation, which

was not so much to idolise my appearance, but rather to see my physique and fitness level as a flaw that needed to be rectified. We are under so much pressure to be perfectly rounded individuals, excelling in everything, and often we get points in portfolios when we succeed! God has no points system, and he knew what he was doing when he made us. '*I praise [God] because I am fearfully and wonderfully made*' (Psalm 139:14).[2]

Is there any imperative to diet, then? If we are focusing on our hearts and striving to be content with God's sovereignty, surely this applies to our physical appearance? We should be content and non-obsessional about our bodies, but we should look after them too. When writing against sexual immorality, Paul reminds the Corinthians that '*your bodies are temples of the Holy Spirit*' (1 Corinthians 6:19). He even affirms obliquely to Timothy that '*physical training is of some value*[3] (but note the second half of the verse) *but godliness has value for all things, holding promise for both the present life and the life to come*' (1 Timothy 4:8). Improvements to our bodies will only last as long as we live on this earth. Transforming our spiritual health will have eternal benefits.

How can we hit the sweet spot of looking after ourselves without obsessing? A good place to start is to keep it objective, perhaps by using a BMI calculator or some other way to set a target weight. Would you be devastated if you gained a kilogram or if your friends failed to notice your transformation? If so, your motivation may have shifted from health to vanity! Keep it all in perspective. I put on a couple of kilograms over Christmas, and I will lose them again, God willing, but the bigger question is: how is my spiritual fitness? ■



REFS

1. *www.exantediet.com*
2. Philippa Hanna's song *Raggedy Doll* (or Triple O's rap version) expresses this sentiment wonderfully.
3. Ergo, there is nothing inherently sinful about being a gym bro/girl.

opinion 2

the Daniel Fast

Hannah Mensah reviews a different approach

Hannah Mensah is a medical student at St George's, University of London

Fasting is the act of abstaining from food or drink for a period to focus on prayer and seeking God's will. Biblical characters who fasted include Elijah, Moses, David, Daniel, Peter and Jesus himself. Scripture highlights the importance of fasting, and how we develop a more intimate relationship with Christ through it. Fasting is not commanded biblically as such, but seems to be assumed and expected.

The 'Daniel Fast' is based on a modern-day interpretation of verses found in Daniel 1 and 10. '*Please test your servants for ten days: Give us nothing but vegetables to eat and water to drink*' (Daniel 1:12). '*At that time I, Daniel, mourned for three weeks. I ate no choice food; no meat or wine touched my lips and I used no lotions at all until the three weeks were over*' (Daniel 10:2-3).

Of course, there is deeper symbolism behind these verses; Daniel's choice in chapter one is a subtle protest against his new ruler and may in part have been explained by observance of Jewish food laws. The fast in Daniel 10 appears to be a clearer example of a fast undertaken to hear from God.

The modern-day 'Daniel Fast' includes eating fruit, vegetables, wholegrains, nuts, seeds, beans and legumes, whilst giving up meat, dairy products, processed foods, and juices.

For the past few years, I have completed a 21-day 'Daniel Fast' once a year to grow spiritually. It is often the highlight of my year, as it is in these times that I feel closest to God. It is a unique experience that allows you to be intentional about seeking God.

Such spiritual gain comes at a cost. It is difficult during the first few days, and when you are doing physical exercise, or mentally taxing work, or study. Sometimes, I find it difficult to keep my focus on God on busier days.

top tips

Here are some top tips to help you gain as much as you can from any fast.

- Make your fast intentional. Before you start, pray and ask God to reveal ways in which you can grow spiritually.
- Pick three moments each day, where you spend intentional time with God. This will help to keep the focus on seeking God, rather than it being about the food you have given up.
- If doing the 'Daniel Fast', consider increasing your portion size as your calorie intake will decrease substantially.

But the beauty of the fast is that you quickly realise that with the coupling of fasting and prayer, you can more intentionally seek the Holy Spirit's leading, and learn to live with an increased reliance on God.

Scripture highlights the importance of fasting, and how we develop a more intimate relationship with Christ through it

A sincere desire to seek God allows you to run towards him with a repentant heart and allows him to minister to you. As you become more filled with the Spirit, you realise that you can bear more fruit of the Spirit, that is, '*...love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control...*' (Galatians 5:22-23). During the fast, I find that God really reveals himself to me, and I can grow in wisdom and understanding. ▪

mythbusters
treatment of Gender Dysphoria in children

Julie Maxwell explores the evidence

Transgender issues are a hot topic. Management of children and adolescents is generating much disagreement with emotive arguments for and against medical treatment for Gender Dysphoria. So, let's look at the available evidence to help guide us in considering how best to help children struggling with gender identity issues.

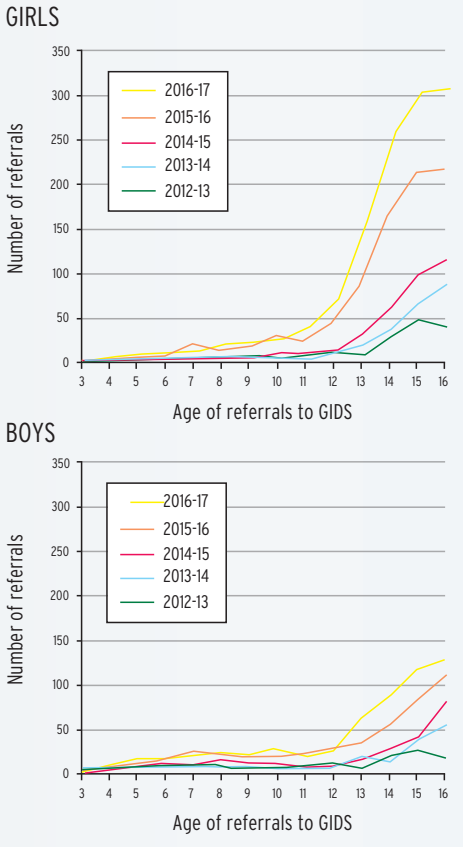
definition and referral

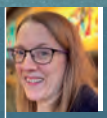
Gender Dysphoria occurs when a person experiences discomfort or distress because of a mismatch between their biological sex and gender identity.

There has been a huge rise in the number of children and adolescents presenting with gender identity issues. The number of children being referred to the Gender Identity Development Service (GIDS) at the Tavistock Centre has risen exponentially since it opened in 2009. There is a significant increase in the number of teenage biological females presenting with gender identity issues.

Transgender trend 2012-2017. Tavistock and Portman NHS Foundation Trust. (Obtained through the Freedom of Information Act (2000))
bit.ly/2TTfbLn

Annual Child Referrals to GIDS since 2012





Julie Maxwell is a community paediatrician in Hampshire

Between 73% and 88% of children who presented before puberty, whether they had socially transitioned or not, did not continue with their intention of changing their gender once puberty started.[1]

However, many children (and their parents) believe that medical (and potentially surgical) treatment is the only way to resolve feelings of Gender Dysphoria, and therefore are extremely reluctant to engage with psychosocial assessment. This view is often fuelled by the belief that not going down the route of gender transition will result in self-harm and suicide. Conversely, unpublished data from the GIDS study on children being treated medically suggests an increase in suicidal ideation after one year.[2]

how good is the data?

A recent meta-analysis by Carl Henegan, Professor of Evidence Based Medicine at the University of Oxford,[3] examined all published trials to date, which enrolled a cumulative total of 1,132 young people. Evidence was limited by small sample sizes and retrospective methods. Most studies lacked control groups and many outcomes were subjective and lacked blinding. One study used a measure of psychosocial well-being that had been shown to improve with age without intervention; adolescence is a turbulent time (even without Gender Dysphoria![4]) that teenagers emerge from.

With follow-up rates as low as 34% in some studies, how can we know what complications and harms are being missed? The flagship service in the UK at the Tavistock Centre does not follow-up beyond 18 years of age, severely limiting their ability to identify harms.

puberty blockers

The first step in medical treatment is puberty suppression with a gonadotrophin-releasing hormone analogue (GnRHa), which is begun when a child reaches Tanner Stage 2 of puberty. GnRHa acts on GnRH receptors to suppress gonadotropin release. It can lower sex hormone levels by 95% in both sexes. In females, GnRHa reduces the secretion of LH and FSH; in males, it shuts down gonadal testosterone production. GnRHa is often referred to as a puberty blocker. These are being used in the context of profound scientific ignorance as previous studies have only been done on their use in precocious puberty.[5] They have not been licensed for Gender Dysphoria by their manufacturers nor approved by NICE.

Stopping LH and FSH and testosterone secretion suspends maturation of foetal and neonatal germ cells leading to a loss of fertility. Since it is extremely rare for children with Gender Dysphoria to discontinue therapy, there is no evidence that normal puberty would resume. There are questions around the potential impact on growth and bone density. One study showed that bone mineral density scores fell during puberty suppression with GnRHa for trans females, and did not improve with oestrogen treatment.[6]

GnRHa treatment was introduced with the aim of reducing the distress of experiencing puberty, to enable the child to explore emotional and psychological issues surrounding Gender Dysphoria. However, virtually all the children who start on puberty blockers eventually take cross-sex hormones, suggesting that changing their minds is rare once natural puberty is interrupted.

Puberty is a time not only of bodily changes, but also hormone-mediated structural changes in the brain. Neuroimaging studies on hormone treatments have shown effects on brain structure such as ventricular volume and thickness, hypothalamic neuroplasticity, and functional

connectivity.[7] The concern, therefore, is that a young person on puberty blockers is left in a developmental limbo and that some young people with Gender Dysphoria will be prevented from finally becoming comfortable with their biological sex by their use.

the Tavistock experiment

The only clinic that prescribes for children in the UK conducted its own trial from 2010. Their website stated that GnRHa treatment 'is deemed reversible'. But the research protocol gained under the Freedom of Information Act (2000) suggested otherwise: 'It is not clear what the long term effects of early suppression may be on bone development, height, sex organ development, and body shape and their reversibility if treatment is stopped during pubertal development.'[8] A paediatrician on the study team, Russell Viner, frankly acknowledged the risks: 'If you suppress puberty for three years the bones do not get any stronger at a time when they should be, and we really don't know what suppressing puberty does to your brain development. We are dealing with unknowns.'[9]

At least 1,000 children, including 230 under 14, have been prescribed puberty blockers at The Tavistock. Given that this is the only cohort of such patients in the UK, after ten years it seems a missed opportunity that there has not been full disclosure of the data in peer-reviewed journals. From the limited data released, the single paper to date from this cohort has not been encouraging despite a misleading abstract.[10] 'There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on GnRHa, children reported greater self-harm, and that girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body – so puberty blockers exacerbated Gender Dysphoria.'[11]

cross-sex or Gender Affirming Hormones (GAH)

Now more commonly referred to as gender-affirming hormones, oestrogens and testosterone will induce masculine or feminine physical characteristics. They often need to be supplemented by other drugs and there are potential health risks of treatment with these hormones.

On the NHS, this treatment can be given to those over 16 years old when criteria are met, and it is deemed that they are capable of giving informed consent[12] to this irreversible, life-changing treatment. It has been reported that some children have been able to access cross-sex hormones at a much younger age privately or via the internet.

Prof Heneghan, in his review of the evidence states: 'Treatments for under 18 gender dysphoric children and adolescents remain largely experimental. There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. We are also ignorant of the long-term safety profiles of the different GAH regimens. The current evidence base does not support informed decision-making and safe practice.'[13]

Giving cross-sex hormones will of course only influence secondary sex characteristics (those that appear during puberty) and will not alter primary sex characteristics (those present at birth).

gender reassignment surgery

This is available on the NHS for those over 18 only and involves varying degrees of surgery.

While surgery may make a person appear cosmetically to be the opposite sex, their genetic make-up and other genetically determined physical and mental characteristics does not change. It is simply not possible to change sex, only to look like the opposite sex.

de-transitioners

There are increasing reports of those who have embarked on medical and/or surgical treatment realising that transitioning has not alleviated their mental distress. There are stories of adults and adolescents requesting to de-transition and return to live in line with their biological sex. One of the best known is Walt Heyer (pictured) [14] He says: 'At first I was giddy for the fresh start. But hormones and sex change surgery couldn't solve the underlying issues driving my Gender Dysphoria. I de-transitioned more than 25 years ago. I learned the truth: Hormones and surgery may alter your appearances, but nothing changes the immutable fact of your sex.'

mental health problems

Gender identity issues rarely present on their own, and most children and young people will also suffer comorbid mental health issues. A disproportionate number of children on the autistic spectrum identify as transgender. [15]

Adolescents who present with Gender Dysphoria, well after the onset of puberty are more likely to also have significant psychopathology and broader identity confusion than gender identity issues alone. [16]

conclusion

The subject of gender identity and transgender is extremely complex and evokes much concern and disagreement. Young people suffering from these difficulties need compassion and help. But at present, these children are being experimented on without enough evidence of the long-term physical, emotional and psychological implications of medical treatments. Healthcare professionals are frequently urged to practise evidence-based medicine and to weigh the risks against the benefit of treatments; current evidence suggests this is not happening in the treatment of children with gender identity issues. ■

summary

Risks of puberty suppression and transitioning treatments in adolescents:

- Medical treatments compound 'developmental limbo'
- GnRHa impairs bone development and fertility, perhaps irreversibly, before adulthood
- Cross-sex hormones further interfere with brain maturation and cognitive development
- Cross-sex hormones can cause thromboembolism, polycythaemia and raise blood pressure
- Surgery cannot be reversed to the natural state

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be prepared: God will always be with you

Leo Hacking reassures us of God's presence during the foundation years

I imagine that many of you will be pondering the time when you leave medical school and start your foundation years. Rather like sailors on a ship leaving the sheltered waters of a harbour embarking on their first voyage across a sea, many of you may be feeling a little nervous about the next step. However, we need not fear if we remember that the Lord will always be with us wherever we go.[1]

Throughout my foundation years, I found it a huge encouragement to remember the Lord's promises to the Israelites in the Old Testament. Although we are now under a new covenant, I think there are helpful things to learn. The Israelites faced ever changing environments, threat of enemy attack and lack of normal comforts.[2] Often their reaction was to fear, and to question why their position was difficult.[3] They had to be reminded that the Lord would fight their battles[4] and lead them by day and by night.[5] What applied to the Israelites is also valid for us today when we face fears, uncertainties and feelings of abandonment by others. We need to take courage and trust that the Lord will never leave or forsake us.[6]

what does it mean that the Lord is with us in our work?

I remember lying in bed trying to get some rest before my first night shift, whilst I was on a paediatric rotation. My heart was beating rapidly

Leo Hacking is a junior doctor in Kent

with doubts and fears about what I could encounter and whether I could cope with the challenges ahead, passed through my mind. Doubts like 'will God still be with me?' unhelpfully took hold. I messaged a friend who said they would pray for me and set off to work. After all my fears, I found the night to not only be manageable but enjoyable. I could see God's provision in helpful and supportive colleagues he placed around me, and in the prayers of other believers. I was thankful for the peace that he gave me in knowing that I am in Christ.[7]

During my first year, I underwent an elective operation. I remember being collected from the pre-op bay and taken to theatres by an anaesthetic assistant called Naomi. As I walked into the anaesthetic room, I remember looking around at a cold, sparse and empty place with white walls, a hard, stone floor and bright white lights (probably an ideal room from an infection control point of view!). It suddenly dawned on me that I would soon be in that bed in front of me, in a much weaker, more vulnerable state as a patient. Faced with that thought and coupled with the uncertainties about the operation, I started to feel more anxious. Part of me wanted to run away. Thankfully, I took courage remembering that Jesus promised the Spirit to us and that we shouldn't let our hearts be troubled.[8] As the anaesthetist was inserting the cannula I spoke briefly to Naomi about her name and it dawned on me that she could be a fellow believer. Then I was injected with a drug that made the room spin, which was very unpleasant. The only thing I could do was to close my eyes and wait for the anaesthetic to knock me out. Around that time, I felt a hand on the back of mine which was probably Naomi's, but it was a great comfort as it reminded me of God's presence.

During my first rotation in F1, after a very busy day, we had a very poorly patient in his forties with advanced liver failure and chest sepsis. Earlier on, the consultant had decided that this patient wasn't a candidate for higher level care (such as HDU or ITU). Practically, I understood this to mean that he was not for critical care reviews, if he got more unwell. After 5pm, I was the only doctor left on the ward. I was asked to review the patient as he was deteriorating. I found him to be in significant respiratory distress and understandably very agitated, despite maximal oxygen. I knew I needed help as I was out of my depth. The SHO said he was too busy to come to help, and the on-call registrar didn't answer his bleep. I felt abandoned. But just at that moment, my gastro registrar (who had been running late from a clinic) arrived to see how I was getting on. I remember thanking God for his grace in granting me that caring registrar at that time, who helped me come up with a management plan.

you will need to be wise and follow God's leading in your life. You will get plenty of moments of joy and excitement. But always remember the Lord's promise that he will never leave you

As with sailors heading out to sea, you know that in foundation years you will get some days that are rougher and other days with calmer seas. You will need to be wise and follow God's leading in your life.[9] You will get plenty of moments of joy and excitement. But always remember the Lord's promise that he will never leave you.[10] ■

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a day in the life : assessing the sick

James Howitt describes a typical working day as a Work Capability Assessor

Over two million[1] people in the UK were claiming Employment Support Allowance (ESA) in 2018. This is money paid to those who are prevented from doing any form of paid work by their medical problems. The current rate is between £73.10 and £110.75[2] per week.

For the majority, they will have had a 'work capability assessment (WCA)' which was introduced in 2008. These assessments are conducted by a healthcare professional, usually a nurse or physiotherapist, but for more specific and complex conditions a doctor is required.

I do a combination of assessments in setups like a GP surgery, and home-based assessments for people who are too unwell to travel. I spend about 45 minutes with each client. As in some areas of psychiatry, the word patient is usually avoided. Much of what I do is like a medical clerking, with a full medical history, and relevant examination. But unlike a hospital clerking, I will enquire about their 'typical day', which forms a narrative of how conditions affect function, what things they particularly struggle with, and what kind of adaptations or assistance is needed.

Once the client has left, I spend about 30 minutes writing up a report, which is then sent to the Department for Work and Pensions (DWP). The point is never to dictate specifically that someone is fit to work or not, however there are 17 areas of physical and mental health functions that must be addressed. Much of this can be nuanced, with function varying day-to-day, and so a requirement that each activity can be completed 'repeatedly, reliably and safely' is considered. Also considered are those who may be functioning well overall, but for whatever reason may be placed at significant risk if expected to work. This could include those on the vulnerable adults register, or in a particularly fragile physical or mental health state.

So that's the nuts and bolts of the job, but more commonly people want to know why? Why isn't my GP deciding this? Why are we bothering to do this in the first place?

First, why don't GPs complete the assessment?

James Howitt is a doctor who performs Work Capability Assessments and a CMF Associate Staff Worker in Essex

Well the WCA was brought in because pre-2008, very few people were required to attend any form of assessment and it was mostly GP medical certificates that were used. However, many of the 'disabling conditions' that were presented were either minor (such as sinusitis) or generally asymptomatic (such as high blood pressure), and were unlikely to cause significant disablement over a period of months or years, but such patients were still entitled to incapacity benefit (remembering those who are off sick with short term conditions are entitled to statutory sick pay).

This isn't a knock against GPs, but let's remember their appointments are ten minutes. In all but the most severely disabled, it's unrealistic to expect an assessment in this time frame, and GPs rarely get significant information about levels of function over an extended period. Part of the evidence for this is that whilst in many cases a GP opinion is sought by a letter sent to them before the assessment, many are not returned, or simple come back as 'unknown'. Sadly, for most of us, the days of family doctors that know us intimately from birth to death are gone.

The other issue with GPs is that it is a struggle to remain impartial. Whilst the generational GP may be a dying breed, it is still important to good care that they have some form of rapport with, and trust from patients. This is at odds with a system which is meant to be impartial. I suspect that some of the 'not-known' replies I receive are from GPs who wish to avoid being untruthful, but may also be aware that their information may not be supportive of their patient being awarded ESA.

Second, why do it at all? It is widely recognised that work is generally good for people,[3] that it meets psychosocial needs and is central to economic means, identity and social roles and status. Unemployment conversely is associated with poor health and higher mortality, and that those who move off benefits into work and re-employment gain the health improvements shared by those in work. However, it is also well recognised that for a minority, work is in fact detrimental and systems to identify those people need to be robust and easily accessible.

This fits with a biblical understanding of work being dignified and given by God, who we see rests following his work of creation in Genesis 1. Adam and Eve are given the work of subduing Eden in Genesis 2, and Jesus in John 5 says, '*my Father is always at his work to this very day, and I too am working*'(John 5:17). But we also live in a fallen world and since Adam and Eve were cast out from Eden, sickness and death have entered the world. We also live in a society where resources are finite, and decisions about how to manage those resources in a fair and effective way must be made.

Some have made complaints that the WCA is a tick box exercise, and that's partly true. But so is getting a mortgage or credit card, antenatal care, or buying groceries, all of which are important parts of living together in society. Without a search for truth, justice for the vulnerable cannot be had,[4] either from a system that is too punitive or simply turns a blind eye to exploitation. To my mind, this makes this a vital area for Christian doctors and nurses to be present. Often with a multitude of conditions, disabling effects can be much more subtle than a missing limb. Without the correct skills and dedication, those unfit for work can often be unfairly treated or disenfranchised. In a world where growing greed can be found in all places, there is a biblical imperative both to speak up for the vulnerable[5] and resist the wolves among the sheep. ■

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local groups: Leeds

Jade Bunsie describes CMF in Leeds

Jade Bunsie is a medical student in Leeds

What makes CMF West Yorkshire different? Yorkshire is not called 'God's own Country' for no reason. With the beauty of the Yorkshire Dales, there is also a rich history (York was a Viking settlement) and, if it were a country, Yorkshire would have finished 17th in the 2016 Olympics (ahead of Canada and New Zealand!). The largest city is Leeds, where I have lived for the past six years, and where West Yorkshire CMF student and doctors' ministry is centred.

Student events cover a 'discussion topic', directly relevant to healthcare students. We're careful to distinguish meetings from other Bible studies locally, and hold most meetings in student houses, to enable a more informal and relaxed gathering. (Who wants to be at the medical school past 5pm?)

2018-19 began with a 'give it a go' event, with around 20 students at the CMF Student President's house, socialising (with biscuits, popcorn and sweets) and reflecting on 'Is University Life Compatible with Christianity?' We discussed areas where stereotypical 'university life' might conflict with Christian principles, and how to tackle these issues in a godly way. We were blessed with the biggest turnout at an event in many years. It was encouraging to see so many students, both familiar and unfamiliar, attend and contribute.

CMF West Yorkshire has a central group of people who make up a Catalyst Team to help serve the area. Roles include Catalyst Leaders (who help the running of the group), Prayer Catalyst (self-explanatory), Transition Catalyst (who helps those who are moving in and out of the area), and International Catalysts (who focus on mission abroad). Each team member undertakes a role they enjoy and are strong in, with medical students and doctors serving.

Our local Catalyst Team Leaders are a great source of support. Noel is a surgical registrar and Laura a paediatrician; both are undertaking PhDs and have two young children, but still host a variety of events, at least on a termly basis, where they welcome us into their home for a talk and homemade food. These well-attended events are a great opportunity for students to meet doctors and gain insight into working life as well as garner advice and support. It is great to meet some of these doctors on the wards whilst on clinical placement and to see a friendly face!

A highlight for me was a talk from Mark Pickering, 'Taking your next step of faith'. It was around the time when I was choosing which deanery to apply to for foundation training, and helped remind me that God has a plan for my life and to trust him with the unknown.

Noel and Laura have also hosted OSCE practice sessions and offered emotional and academic support. It is a real privilege to have doctors willing to invite you into their home during periods of exam stress, and for them to listen and help. During my years here, it has been amazing to have a stable sense of support from people that don't merely understand what you're going through on a spiritual level, but also understand the stress of placements and the demands of medical school. I will no doubt find it very difficult when I leave Yorkshire to start work in August, and lose this home away from home. ▪

counterparts : Romania

Adrian Balan & **Rut Muresan**
are medical students at Victor Babes University, Romania

Adrian Balan & **Rut Muresan** reflect on life in Romania as medical students

It is a great opportunity for me to write for *Nucleus*, right after my attendance at the Sydenham Conference in London, which was a real blessing. I met many devoted Christians and I saw a lot of passion for medicine and for being a light in the medical community. I was amazed by the leadership team at CMF, learning that the greatest investment is in others, serving them, and following the example of the Lord Jesus Christ. I took home all these examples, and I try to apply them every day in my ministry.

Romania is a spectacular country, with beautiful and welcoming people. Between 1946 and 1989 Romania was under a communist regime, which represented a dark era for our nation, especially for Christians. After 1989, Romania became a democratic republic, and since 2007 is a member of the European Union. Although we have had hard times, Romanian Christians can say loud and clear: 'God is my shepherd.' And because of that, Christian doctors united their forces and developed Christian Medical Fellowship in Romania in 1990, the first non-governmental association in Romania. Today, CMF in Romania has more than 200 members across the country. We are thankful to our Lord for this.

Being a Christian medical student in Romania has its ups and downs. The greatest blessing is that we are able to meet, encourage each other and gain strong Christian principles to live by. I think the hardest part is staying firm in our principles, even when everything around is corrupt. The influence communism has had on our country is still visible in the medical system: doctors can't always get a job after they finish residency and in the poor conditions in some of our hospitals. At the same time, Romanian students can get in contact with patients and practise more than students from other countries. This can allow you to learn more about how to be 'salt and light' in the medical field, in the way you tell people about God, and in the way you treat them as a doctor.

Romania's healthcare system is not well administered. Insurance is not expensive and that's a good thing, but it can be low in quality in some parts of the country. People are not informed about health prevention, and lots of medication for chronic diseases is not available.

> although we have had hard times, Romanian Christians can say loud and clear: 'God is my shepherd'

We do have very well-trained doctors that fight for changes, and we can see the results of their work in some of the biggest hospitals. As a Christian organisation, we try to educate future doctors to be good practitioners, but more than that to take care of their patients' souls and minds.

Romania is a blessed country and medical students who are part of Romania's CMF are very thankful for the privilege of being born here. We pray to be able to spread God's word in the medical field. Our desire is to invest in medical students, so that they become doctors with Christian principles with a willingness to serve God in every aspect of their life. ▪

my trip to... : Egypt

Jennifer Black reports on an Egyptian adventure...

In February 2019, I attended the METNA conference in Egypt. METNA is the Middle Eastern division of the International Christian Medical and Dental Association (ICMDA) and the conference brings together Christian health professionals and students from the region, with representatives from Libya, Jordan and Egypt (amongst others). This year the focus of the conference was '*You are the light of the world*' (Matthew 5:14) and we spent three days together learning what this means as Christians and healthcare professionals.

> it reminded me that throughout the world we worship in thousands of languages but are united in one faith by one Saviour

Led by the national METNA leaders, each day started with a time of devotion. After a traditional Egyptian breakfast, we had the first of the main talks. The speakers unpacked Matthew 5:14, what it means to be light, why we need to 'shine', how we can be light and what this should look like in practice. I was especially inspired by the talk 'What it means to be light', where the speaker drew parallels between the characteristics of light and the character of a Christian. There was also worship in Arabic. It was wonderful to hear worship songs sung in a different language and from a different culture; it reminded me that throughout the world we worship in thousands of languages but are united in one faith by one Saviour.

We also heard from representatives from different countries in the METNA region, who gave us ways to pray for their ministry and their countries. It was humbling to meet brothers and sisters who live sacrificial lives to reach people in a region of the world, which is desperately in need of the gospel. Security means that I cannot write about individual ministries, but clearly God is working across the Middle East in incredible ways! In the afternoon we had our second meeting with worship and the second of the main talks. We then split into small groups to discuss everything we had heard that day – it was a valuable time of listening and learning from one another, especially given the mix of cultures, ages and experiences!

It's hard succinctly to summarise everything that I enjoyed about this conference. The main talks were fantastic – challenging us to be bold in our witness for Christ and encouraging us with the reminder that God has given us the resources we need to do this.

During my time away, I was challenged to 'be light' and to be distinctive in an increasingly secular society. Sometimes in the UK, I feel that the choice between following Jesus or the world can be extremely subtle. I personally recognised the need to discern better when I am being asked to make that choice. The time away was one of great blessing, especially meeting (self-professed) ordinary, but godly men and women, who in God's strength live extraordinary lives for his glory. The impact of their faith is being seen throughout the Middle East. ▪

Jennifer Black is a medical student in southern England
Some names and details have been changed to protect conference participants

Review

film: *The Greatest Showman*

Loosely following the life of Victorian entrepreneur Phineas Taylor Barnum, *The Greatest Showman* transports us back to the exhilarating and controversial, emerging world of circus entertainment.

We meet Barnum, a warm hearted, inclusive individual who seems to want to bring purpose and employment to the lives of the misfits of his time. Following the failure of Barnum's 'museum of curiosities', the story begins as we meet some of the eclectic individuals who make up the Barnum circus: a bearded woman, a hair covered man, a dwarf, and an eight-foot 'giant'.

Song after song spells out the desires of the hearts of those in the troupe. Whether it's the defiant stance of the bearded woman, happy in her own skin in the song '*This Is Me*', or the struggle against racism in '*Rewrite the Stars*', they are expressions of the fundamental desire to be accepted and loved. Each musical number is spectacular. The costumes are as vibrant and the choreography as jaw-dropping as the real Barnum himself would have wanted. Although the storyline may be wanting and the character development shallow, the theatrical effects are amazing.

However, although Barnum wants to be a success in his family and business, he loses his way. The success of one act leads Barnum far from the things he loves most: his household and showmanship.

The common denominator of the plot and all the sub-stories is the search for acceptance, welcome and love. Barnum brings together people who have been rejected and gives them something to belong to, as he himself is accepted by those he's wronged. As the perceptive bearded woman puts it, 'Maybe you are a fraud. Maybe it was just about making a buck. But you gave us a real family.'

Barnum's circus celebrated diversity, yet it's hard to know what was fake and what was authentic. Was Barnum an altruistic philanthropist or a shrewd businessman exploiting the people in his show? In 2019, the longing for acceptance hasn't died. The way the movie has been celebrated so much shows that people still crave to be welcomed and loved.

This fundamental striving for belonging is the fallout from the catastrophic fragmentation of our relationship with God at the fall. When we see how Christ welcomes us into God's family, we see how differing people can be loved and outsiders can be brought in forever. It's an astoundingly beautiful truth of the gospel: everyone is welcomed into an unconditional, indiscriminate family for eternity, and the one who welcomes us rejoices over us with singing.[1] What a truth the world wants and needs to know! ■

Fiona Houghton is a medical student in Nottingham

REF 1. Zephaniah 3:17

Reviews

film: *I, Daniel Blake*

I, Daniel Blake makes for uncomfortable watching. It follows the fictional story of Daniel Blake, who is told by his doctor he is unfit to return to work following a heart attack. But when he applies for medical disability benefit, he is refused. We follow Daniel as he, and young mother of two, Katie, struggle to negotiate the seemingly complex and robotic welfare system.

This is clearly a film with an agenda, so I should be upfront about mine straight from the off. As an actual doctor performing the medical assessments for the benefit which Daniel is refused, there were some parts of the film that left me furious, and others that left me heartbroken. I'll address the latter below before dealing with the former.

This film spotlights rising poverty in the UK, with real world food bank usage rising 13% in 2018[1] and some 14 million people said to be living in poverty.[2] I applaud how the film challenges the damaging stereotypes of those claiming benefits as lazy, work-shy or 'scroungers'. This narrative is pushed by political groups and unfairly shames some of the most vulnerable in society. Both the main characters are like many, victims of poor circumstance and timing, and not at fault for their situation.

At every turn, Daniel is confronted by the bureaucracy of the system he is in, struggling both against his computer illiteracy in a digital age, and the mountain of red tape installed to try to discourage the dishonest, while protecting the deserving.

I agree with director Ken Loach, in his uncompromising portrayal of UK poverty, and about the flawed system we currently have. He does however, border on demonising those working in the system, and whilst I'm deeply saddened if this is experienced by even a minority, it is certainly not the norm.

The way Daniel's medical is conducted is frankly appalling and utterly unacceptable. However, I have never seen or experienced anything even close to this. The whole thing is a 'how-not-to' example, and while we only see a snapshot of his assessment, it is very clearly aiming to look incompetent. From a job centre employee being disciplined for showing basic human kindness, to the ever-looming government 'decision-maker' used like a Damoclean sword by staff, it would all be laughable, if it wasn't so insulting to those who try and guide some of the vulnerable through hardship and difficult times.

I, Daniel Blake is a film that dramatises events to create the saddest possible narrative with which to make its point. But it is also a stark reminder of the rising gap between rich and poor, and that social justice requires more than just paying our taxes. It's a reminder that we need to look at our greed as a society to ask why we feel more comfortable having 'subcontracted' such charity to the state. It's a reminder that we need to love our neighbour, and that as Christians our neighbour may not always live next door. ▪

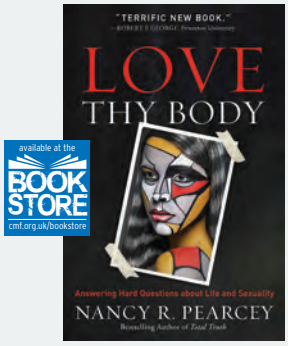
James Howitt is a doctor working in benefits assessment and CMF Associate Staff Worker

REFS

1. The Trussell Trust. End of Year Stats (2018-2019). *bit.ly/2srmRXP*
2. Social Metrics Commission. A new measure of poverty for the UK. September 2018. *bit.ly/2xnjYvt*

Reviews

book: *Love Thy Body*



Love Thy Body: Answering Hard Questions about Life and Sexuality
Nancy R. Pearcey

ISBN 9780801075728
Baker Books, 2018. £12.00

'*Human life and sexuality have become the watershed moral issues of our age.*' So begins *Love Thy Body*. Many Christians would agree, looking at the debates on newspapers involving anyone from Saracens rugby player Billy Vinupola to US actor Laverne Cox, or Jacob Rees-Mogg MP.

Pearcey aims to talk about the underlying philosophies and theologies behind human life and sexuality. Her book looks at the fundamental principles and how they illuminate each topic, rather than approaching each 'issue' in turn. The result is a cohesive and substantive work equipping the reader with strong foundations on a range of topics such as sexual promiscuity, abortion, transgender, homosexuality and euthanasia.

Pearcey considers the idea of a mind-body split, on which secular morality is frequently based. A person is seen as a soul within a body and therefore our bodies have little to reveal about our identity. Rather, it is our minds that instruct our bodies on their meaning. This implies that your body does not reveal anything about your sex, sexual orientation, value or personhood.

This is not what we see in the Bible. The Bible reveals that the human is a unified entity of mind, body and soul. Indeed, the second person of the Trinity came down incarnate (*in-carne* – in flesh) in the person of Jesus.

The unity of mind-body-soul in one being impacts how we live out the truth of the gospel. Pearcey shows how this good news has changed cultures: early Christian communities recognised the innate dignity of women and affirmed and defended the value of newborns and children.

With a study guide at the book's end to help the material seep in, this is the book to read this year for Christian medical students and deals with topics and world views that will come up both in and out of work. ■

Grace Petkovic is a junior doctor in north west England

Review

book: *12 Ways your Phone is Changing You*

12 Ways your Phone is Changing You
Tony Reinke

ISBN 9781433552434
224pp, Crossway. £8.39

We've been set free by Christ, right? Then how come our phones often seem to control us? We are quick to affirm our freedom in Christ, yet easily find ourselves living as though still enslaved. Smartphones often exert such a pull on us.

Author, Tony Reinke, is a journalist and writer for *desiringgod.org* and is by no means a technophobe; he is happy to admit that his phone is one of the most useful tools in his ministry. However, he reminds the reader that in following Christ, our highest calling is to enjoy our Father God under his lordship. Our smartphones are to be used for his glory and the good of others.

Reinke leads with a brief theology of technology before launching into the '12 ways…' some of which are expected (eg. addressing pornography), but others I hadn't considered before (eg. the fragmentation of our lives and disorientation of our place in time). Alongside each warning, Reinke helpfully offers disciplines to redeem our phone use. Packed with quotes from influential pastors, ethicists and commentators on culture, much high-level thought has gone into this book, but not at the expense of its readability. More importantly, it's saturated in Scripture – read it in one hand with Bible (or Bible app) in the other!

Knowing this book might be uncomfortable reading – I was initially reluctant to pick it up, but I am so glad I did. In exposing underlying heart conditions, it left me with big questions to ponder and changes to make, refocusing me on the wonderful goal of knowing and glorifying God, in which my phone has a part to play. ▪

Jeremy Foster is a medical student in Brighton and chair of CMF's National Student Council

news reviews

Alex Bunn, Rachel Owusu-Ankomah, Marolin Watson

implications of new in utero surgery for fetuses with spina bifida

In October 2018, *in utero* spinal surgery was performed in the UK for the first time on two fetuses with spina bifida.[1] In February, the Secretary of State for Health and Social Care, Matt Hancock confirmed that the procedure will be available on the NHS and take place between 20 and 26 weeks gestation. Anaesthesia will be administered to the fetus prior to surgery.[2]

Currently, the age at which a fetus is considered susceptible to pain is 20 weeks, though some studies indicate pain is felt from 15 weeks. This raises uncomfortable questions about the level of pain experienced by unborn babies aborted after 15 weeks.

Statistics for 2017[3] indicate that 197,533 abortions were carried out in England and Wales. The majority were carried out on fetuses at less than 13 weeks gestation (9 out of 10) and four out of five at less than ten weeks. There were 252 abortions of fetuses 24 weeks or over (0.1% of the total).

Most abortions (66%) are carried out medically using an abortifacient drug like mifepristone. The remainder are carried out surgically, either by vacuum aspiration (up to 15 weeks) or dilatation and evacuation (over 15 weeks) – the stage at which the fetus may be presumed to experience at least some level of pain.

Feticide, before abortion, is recommended by the RCOG in cases where the unborn baby is 22 weeks or more and involves stopping the heart either by lethal injection or as part of the procedure. This recommendation was apparently followed in 96% of cases, but it can take several hours for the fetus to die.[4]

There is currently a disconnect between the treatment of fetuses destined for life and those destined for death, though their capacity for suffering is equivalent. Might this lead society to question our attitude toward the way in which late-term abortions are carried out, or even whether they should be carried out at all?

1. First UK surgery in the womb for baby with spina bifida. *Great Ormond Street Hospital* 24 October 2018. *bit.ly/2PSO8OW*
2. Spina Bifida: Surgery: Written question – 217544. *UK Parliament* 14 February 2019. *bit.ly/2TRCzZN*
3. Abortion Statistics, England and Wales: 2017. *Department of Health and Social Care*. December 2018. *bit.ly/2GtUJyo*
4. Feticide. *British Pregnancy Advisory Service*. *bit.ly/2uHX4Od*

'abortion as a moral good'?

An article by Katie Porter published by *The Lancet* on 23 March 2019[1] describes a debate between two 'Christians' – one a pro-life family physician and the other an obstetrician involved in abortion care. The writer is encouraged by the fact that the debate is amicable, and the protagonists respect each other's commitment to patient care.

As a bioethicist, Porter is troubled by the fact that medical ethics has become a 'largely secular enterprise in the USA'. When abortion was illegal, there were Christians who spoke against the injustice of making it a criminal offence. But how since its legalisation, those who oppose it are largely doing so on moral and religious grounds – thinking of the fetus and its right to life rather than the woman and her right to 'choice'. Consequently, Porter believes the debate has become polarised, with people on opposite sides of the abortion debate 'talking past each other'.

Her solution is to correct the 'false assumption' that only pro-lifers are thinking ethically. However, as she unpacks her argument that being pro-choice is equally 'moral', the irreconcilable differences in world view and underpinning attitudes toward abortion becomes apparent. The debate is pushed no further forward.

1. Watson K. Abortion as a moral good. *The Lancet* 23 March 2019. *bit.ly/2Uxz9zT*

news reviews

Alex Bunn, Rachel Owusu-Ankomah, Marolin Watson

abortion and mental illness

Research around the negative emotional and mental health consequences of abortion is ambivalent as it must consider many factors and is sometimes influenced by bias. To be significant, it must be compared to similar negative consequences attending an unwanted pregnancy carried to full term, and the guilt a mother might feel if she gives up her baby for adoption.

In a paper describing the results of a 30-year longitudinal study, Prof David Fergusson et al[1] (with apparently no axe to grind) found that 'women who had had abortions had rates of mental health problems that were about 30% higher than rates of disorder in other women.' However, the research suggests that some of these conditions, eg. anxiety and substance use disorders were pre-existing (ie. not a result of their experience of abortion) and that 1.5 – 5.5% of the 30% were directly attributable to their experience of abortion.

It is worth noting that 'none of the other pregnancy outcomes (pregnancy loss, live birth following unwanted pregnancy or a pregnancy having an initial adverse reaction, and other live birth) was consistently related to significantly increased risks of mental health problems.'

Not all research agrees with Fergusson's conclusion, [2] but this ambiguity surely means that the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH) are not justified in confidently declaring in a factsheet for schools[3] that 'abortion does not cause mental illness.'

1. Fergusson D et al. Abortion and Mental Health Disorders: evidence from a 30 year longitudinal study. *Br J Psych* 2008;193:444-451. *bit.ly/2JZhNHK*
2. Induced abortion and mental health. *Academy of Medical Royal Colleges* December 2011. *bit.ly/2FVgKF3*
3. FSRH-RCOG abortion care factsheet to support RSE lessons. *FSRH bit.ly/2uFqE79*

RCP officially neutral about assisted suicide

The Royal College of Physicians (RCP) has traditionally been opposed to the legalisation of assisted suicide, but in response to pressure from a vocal minority opposed to its stance, it carried out a poll of its members earlier this year. Instead of giving members a clear choice between two options (to legalise or not to legalise), the RCP required a 60% majority for the two main options and introduced a third – that of neutrality around the issue, thus making it much more difficult to get a clear majority for any one of these options.[1]

In the event, 43.4% voted to maintain opposition – with 25% voting to go neutral. As a result, the RCP has decided that as of 21 March 2019, it will no longer oppose the legalisation of assisted suicide.

Four doctors, two of whom are CMF members, are taking the RCP to court over this decision, and would welcome your support (visit *www.gofundme.com/rcp-poll-challenge* for details).

1. No majority view on assisted dying moves RCP position to neutral. *Royal College of Physicians* 21 March 2019. *bit.ly/2WhBLPd*

the world's first malaria vaccine

Half of the world's population are at risk of malaria with sub-Saharan Africa carrying most of the global burden of disease (90% of all cases and 92% of all deaths). According to 2017 data, 61% of the world's 435 000 annual malaria deaths occur in children under five-years-old.[1]

A new tool in the fight against malaria is being clinically tested in young children across three African countries: Malawi, Ghana and Kenya. RTS,S/AS01(RTS,S) has been in development for three decades and is a first generation vaccine against the most deadliest malaria parasite - *plasmodium falciparum*,[2] which is responsible for

99.7% of cases within the WHO African region.[3] It provides partial protection against malaria and there are hopes that it will be used as a complementary tool to existing measures such as insecticidal nets, prompt diagnostic testing and treatment of confirmed cases with antimalarial medicines.[4]

At Phase Three trials, RTS,S produced promising results. Children who received four doses, experienced significant reductions in malaria and malaria related complications.[5] The trials hope to answer questions about feasibility: vaccination delivery its role in reducing childhood deaths and vaccine safety. The hopes are that 360,000 children per year will be reached in selected areas, with data reporting as early as 2022.[6]

1. Malaria. *World Health Organization* 27 March 2019. *bit.ly/2UfzJ5E*
2. First malaria vaccine in Africa: A potential new tool for child health and improved malaria control. *World Health Organization* 2018 *bit.ly/2VD7JJe*
3. *Ibid*
4. *Ibid*
5. *Ibid*
6. Q&A on the malaria vaccine implementation programme (MVIP). *World Health Organization* April 2019. *bit.ly/2Wg2wUV*

harassment in healthcare

The BMA has launched an enquiry into sexism and sexual harassment. Senior female GPs have exposed a culture of 'institutional sexism'[1] within the BMA's GP Committee, reporting belittling, crude and sexist comments, being ignored or frozen out of meetings and sexual harassment. Drawing upon examples of best practice, the independent investigation[2] will review the allegations and make recommendations to address gender bias and harassment in the BMA. The profession is following calls in many areas of public life to reform its treatment of women. Let's lead by example as Christians and consider how we can live out the Bible's teaching that 'Do not rebuke an older man harshly, but exhort him as if he were your father. Treat younger men as brothers, older women as mothers, and younger women as sisters, with absolute purity.' (1 Timothy 5:1-2)

1. Bostock N. Harassment, exclusion and innuendo: women frozen out by 'sexist BMA culture' *GPonline* 1 April 2019. *bit.ly/2CNinT0*
2. Independent investigation into sexism and sexual harassment at the BMA. *BMA* 26 April 2019. *bit.ly/2DGhEDK*

doctors blame themselves for mental health problems

A survey of UK doctors found that most doctors (80%) were at a high or very high risk of burnout, with junior doctors most at risk.[1] Researchers from Swansea University asked doctors in training from a range of specialties about whether being a doctor had affected how they accessed support for mental health problems. The survey revealed a prevailing view that 'mental illness is equal to weakness' and that some doctors continued to work even when their illness impaired their ability to do so.

The researchers suggested that one way to tackle stigma was for NHS employers to include information about the prevalence of illness among doctors at induction sessions.

This follows a large BMA survey, open to all UK doctors, which received more than 4,300 responses, including around 1,400 from medical students. More than a quarter (27%) of respondents reported having been given a diagnosis of a mental health condition at some point and that 40% currently had a psychological or emotional condition. This is similar to the prevalence in the general population and shows that healthcare workers and students are not immune to mental illness. Let's remind ourselves of Jesus' attitude to the 'harassed and helpless' crowds he met. He didn't denounce them for weakness, instead he had compassion on them (Matthew 9:36).

1. Rimmer A. Doctors still see own mental health problems as sign of weakness, research finds. *BMJ* 23 April 2019. *bit.ly/2PL39mY*

HEROES + HERETICS

Kelly Hibbert looks at a missionary pioneer

HERO + HERETIC 27: HELEN ROSEVEARE

'Even in the midst of unimaginable cruelty and suffering and danger, his grace was sufficient'

IMAGE PA

Helen Roseveare

How is Helen Roseveare remembered? As a pioneering medical missionary? A renowned speaker and author in the late 20th century? A role model for Christian women? She may have been all these things, but I suspect she would not want to be remembered for them. She overcame enormous challenges, but she would not want us to think that they were overcome in her own strength. Helen Roseveare's identity was firmly rooted in Christ; her longing was to know more of him and to point others to him. She was unashamedly honest about the struggles she faced throughout her life. Through these struggles, God was able to use her (albeit unwillingly at times) in amazing ways. As we look at her life, we can learn much from her experiences.

background

Helen Roseveare was born in 1925 in Hertfordshire, England. She was the second of five children, and described herself as 'endlessly active, restless with animal spirits, always in mischief, with an urge to excel, to be noticed'[1] – traits that would remain with her for life and which would underlie many of her personal trials as well as successes. She first resolved to become a missionary at the tender age of eight, whilst hearing about mission work in India[2] – '*When I grow up, I will go to tell other boys and girls about the Lord Jesus.*'

But it was during her teenage years at boarding school in Wales that Helen consciously began searching for God. Yet she later writes that her beliefs at this time were merely superficial: '*I've no idea what I thought of God, or who I thought He was; but there was Somebody, God, who was bigger than everything around me, and I needed Him.*'[3] At that time, she believed: '*I could reach Him only if I were absolutely honest.*'[4]

I imagine many of us can relate to that instinct that we can somehow reach God by our own efforts. Helen was keenly aware that everything in the world, including life itself, seemed useless and meaningless; there had to be something more. This led to further efforts on her own part to reach out after the 'Unseen' – she dabbled in Anglo-Catholicism and regularly attended Confessions and Mass.[5] Yet there was still a great sense of emptiness and futility. It seemed that however earnestly and sincerely she tried to help others,

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there was a great void in her life.

Helen went to study medicine at Newnham College, Cambridge, in 1944. She experienced the same fears of leaving home, the same loneliness in starting university, and the same feelings of ignorance in her studies that many students at medical/nursing school can surely relate to! During her first term, she was struck by the friendliness and welcome of a group of Christian students in her College, and particularly by their love of Scripture. She writes of these students, '*Their lives and faces radiated a happiness and peace that was very nearly infectious, and quite obviously satisfying.*'[6] Elsewhere, she writes: '*They had a peace about them that I found very intriguing.*'[7] She began to accompany them to the Cambridge Inter-Collegiate Christian Union. A providential outbreak of mumps at home left her unable to return for the Christmas holidays, and this led her to attend a house party for training Christian leaders. Here it was that '*God poured out His grace in forgiveness, in cleansing from all the uncleanness of sin, and in revealing, at this time, the amazing wonder of the friendship of Christ.*'[8]

Helen Roseveare

With a renewed determination to become a missionary, Helen joined the Worldwide Evangelisation Crusade (WEC) and spent several years living at the mission's headquarters. On one occasion she overheard herself being described as '*proud, always knowing better than others, unable to be told things or warned or criticised, difficult to live with.*'[9] However, eventually, she was accepted as a member of the mission and following extensive preparations including a four-month crash course in French, and another four months studying tropical medicine, she departed for the Belgian Congo in 1953.

At first, Helen was based at Ibambi where she worked hard to set up a hospital and training centre. She was passionate to train national workers as 'nurse-evangelists',[10] who could use their medical skills as a springboard for taking the gospel to the Congolese. In 1955, four of her students passed the state examinations to qualify as assistant nurses. While rejoicing in their success, Helen was informed that the medical programme, and therefore herself, would be moved seven miles north, to Nebobongo, a disused leprosy colony. Here, she had to begin work from scratch. Initially she resented this change and was filled with anger. Seeing her rage, a fellow-missionary prayed for her, and Helen began to see that it was the Lord himself who was sending her to Nebobongo.[11] She fully trusted that God would use this move to make her more like Jesus, and she submitted willingly to his purposes.

Helen's life as a missionary in Nebobongo was filled with daily difficulties – the work there involved building a new hospital, constructing a village for the workers, teaching orphans based at the station, administrative tasks, medical responsibilities and leading Bible studies. She faced problems of understaffing and overworking to the extreme. Along with local Congolese staff, she established a 100-bed hospital and training centre and set up 48 local clinics.[12] Yet this was not the end of her story.

privilege of suffering

The Belgian Congo achieved independence in 1960, and a time of great political unrest followed. The constant threats, particularly for Westerners, led many of Helen's colleagues to leave the country, but she remained faithful to her call and steadfast to her African brothers and sisters. In 1964, the Simba rebellion broke out and Helen endured five months of captivity and savage mistreatment at the hands of the rebels. She was taken captive, humiliated, beaten and raped on two occasions. When speaking about this ordeal later, she stated that during the wild panic, horror and unknown fear '*...suddenly, there was God. I didn't see a vision, I didn't hear a voice, I just knew with every ounce of my being that God was actually, vitally there... He surrounded me with his love and he seemed to whisper to me, "Twenty years ago, you asked me for the privilege of being a missionary. This is it. Don't you want it?"... it was as though he clearly said to me, "These are not your sufferings. They're not beating you. These are my sufferings. All I ask of you is the loan of your body." And an enormous relief swept through me.*" [13]

DOCTOR AMONG CONGO REBELS

This is the dramatic, most moving human story of the Congo Doctor—Dr. Helen Roseveare — during the days of the 'rebel' movement in Congo. In peril in an isolated mission station in north-east Congo Dr. Roseveare and her colleagues maintained their work against all odds. Those odds included personal assault, the death of colleagues, and the constant fear of brutality. But through the story shines the light of an inner calm which rested on a personal faith in the living God and the power of the Gospel. This is not only the story of a missionary miracle but a witness to the deliverance of a soul from the fear of death, and from the fear of worse than death.

The photo is of Dr. Roseveare with Lieut. Joe Wepener leading Command 54 which liberated her and her colleagues.

My Lord Katie. *bit.ly/2LH579i*

After suffering much, Helen became aware again of God's '*wonderful, unchanging love, the full peace of his forgiveness*'.[14] This experience shaped her subsequent ministry, as she boldly testified that God's grace is all-sufficient. She was overwhelmed at the privilege of being trusted by God to endure suffering. She knew that whatever happened was part of God's plan, even if she couldn't see how or why.

dependence on grace

One of the wonderful themes of Helen's life is her dependence on God's grace: '*My grace is sufficient for you*' (2 Corinthians 12:9). Yet this is not something which came naturally to her and she is very honest in speaking of her reluctance to fully accept God's grace. During her first furlough in 1958, she resigned from being a missionary. This was partly borne out of frustration that she was a single woman without a husband to help with the work. Following this decision to resign, she found '*I had no peace. I knew I had acted rashly and without seeking any guidance from God.*' [15] Yet at a Christian convention, she wrote: '*God graciously renewed my call to serve him*'.[16] She knew she would need God's grace every day to persevere in the work he had called her to – the grace of God made possible through Jesus's death on the cross.

battle against pride

Linked to this lesson in dependence on God's grace was a battle against pride. In a 1975 sermon entitled 'The Cost of Declaring His Glory', Helen said '*The first major cost was to my pride.*' [17] She writes of her early years in the Congo, '*I was so often critical and proud in my outlook. Along with this my communion with the Lord shrivelled... I longed for liberation and peace and joy.*' [18]

Helen worked extremely hard to overcome many challenges whilst in the Congo, putting in long hours and carrying out a variety of tasks, often with little recognition. She strove for high standards in all aspects of her work. She resolved never to turn anyone away – to '*receive every visitor, whatever the hour, in His name and for His sake, showing His love.*' [19] She was dependent on prayer and walked closely with the Lord, prioritising

time with him. Yet despite testifying to the all-sufficiency of God's grace, Helen sensed God saying to her '*you want "Jesus plus". Plus a sense of success…*' [20] It was a personal spiritual battle: '*My heart ached. A battle was raging inside me… Yes, I did need others to think of me as a success. Yet, at the same time, my heart knew that Jesus was all I actually wanted or needed.*' [21]

What was the solution to this raging war? '*At last, broken-hearted, I confessed to God my pride, and told him 'Yes, I only want Jesus – not "Jesus plus."'* In confessing her pride, and fixing her gaze on Jesus as the one who can meet all our needs, Helen experienced God's peace restored in her heart.

longing to know Christ better

On the night Helen became a Christian, a Bible teacher named Graham Scroggie wrote in her Bible, Philippians 3:10: '*I want to know Christ – yes, to know the power of his resurrection and participation in his sufferings, becoming like him in his death.*' [22] This became an immense desire for Helen – to know Jesus more deeply, even in the depths of suffering, and therefore grow to be more like him. Her wholehearted and earnest longing to please God, compelled by his love, shone through her life.

During an interview for the London Women's Convention in 2010, she was asked for any advice to share with the next generation of women. Her response is filled with passion and wisdom: '*Have you fallen in love with Jesus? I know you know he died to save you; I know you know you ought to love him. But do you love the Lord Jesus? Not just as Saviour and Friend, but as Lord and Master. Is he all in all to you?… Are you allowing God to be totally in control of everything, because of your love for him?*' [23]

conclusion

Helen returned from the Congo in 1973 due to her mother's declining health. During her later years, she travelled around the world to speak of her experiences and wrote several books. She went to be with the Lord in December 2016.

reflections:

- Helen became a Christian at university through the witness of friends. Are we making the most of opportunities to share the love of Christ and to speak about him?
- Are we seeking 'Jesus plus'? Or are we resting in the knowledge that his grace is all-sufficient to meet our every need?
- Do we, like Helen, long to know Jesus better? Do we prioritise seeking to know him?
- Do we trust that God's plans are perfect, and that he uses all our experiences to make us more like him?

Recommended listening:

- Howard BC. The Extraordinary life of Helen Roseveare. The Gospel Coalition Podcast 28 September 2018. *bit.ly/2Z1ydD7*

Without doubt, she was a truly remarkable woman, a great hero of the faith, and we all have a lot to learn from her legacy. ▪

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WRITE

ETHICS

GO OVERSEAS

APOLOGETICS

SPEAK

LEAD

FAITH : MEDICINE : LIFE

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