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Transplantations, Adoption & Wellbeing

Adoption & Fostering A Theological Perspective

Stolen Generation, Consequences

Adult 'Survivors' of Adoption

Mission & Healing in Historical Perspective

Adoption in the Old & New Testaments

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editorial

'Adoption' a Metaphor for Life

Welcome to the journey with *Luke's Journal* in 2011. The focus of the articles in this Journal is to explore the interface between Christian faith and professional practice for Doctors and Dentists in Australia. We have chosen to explore the theme of adoption on this basis. Adoption is a metaphor for life and faith and a range of practitioners have developed this theme for this edition.

Children need healthy families to grow and develop to their best potential. The paths to adoption and more recent social structures, such as fostering and supported accommodation programs are multiple. In modern Western societies, maternal mortality is low. Planned adoption at birth is also infrequent in the context of access to both abortion and contraception in society. Social Security allows mothers, in particular, to parent children with or without the financial and emotional support of fathers. Other models, such as surrogacy birthing are evolving.

From birth a range of factors come into play. From tragic accidents which leave children orphaned to the removal of children from families for their own safety in the context of violence, abuse or neglect. With birth adoption rates low, couples facing infertility are looking to international adoption where a new range of medical, cultural and attachment issues come into play. Failure in this context can see children returned to their country of origin.

Adolescents are another subgroup of children with special needs that can stretch medical, family and institutional supports around them.

For this edition some of the authors will share their personal experiences of adoption and its impact on their professional lives. There is an element of suffering and despair which mirrors most of life's experiences and institutions. We will draw attention to these factors which are 'stretch' challenges to Christian professionals seeking to exercise best practice in the name of Jesus.

The "stolen generation" of indigenous children, the tragedy of dysfunctional State-sponsored institutional care, are slow-to-heal wounds in our society and bear many flow-on medical and psychosocial-spiritual consequences.

We have asserted that adoption is a metaphor for life. Adoption is a significant Christian image of the way God chooses to relate to the world and its struggle with sin. In Christ, God lovingly takes us back from our prodigal ways into his family. Adoption is a way of conceptualising our new creation in Christ. The Christian message is that we can all be born again and embraced by the love of God.

Finally, the idea of adoption has a wide range of uses in our language. It speaks of the ability of humans to change, to consciously adopt a new attitude. It can describe positive non-binding relationships: including a lonely person in the circle of family and friends, adopting an elderly person as a surrogate grandparent for children. Adoption allows us to imagine in the image of God. May the Spirit who empowers us to say "Father", give us ears to hear and eyes to see the full possibilities of adoption.

Dr Paul Mercer

LUKE's journal

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Members of CMDFA are invited to submit articles or letters to the editors for publication in ***Luke's Journal***. Articles may or may not be on the advertised theme. Writers may wish to discuss their potential contribution with the editors or their state editorial representative before submitting. **Articles, letters, book reviews and lengthy news items** should be submitted (preferably in electronic form) to the **editors** with a covering letter requesting their consideration for publication.

Advertisements and short news items should be submitted directly to the **sub-editor**.

See page 2 for contact details.

Adoption and the

The term that the Apostle Paul used for adoption in the New Testament was *hyiothesia*. The expression *hyiothesia* comprises 2 Greek words: *hyios*, "son" and *thesis*, "placing", and denotes either the process or act of being placed or "adopted as children". No other author in the New Testament employs this expression. Further, the concept is not clearly articulated within the Old Testament[1].

Ancient Greek Writings

The earliest known occurrences of the term in the Greek world are found in funerary inscriptions in the second century BC at Adelphi and Crete. The first known literary appearances are found in the writings of two Hellenistic historians, Diodorus Siculus and Nicolaus Damascenus. Diodorus uses the "adoption" term in the story of Aemilius and Scipio. He writes "when Aemilius, his real father, died and left his property to him and to Fabius, the sons he had given in adoption (hyiothesian), Scipio performed a noble act, which deserves to be put on record" (Diod. Sic 31.27.5). Diodorus also employs the expression in the Greek myth of Zeus, who persuaded his wife Hera to adopt Heracles (Diod. Sic. 39.2).

Mesopotamia

It does appear that adoption occurred in Mesopotamia (modern day Iraq) during the middle part of the second millennium BC. This is derived from writings called the Nuzi Texts. The Nuzi texts were discovered in North-Eastern Iraq between the years 1925 and 1931. The find comprised 4000 clay tablets dating back to the 15th century BC. The tablets contain private contracts and public records covering topics such as land, family law and order. The custom of adoption is described here as a process whereby a childless couple adopted a son to serve them as long as they lived and to bury and mourn for them at death. In return for these services the adopted son was designated an heir. This process involved slavery, adoption and inheritance.

The Nuzi texts also make it clear that if the adopter has a son, the adopted must yield to the real son the right of being chief heir. Unlike in Mesopotamia, Paul's letters demonstrate that in the case of inheritance, an adopted son is no different from the naturally born son and, more importantly, could never lose his rights or forfeit his adoption privileges or inheritance. Paul says the adopted children are "co-heirs with Christ" (Rom 8:17). It is argued therefore that it is unlikely that Paul would have drawn on the Mesopotamian background which taught otherwise.

Old Testament Writings

Hyiothesia is not found in the Old Testament and is absent from other classical Greek writers and other Jewish literature of the period (e.g. Philo and Josephus). It is therefore somewhat controversial whether adoption did occur in the Old Testament. Some authors have argued that the examples of Eliezer, Moses, Ephraim and Manasseh, and Esther represent a Hebrew adoption formula. The analogy includes the syntax and artificial kinship relationship that is established. For as a woman from one family becomes a man's wife and part of his family by marriage, similarly a child from one family becomes part of another family by adoption.

The following examples are cited as possible examples of adoption.

1. Eliezer, Abraham's Slave (Genesis 15:3)

The Old Testament account reveals how Abram's inability to father a child until he was 75 years old, when Isaac was born, is expressed in his anguished prayer to the Lord in Genesis 15:2-3.

But Abram said, "Sovereign Lord, what can you give me since I remain childless and the one who will inherit my estate is Eliezer of Damascus? And Abram said, "You have given me no children; so a servant in my household will be my heir."

Old Testament

Some scholars believe there is similarity between this case and Mesopotamian practices as outlined above. However, only inheritance is referred to in this verse. The Bible itself does not represent this as an act of adoption. Further, it does not appear that the custom took root in Israel with only a few other examples that can be cited in the Old Testament.

2. **Moses (Exodus 2:10)**
   When the child grew older, she took him to Pharaoh's daughter and he became her son. She named him Moses, saying, "I drew him out of the water".

   This verse contains a formulaic expression which describes Moses' adoption by Pharaoh. Moses was raised in Pharaoh's household by Pharaoh's daughter. However, Moses refused to consider himself an Egyptian.

   By faith Moses, when he had grown up, refused to be known as the son of Pharaoh's daughter (Hebrews 11:24).

   It would seem unlikely that Moses was adopted by the Pharaoh's household due to his dissociation from the Egyptians. There is also no mention of an adoption procedure. Adoption did not occur in the legal sense. There is no acknowledgement of one born outside the family as having the same rights of a child born into the family. This case is perhaps more akin to a "foster care" situation.

3. **Ephraim and Manasseh (Genesis 48:5)**
   Now then, your two sons born to you in Egypt before I came to you here will be reckoned as mine; Ephraim and Manasseh will be mine, just as Reuben and Simeon are mine.

   Many authors also refute this as a case of adoption. When Jacob takes Joseph's two sons upon his knees, he was probably not adopting them but more likely raising them to equal status with his own sons. He was treating them as sons rather than grandsons. Jacob was allocating rights of succession to those already within his family, rather than those outside of the family. It is argued this is a case where the rights of the firstborn were transferred to a younger son. Unlike a real case of adoption, no third party was involved.

4. **Esther (Esther 2:7)**
   Mordecai had a cousin named Hadassah, whom he had brought up because she had neither father nor mother. This young woman, who was also known as Esther, had a lovely figure and was beautiful. Mordecai had taken her as his own daughter when her father and mother died.

   The book of Esther occurs within the context of exile, where the people of Israel are living in a foreign land (Persia) where other laws and adoption procedures were in operation. However, it is unlikely Mordecai would have used a foreign adoption process when it seems that the Jews were still expected to obey their own laws (which did not include adoption).

   Then Haman said to King Xerxes, "There is a certain people dispersed and scattered among the peoples in all the provinces of your kingdom whose customs are different from those of all other people who do not obey the king's laws; it is not in the king's best interest to tolerate them (Esther 3:8).

   It is also unlikely that Esther would have been formally adopted, because as a woman she could not have continued the family line.

Conclusion

The evidence for adoption as a legal procedure in the Old Testament is not strong. In the event of a childless couple, other mechanisms were in place in Israelite society that obviated the need for adoption, such as levirate marriage[2]. Polygamy, while not being the ideal, was another means of having an heir. "Provisions such as polygamy, the giving of a concubine to provide children, and the levirate marriage took care of most situations. This probably accounts for the fact that there are no laws on adoption in the Old Testament and that even the word is lacking"[3]. The Old Testament laws do not really give any directives about adoption, and even if it was acknowledged, it had little influence on the daily life of the Hebrew people. Paul had extensive understanding of the Old Testament and used it to inform his understanding of Jesus Christ as Lord and Saviour in his writings. It does not appear this was the case in his use of the word *hyiothesia* and the theme of adoption which he expands upon so eloquently within his New Testament writings. Paul does however use the term to expand upon truths found within the Old Testament such as the nation of Israel being adopted as sons.

> *...the people of Israel. Theirs is the adoption as sons; theirs the divine glory, the covenants, the receiving of the law, the temple worship and the promises (Romans 9:4).*

References:

1 This article is based on an appendix entitled "Some alleged cases of adoption in the Old Testament" found in Burke TJ. (2006) *Adopted into God's Family Exploring a Pauline Metaphor*, Downers Grove: IVP.
2 Levirate marriage is a type of marriage in which the brother of a deceased man is obligated to marry his brother's widow, and the widow is obligated to marry her deceased husband's brother (see Deuteronomy 25:5-6).
3 Morris L. (1988) *The Epistle to the Romans*, Grand Rapids: Eerdmans; Leicester: IVP.

Adoption in the New

The apostle Paul employs a rich vocabulary to describe how Christians relate to God. This includes election (Ephesians 1:4), justification (Romans 3:24) and redemption (Galatians 3:14). The notion of adoption (or *hyiothesia*) is another metaphor that has attracted less attention. Originally it was used to denote the process or act of being adopted as a son(s). The term is unique to the writings of Paul, occurring five times in three of his letters. It is striking that Paul uses his adoption metaphor in letters to communities directly under the rule of Roman law.

New Testament Verses Referring to Adoption

Romans 8:15
The Spirit you received does not make you slaves, so that you live in fear again; rather, the Spirit you received brought about your adoption to sonship. And by him we cry, "Abba Father."

Romans 8:23
Not only so, but we ourselves, who have the first fruits of the Spirit, groan inwardly as we wait eagerly for our adoption to sonship, the redemption of our bodies.

Romans 9:4
...the people of Israel. Theirs is the adoption to sonship; theirs the divine glory, the covenants, the receiving of the law, the temple worship and the promises.

Galatians 4:5
...to redeem those under the law, that we might receive adoption to sonship.

Ephesians 1:5
...he predestined us for adoption to sonship through Jesus Christ, in accordance with his pleasure and will ...

Paul's Use of the Term Adoption

Paul always used the term metaphorically. Adoption describes the family character of the Christian faith which Paul understood and for him was a basic description of what it meant to be a Christian. He used it to denote the blessing of God's people by their heavenly Father.

In recent times, theologians such as Burke[1] and Murray have argued that adoption is best understood as a concept separate to justification. They argue that adoption is distinct but also related to justification and regeneration. Table 1 shows the views of three different theologians in relation to their understanding of adoption and its relationship to other theological terms.

Theologian	
Abraham Kuyper[2]	Regeneration/adoption, faith, justification, sanctification, glorification
Louis Berkhof[3]	Regeneration, faith, justification/adoption, sanctification, glorification
John Murray[4]	Regeneration, faith, justification, adoption, sanctification, glorification

Adoption should not be subsumed under justification. Justification is the primary blessing of salvation upon which all other saving benefits depend.[5,6] but even though adoption is related to justification, it is nevertheless "an act of God's grace different, distinct from and additional to justification". "God does not only justify people and then leave them destitute with nowhere to go – he adopts them into the warmth and security of his household"[7]. "Adoption is the highest privilege that the gospel offers. Adoption is the apex of redemptive grace and privilege"[8].

Adoption is Distinct from Regeneration

While the consequence of adoption and of regeneration is that we become God's children, it is important to observe the differences between these two metaphors. The notion of regeneration features in John's writings.

John 1:12 – 13
Yet to all who did receive him, to those who believed in his name, he gave the right to become children of God— children born not of natural descent, nor of human decision or a husband's will, but born of God.

1 John 3:1-3
See what great love the Father has lavished on us, that we should be called children of God! And that is what we are! The reason the world does not know us is that it did not know him. Dear friends, now we are children of God, and what we will be has not yet been made known. But we know that when Christ appears we shall be like him, for we shall see him as he is. All who have this hope in him purify themselves, just as he is pure.

Regeneration, a Johannine term, delineates the imagery of natural birth, which the author uses to emphasise the fact that Christian sonship does not occur naturally but by spiritual rebirth. In contrast, adoption is a forensic term and denotes a legal act or transfer from an alien family into the family of God. "Not birth but adoption is Paul's analogy for the manner in which childhood begins in the

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believer"[9]. Paul and John use two very different metaphors to express ways by which Christians become members of God's family. Sonship by adoption should be distinguished from sonship by regeneration[10].

Applications of Adoption to the Christian Life

1. **Adoption is centred in the person and work of God's Son, Jesus Christ.**
   When Paul speaks of adoption in his letters it is important to note that he follows a pattern where he relates adoption to Jesus Christ, God's Son. Paul's understanding of adoption is grounded in the person and work of Jesus Christ, God's Son.

2. **Adoption demands an appropriate ethical response.**
   In his letter to the Ephesians, Paul argues that having God as our Father should mean that as adopted children we behave in a manner worthy of someone who claims to be a member of God's new family. That is, our behaviour should resemble the family which we have been adopted into, rather than our behaviour earning our status as a family member. Does regeneration relate to "nature" and adoption relate to "nurture"?

3. **Adoption expresses the tension between the "now" and "not yet" found within the Kingdom of God.**
   There is a tension between what Christians have now and what will happen in the future. We have the spirit of adoption (Romans 8:15) but its completion lies ahead "as we wait eagerly for our adoptions as sons" (Romans 8:23). This extends to our inheritance as co-heirs with Christ (Romans 8:17). ∎

References:

1 This article is a brief summary of the work of Trevor Burke. More detail can be found in Burke TJ (2006) *Adopted into God's Family Exploring a Pauline Metaphor*, Downers Grove: IVP.
2 Kuyper A (1900) *The Work of the Holy Spirit*, New York: Funk & Wagnalls.
3 Berkhof L (1981) *Systematic Theology*, Edinburgh: Banner of Truth.
4 Murray J (1961) *Redemption Accomplished and Applied*, Edinburgh: Banner of Truth.
5 Carson DA (1994) "Reading the Letters" in DA Carson, RT France, JA Moyter and GJ Wenham (eds), *New Bible Commentary 21st Century Edition*, 1108 – 1114, Leicester: IVP.
6 Packer JI (1988) *Knowing God*, London: Hodder and Stoughton.
7 Burke TJ (2006) *Adopted into God's Family Exploring a Pauline Metaphor* Downers Grove: IVP.
8 Packer JI (1988) *Knowing God*, London: Hodder and Stoughton.
9 Schlatter A (1995) *Romans: The Righteousness of God* Peabody: Hendrickson.
10 Berkhof L (1981) *Systematic Theology* Edinburgh: Banner of Truth.

"God does not only justify people and then leave them destitute with nowhere to go – he adopts them into the warmth and security of his household"

The **Theology** of Adoption

"...You are to give him the name Jesus" (Matthew 1:21)

Joseph is commanded to personally name the child.This is deeply significant. It means that Joseph, in naming the child, acknowledges him as his own son and thus becomes the legal father of the child according to Semitic law. As a result of this legal adoption, Joseph's ancestry as a descendent of David transfers also to his legal son. Biologically, Jesus is begotten by the Holy Spirit and is thus the "Son of God" (Luke 1:32a), but legally he is the son of Joseph and heir to the promises of David, Joseph's ancestor.

God offers the rights of adoption to each and every person. That is the salvation message. Paul in his letter to the Romans (8:15) uses the image of adoption so beautifully.

> *"The Spirit you received does not make you slaves, so that you live in fear again; rather, the Spirit you received brought about your adoption to sonship. And by him we cry, 'Abba, Father.'"*

In this illustration Paul contrasts the idea of slavery and adoption as two vastly different ways to come into a household in biblical times. The slave that lives in fear is the negative example and the child who has come into the family through adoption is the wonderfully positive example. The adopted child has the freedom to know the father as "daddy". There is such intimacy in that term. In Paul's theology the adopted child has all the privileges that a father can give.

Often in adoptive families the child is well aware that their parents have chosen to have them to be part of the family. The child may not ever realise the great lengths and expense their parents have gone to in order to bring the child into the family, but that is not the point. The idea of being specially chosen is what is really powerful to a child needing to be loved and belong. The same theology comes across from Paul again in Ephesians 1:4–6.

> *"For he chose us in Him before the creation of the world to be holy and blameless in his sight. In love He predestined us for adoption to sonship through Jesus Christ, in accordance with his pleasure and will — to the praise of his glorious grace, which he has freely given us in the One he loves."*

How can we ever comprehend the great price that God paid by giving Jesus for us? What we can appreciate is that before anything was created, God had chosen us to be His children. God had chosen us to be in intimate relationship with Him because that was what He wanted. God's great love and mercy drove Him to do whatever it took to build that relationship with you and me.

The other side of the story is that as we grow we have our own choice to make as to how we respond to the unconditional love that God offers us. We can chose to stay in relationship with our adopted father or to explore the alternatives the world has to offer. Our free will is there to be used one way or the other. Adopted children have similar choices as they grow and desire to experience what the possibilities may have been like if they had not been adopted. The quest for the biological parents can be heartbreaking. The pain can be devastating for the adoptive child and parents alike. Questions need to be answered even when there are no answers. When the searching comes to an end we still have the image of God as the father of the prodigal waiting to welcome the child home with celebrations and fatted calves.

The love that I have for my own children is modelled on the love that I know God has for me. I love each child with all my heart, whether they are mine through the biological process of birth or through the legal process of adoption. They are loved the same. I know that God's love for each of His earthly children is beyond the limits of my understanding. I am honoured to have the experience of fatherhood to help me grasp some of the depth of God's great love that I may help others know God's love too.

By ***Rev Matthew Bond***
Father of 5 and Minister at Burnside City Uniting Church, South Australia (An author with a theological bent to write something creative and helpful around the theme of adoption and the scripture.)

Adoption

By **Dr Wendy Bourke**

Dr. Wendy Bourke is a general adult psychiatrist working for the Sunshine Coast Mental Health Service. With her husband she has 2 married adult children, and 3 grandchildren. A longtime member of CMDFA, she enjoys walking, gardening, reading and time with the family.

This is a word generally understood by people, and it touches on the lives of a surprisingly big percentage of the population. In my life I have been involved in various ways, firstly in my personal life, and secondly in my professional role as a psychiatrist.

Adoption, as defined by the dictionaries I consulted, is 'an act of taking into a relationship not previously occupied' especially in relation to taking a child as one's own, assuming the rights and duties of parents towards that child. The words 'choice' and 'formal legal act' are included in the definition.

God has set the standard for adoption, as he describes us who believe in the Lord Jesus as his adopted children. Romans 8 verses 14-17 describes our relationship with God in these terms.

> *"For all who are led by the Spirit of God are children of God. So you should not be like cowering fearful slaves. You should behave like God's very own children, adopted into his family, calling him "Father, dear Father." For his Holy Spirit speaks to us deep in our hearts and tells us we are God's children. And since we are his children, we will share his treasures – for everything God gives to his Son Jesus Christ, is ours too. But if we are to share in his glory we must also share his suffering."*

> *"God sent him to buy freedom for us who were slaves to the law, so that he could adopt us as his very own children. And because you Gentiles have become his children, God has sent the Spirit of his Son into your hearts, and now you can call God your dear Father. Now you are no longer a slave but God's own child, and since you are his child, everything belongs to you." (Gal 4:6, 7).*

We have been able to trace our family line back to the arrival of our ancestors on a convict ship in the latter part of the eighteenth century, with my grandchildren being the seventh generation born in Australia. There has been a pattern of adoptions in and out of the family, children being fostered and second marriages over several generations, making our family tree a complicated one.

The names and histories of the children fostered by my grandparents have not been passed down, but the adopted children are clearly family and we have made no distinction between them or their children and those born naturally into the family. They were ALL my aunts, uncles, cousins, nieces or nephews. In our large family gatherings there is a group of people who superficially resemble each other with fair hair and fair complexions, inclined to be mesomorphic in build. There is noticeable diversity in the rest of the group. However we all share a sense of belonging to this family, with shared

memories, and a shared inheritance, just as those adopted into God's family share in the inheritance of eternal life, of unity in the Spirit with other believers, the benefit of Jesus constantly interceding for us, the guidance of the Holy Spirit, assurance of salvation and other rich spiritual blessings. God created the first family and gave us a pattern for living in harmony with each other. Adoption is one way to make families stronger and happier and clearly echoes the adoptive relationship believers have in the family of God.

As a psychiatrist I have assessed couples for their suitability to become adoptive parents; counselled those who have given children up for adoption, sometimes decades previously and are still mourning their loss; adopted out people who question their lovability as babies or wonder why their parents hadn't tried harder to keep them; those who want to find their biological parents or have done so and been disappointed; and parents who search fruitlessly for the child they gave up, and those who find their offspring, but find an ongoing relationship of any kind difficult to establish. There are adopted people who profess no need to know their biological parents. Some don't want to upset their adoptive parents, but some seem genuine in being content with their situation.

Another way of being involved in this area is that of counselling the pregnant woman who feels conflicted about whether to have a termination or to let the pregnancy proceed and adopt the baby out or to raise the child herself. I consider the modern practice of open adoption, where the relinquishing mother has a choice as to who can adopt her child and can receive photos and progress reports as the child grows, helps women decide which option to take. The baby who is adopted into a secure loving family is blessed and it is clear that adoption is part of God's plan to allow people to grow up in a family, as this is His blueprint for the way we are to live our lives.

Adoption & Fostering

A theological perspective

The day we met our son Brandon at his foster parents' home in a rural district of Manila was one of the most unique and surreal experiences of my life. I tell you it was a very strange feeling meeting this little twenty-month-old boy for the first time. We knew something of Brandon, yet did not yet know him and he certainly did not know us. Yes, he'd seen our photos, but he'd never met us or heard our voice. Brandon didn't speak our language, he didn't eat our food and he didn't look like us. All Brandon had known in life was this loving, caring foster couple. They were his 'mama and papa'. They were his whole world.

"The concepts of adoption and fostering conjure up a bag of mixed emotions – not to mention memories of various government policies trialed and discarded."

It was a time of mixed emotions – joy at finally meeting our son, yet sadness for Brandon and his foster parents who evidently loved each other so very much. Just two months earlier, we had been in the foster parents' shoes, kissing our foster son goodbye for the last time as he was returned to the care of his extended family. In that moment, I questioned what we were doing. Was adopting Brandon and carting him back to Australia, really the best thing for him? Had the department made a good decision to move our foster son to the care of his extended family when he was so well settled in our family?

The concepts of adoption and fostering conjure up a bag of mixed emotions – not to mention memories of various government policies trialed and discarded. This article is not so much a critique on current policies but a reflection of adoption and fostering from a Christian theological perspective.

The words 'foster' and 'adoption' are seldom used in the Bible. In fact, the word 'foster' occurs only once in the NIV,[1] while 'adoption' in the NIV is used once in the Old Testament in reference to human adoption and five times in the New Testament in relation to spiritual adoption.[2] Although these particular words aren't frequently used, the concept of 'alternate care for children' is certainly well developed. For the Bible has much to say about those in society who are the beneficiaries of adoption and fostering, who in the Bible's language are 'the orphans and the fatherless.'

So we want to approach this topic exploring the Bible's teaching on 'orphans' and 'the fatherless', as well as reflecting on spiritual adoption and how this relates to earthly adoption. But first we need to start with God as Father.

God as Father

One of the ways God is described in the Bible is that of a father. As a father, God has a loving paternal concern for his children. He longs to be in relationship with them, to care for them and provide for them.

Most notably we see God's fatherly love in his longing to be in relationship with his estranged children. Genesis 3–11 is a story of humanity rejecting their father God and going their own rebellious way. But the rest of the Bible, from Genesis 12 onwards, is a story of God seeking to bring humanity back into relationship with himself – to woo back his rebellious children. The restoration of relationship begins with God's adoption of Israel (Romans 9:4), first Abram in Genesis 12 and then eventually the Jews and the Gentiles through the coming of Jesus Christ into the world. Through Jesus, the restoration of relationship through the offer of adoption has been opened up to the whole world. From the day of Pentecost onwards we see God's Spirit of adoption (Romans 8:15) come upon not just the Jews, but the Samaritans and Gentiles. God's adoption had now opened up to the whole world to be reconciled to their heavenly father and become his children. It's this adoption that is highlighted in the New Testament, a *spiritual, heavenly adoption* for want of a better name.

As important as earthly families are, the Bible is clear that there is an even more important eternal family to which we must belong - the family of God. Being part of God's family, begins on earth and will go on for eternity in heaven. So whether we are adopted into earthly families or not, there is one adoption we must all partake of, and that is to be adopted by God our Father, to be his 'sons' and inheritors of heaven.[3]

What a great hope for all of us! We may have lost our earthly parents, we may have had a horrific childhood or experienced the pain of a family break up, but the reality is that in Christ we have an eternal family and a heavenly Father who will never leave nor forsake us.

God's Fatherly Heart

We see in the Bible that God is perfect. This means that he shows love and kindness to all people, even his enemies. We see this in Matthew 5 where Jesus exhorts his disciples to be loving and kind towards their enemies, for in so doing they are being like their Father in heaven who, 'causes his sun to rise on the evil and the good, and sends rain on the righteous and the unrighteous.'[4]

We see especially in his relationship with his children Israel that he particularly looks out for and protects

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the weak and frail among them. God is described in Deuteronomy as the one who 'defends the cause of the fatherless and the widow, and loves the alien, giving him food and clothing.'[5] And in the Psalms he is described as, 'a father to the fatherless, a defender of widows, or elsewhere it says, 'the Lord watches over the alien, and sustains the fatherless and the widow.'[6] It is clear that God has a special concern for these weaker members of his family.

This attitude is also enshrined in his laws for Israel. Israel was commanded to provide for and protect the rights of 'orphans and the fatherless' within their communities. Part of their tithe (giving ten percent of their income to God) was to go to support the orphans and the fatherless.[7] As well, they were commanded at harvest time not to harvest their fields twice, but rather to leave the leftovers of their harvest for the orphans and widows and poor to collect.[8]

God's attitude is also seen in the strong warnings and dire consequences for those of God's people who abused or neglected orphans and fatherless.[9] In Deuteronomy it says, '*Cursed is the man who withholds justice from the alien, the fatherless or the widow*'.[10] In Job, his accusers accuse him of abusing, and not providing for the needs of orphans and the fatherless; this is obviously seen as a heinous sin.[11] This is also one of the sins that the prophets condemn Israel for, which eventually leads to the end of Israel, the destruction of Jerusalem, and Judah's exile to Babylon.[12]

In the New Testament, the early Christians share God's heart. In Acts 6 and 1 Timothy 5 we see the early churches' provision for widows, and we can assume this included the fatherless and orphans as well. And most significantly, James really sums up the biblical teaching on this when he declares, 'Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress and to keep oneself from being polluted by the world'.[13] And this physical concern is also seen in the spiritual realm, for Jesus on his departure, tells his disciples that he 'will not leave them as orphans.'[14]

So there is ample evidence in the Bible for God's heart of concern for orphans and the fatherless. And we also see that God wants us to be like him and have this same concern for orphans and the fatherless. We see this most pointedly in his instructions to Israel in Deuteronomy 24; after commanding them not to mistreat the weak, he then explains why. He says, 'Remember that you were slaves in Egypt and the Lord your God redeemed you from there. That is why I command you to do this'.

God's Fatherly Provision

God's provision for orphans and fatherless was to place them in the community of his people, in families who were to care for them, provide for them and protect them. We see this in his instructions to his people in both the Old and New Testaments. In Psalm 68, in the context of God being the father to the fatherless (68:5) it then says, '*God sets the lonely in families*'. God's people are to be family for the lonely, the orphans, the fatherless and the widows.

Job is an excellent example of this. Job rescued the fatherless who had no one to assist them (Job 29:12), he shared his food with them and raised them as if they were his own sons – he was like a father to them (Job 31:17–18). He also did all he could to defend and protect them in court (Job 31:21). Perhaps today we would say that Job was an unpaid foster-carer.

But we also see Mordecai take a step further than this and adopt Esther. Esther had no father or mother, so Mordecai took her as his own daughter, or as it says, he adopted her.[13]

The New Testament church has this same responsibility as we see in Acts, 1Timothy and James.

We see that it's part of Israel's and the church's mandate to love one another, to be good to all, especially the household of faith. There is a special concern that we as God's people are to have towards our fellow believers and especially our own families. In fact, it's so strong that Paul says to Timothy that, *'if anyone does not provide for his relatives, and especially for his immediate family, he has denied the faith and is worse than an unbeliever'*.[15]

God's Fatherly Provision in 2011

God's Fatherly heart pours out for the parentless children of today, just as it did in the times of Israel. God urges Christians to pour out our hearts, just as God himself does. Adoption and fostering are two ways in which Christians can care for the parentless children of today, whether temporarily or permanently.

References:
1 Isaiah 49:23
2 Romans 8:15, 23; 9:4; Galatians 4:5; Ephesians 1:5
3 We see this most clearly in Ephesians 1:5 and Romans 8:23
4 Matthew 5:44
5 Deuteronomy 10:17-18
6 Psalm 10:14; 68:5; 146:9 (NIV)
7 Deuteronomy 14:29;26:12 (NIV)
8 Deuteronomy 24:19-21
9 Exodus 22:22; Deuteronomy 24:17; 27:19
10 Deuteronomy 27:19
11 Job 6:27; 22:9; 31:17,21
12 Isaiah 1:17, 23; 10:2; Jeremiah 5:28; 7:6; Ezek 22:7; Zech 7:10; Mal 3:5
13 James 1:27
14 John 14:18
15 1 Timothy 5:8

By **Dr Paul Mercer**

Adult 'Survivors' of Adoption
A Case Study

Case of Mary/Maree

- Mary adopted out at 2 years of age (youngest of 10, 9 alive).
- Story of paternal sexual abuse of older sisters.
- Mary separated from siblings and adopted by family M.
- In this family she "replaced" a 9 year old girl, Margaret, who died tragically of meningitis.

Q What is the prevalence of adoption in our society?

Does adoption have good or bad press?

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In the M family Mary was treated quite paradoxically

- Her name was changed from Mary to Maree.
- She became aware of her important role as a replacement for Margaret. At times this meant she almost became angelic – dressing in a fairy's costume and dancing (she was good at this).
- Her eldest step sister Phyllis was a very dominant personality and readily scapegoated and humiliated Maree if things went wrong.
- Maree suffered date-rape at 19. She was ashamed and continued intercourse until she became pregnant. Phyllis wanted to disown her at this point.

Q How important would Maree's pre-adoption experiences have been for her?

Are outcomes likely to be different for adopted children with relatives or non-relatives?

* * * * * * * * * *

Maree's step family pressured her into marrying Roland. Early in the pregnancy, Maree contemplated an abortion and when Roland discovered this he turned on her. The marriage continued in a constant state of antagonism. Roland began to drink heavily and was violent to Maree and her four sons.

Roland came from Western Australia to Queensland. None of his family attended their wedding. Maree once wrote to Roland's mother. She replied but the letter was addressed to Roland telling him to lift his game. His violence was only fuelled and he banned all contact with his family or origin. Eventually Maree's eldest son became so distressed he suicided.

Family life became even darker.

Maree separated and divorced her husband but he soon was found dead from his alcoholism. To complete Maree's bitterness her third son was killed in a motor vehicle accident. She lives with her youngest son and is estranged from her second son who blames Maree for his father's death.

Q Do you think Maree has a strong healthy sense of 'self'?

* * * * * * * * * *

At the age of 44 Maree was stunned to discover she had been adopted. Her eldest brother was seeking to reunite the family and eventually found her. Maree was immobilised by this discovery and it took 12 years to start to actively come to terms with it. She discovered her original name was Mary and slowly she felt an inner desire to rediscover Mary and 'throw off' Maree.

The emotional work has been heavy going and distressing to the point of deep depression (requiring antidepressants).

Mary had no memories of her biological family. Her anger toward her step sister was such she felt as if 'soul murder' had occurred. Mary found working through a video series *Bradshaw on the Family* helped metabolise her pain. She began to reconnect with her wider family. Her independence, sense of self-worth and optimism steadily returned to healthy levels over a 12-month period.

Q How important is it for us to know who we are?

How helpful is the Biblical concept of 'adoption' in working with people like Mary?

Are you surprised Mary took so long to reconnect with her 'family'?

By **John and Lilli Parsons**
Pacific Health Medical Centre, Qld

Our **Journey** of Adoption

Happy House was a small delightful cottage on the steep rolling hills of Murree, in Northern Pakistan. It was the first home of our married life. The dwelling had been allocated to us for learning the Sindhi Language. We were first term missionaries with Interserve, destined to work in the Sind province of Pakistan.

Seven years and two terms later we were returning home with mixed feelings after accepting the truth that we had not been able to have children. Torn between our desire to stay on the Mission Field, and our desire for a family, we had decided to come back to Australia to seek further infertility treatment. After two years of effort in Brisbane we had had enough and decided to launch down an unknown road to pursue overseas adoption.

In early 1989 we nervously walked into the Family Services Building in Brisbane for our first introduction to overseas adoption. Joining us were four other couples. Little did we realise we had just entered into a worldwide extended human family of parents who had adopted children outside of their own culture. Two of these couples and their adopted children remain our close friends to this day. Since this time whenever we meet parents or children of families who have adopted, there is an instant rapport between us because of mutual shared disappointment, suffering and joy.

The next two years were filled with interviews, more meetings, more form filling (including a ten page questionnaire enquiring into our marriage relationship), learning Spanish and working hard to save necessary funds. We were given a choice by Queensland Family Services as to which country adoption was appropriate. Country of origin depended on the current agreement with nations which at that time were allowing adoptions into Australia. Despite our interest and commitment to Asia, we had always loved Latinos. We decided to go to Colombia.

Two years after starting the adoption procedures we landed in Bogotá, capital of Colombia, at that time one of the most dangerous countries in the world. We were able to stay in the Wycliffe/SIL guesthouse in Bogotá. Two days later at the FANA Orphanage in Central Bogotá, we sat nervously in the 'birthing room'. The walls were decorated with gold plated leaves. Each leaf meant to represent one precious life given to a new family. We rejoiced that day with two other couples, one from France and one from USA. In the 1990's, overseas adoptions from this orphanage occurred at the rate of one per day, most children going to families in the USA.

The founder of the orphanage, Mercedes Pineda de Martinez, herself a parent of adopted children, handed us our new son, Christopher. Like many parents our joy was overwhelming. In that room I first heard these words of Mercedes: 'Children are not conceived in the womb, but in the heart' and 'we are not just looking for a child for a family, but a family for a child.' From that day, Christopher remains our child in our hearts.

Four years later we repeated the process and stood in the birthing room to accept our daughter, Sophie. We now seemed blessed with a complete family. Over these six years our lives were enriched with two beautiful children, many wonderful friends and a deeper understanding of South American people and Spanish culture.

Christopher is now 19 and Sophie 15. Our lives continue to be transformed by the circumstances of our children. Both have been able to study Spanish at school, and we have many friends amongst the Colombian community in Queensland. In my General Practice I have many Spanish speaking patients, whom I share a love for Spanish, all things Latino and of course soccer.

Over the years of blessing with our children I have often reflected on certain truths. By God's grace through Jesus Christ we have received "…adoption as children" (Galatians 4:5 NRSV). One day Sophie was asked to draw her Family Tree. She said "Dad, I need two trees, one for my Australian family and one for my Colombian family." Likewise we as Christians share two families, our own physical family and the spiritual family of all those united by undeserved new birth in Jesus Christ.

If you deeply believe in the providence of God you hold that *'he pays even greater attention to you, down to the last detail – even numbering the hairs on your head!'* (Luke 12:7 The Message) and *'..so it was not you who sent me here, but God.'* (Genesis 45:7 NRSV). Our close friends have a son and daughter the same ages as ours adopted from Colombia. Their son Fabian was the adoption before Christopher and their daughter Maddie was the adoption after Sophie. We have often reflected how close it was to being the other way around. But we deeply believe that God chose Sophie and Christopher to be with us, and not Maddie and Fabian.

Sometimes things happen to us we would never choose. But in the purposes of God... *'we felt that we had received the sentence of death; but that was to make us rely not on ourselves but on God who raises the dead.'* (2 Corinthians 1:9 RSV). While it would be the choice of most couples to have their own biological children, we rejoice and give thanks that through the adoption of our children we have learnt to rely on God more. To him be the glory.

On Track – Working

Why would a medical professional care about adoption? Personally, some human beings care more than others. You might be one of the many who act upon your concern. Also you would have the same chance as anyone to have a personal history that includes adoption. Professionally, children in 'alternative' care seem to always have more medical issues whether it be due to stress, disjointed case histories, or as yet unknown genetic disorders. I bet you have been held up yourself with these children because of Medicare, identification, or case history issues!

My understanding of any life metaphor is that its meaning must somehow relate to the literal word meaning. I think in the simplest form 'adoption' always includes: the transfer of ultimate responsibility for a person, to move from one party to another. In Australia this practice goes far beyond adoption as it is popularly viewed. Little orphan 'Annie' had quite a straight forward adoption in the end.

Many historical and ideological factors influence the unique shape of how an adoptive relationship may take place. These include varied points of commitment to a range of variables. They include:

- The permanent or temporary nature of the relationship.
- The legal or informal nature of the arrangement.
- The sense of ownership and/or freedom of individual parties.
- The adoption serving individual family and/or societal needs.
- The balance of the relationship around benefit gained and/or benefit given.
- The balance of responsibility of the adopter and/or on the adoptee.
- The role of emotional and/or functional bonding between the parties.
- The role of care and/or duty between the parties.

Every one of these issues affects me.

Professionally, I run a residential program for young people. In the medium term the buck stops with me for their daily care. Personally, I also have at least two extra children that are not mine biologically in my own home. The buck also stops with me for them.

Where I work is called **Ontrack Youth Residential Care**. We provide holistic daily care and accommodation to six young people aged 12-17 years. It is a ministry of Queensland Baptist Care [http://www.qbc.com.au]. The relationship we have with young people is medium term 6-18 months. Our purpose in this time is to help young people to return to a lower level of care, or to return to their families of origin, if safe. It is formally not called adoption but foster care. Legal adoption is technically possible for young people in long term foster relationships with families, but it is not common at all.

Young people come to Ontrack through the Department of Communities. This makes the arrangement very legal. Youth Workers and Managers have no ownership over the young people. That is balanced out between the parents' ultimate claims that remain over the young people, and the state's [hopefully] temporary assumption of responsibility. As a professionally run facility our program serves society in general as well as serving the individual families that cannot legally care for the young people we accept. It is only designed to serve the carers' families through normal employment rewards for service, but employment is generally only sought by those who are legitimately in a personal place that they have 'something to give'. Our volunteers give up their rights to remuneration all together. The balance of responsibility between carers and young people is legally totally on parents and carers. Under the rights and responsibilities section of the Queensland government's child safety website, carers have responsibilities, and children and young people have rights [http://www.childsafety.qld.gov.au/fostercare/rights-responsibilities/index.html]. The task that carers and parents must face practically though is how to prepare young people to assume total responsibility for themselves by the time they are 18 years old.

The details mentioned to date are completely about young people receiving justice, but what is ultimately sought is the understanding and experience of loving relationships. In my environment professional boundaries are required. I am not neutral [there is no such thing as neutral], but at the same time I cannot 'love' them. The best I can do is appropriately care about our young people in a way that admits emotion but does not let it override my role and reason. This in itself is

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with Children at risk

a way of expressing 'tough love', as well as a way to protect my emotional resources enough to be able to continue appropriately caring long term for an ever changing variety of residents. Each staff member must find a way to do this. The law and literature name this 'attachment'. Appropriate attachment is desired but it cannot be forced. It has to be honest and voluntary; freely given and freely received. In many regards carers and parents are opportunity providers. The results are never guaranteed. Caring entails risks but rewards in ways justice responses never can for carers as well as children and young people.

In my daily work at home and at Ontrack I am always aiming to reflect the character of God and live out his image in me. This article was just meant to be a reflection of that journey rather than, 'this is how you do it!?'. As you can see the environment

"God is the parent; creative and adoptive. He takes on others he does not 'need too'."

is challenging but it must start there, not in theory alone. In terms of God's adoption I see general and specific themes in creation and redemption that apply. God is the parent; creative and adoptive. He takes on others he does not 'need too'. He seeks to give both just and loving responses to his children. He is vulnerable in risking rejection and is rejected by many. He walks with all and understands their joy and pain intimately. For you today I'm hoping you might see how God is being that for you, and how practically you might be able to share this in your home and work practice.

Clinical Realities and

Adoption from birth can be a very positive and life-giving experience; particularly when parents are well trained, committed and loving. In practice there can be a wide range of outcomes. Adoption/fostering or other nurturing models can be broken down into:

- Baby adoptions.
- Good start late adoptions.
- Poor start late adoptions.

During 2009-10 there were 412 finalised adoptions across Australia. This represents a dramatic decline since 1971-72 when there were 9798 adoptions. 1-2% of the population are adoptees. In 2009 there were 34,069 Australian children living in out of home care (47% foster care, 45% relative/kinship care). *(Australian Institute of Health and Welfare website).*

"Most children in foster care, if not all, experience feelings of confusion, fear, apprehension of the unknown, loss, sadness, anxiety and stress."

The best overall outcomes for development and health occur for baby adoptions where close relatives are involved. Significant levels of pathology are seen where children have multiple problematic fostering or adoption experiences. There are comparative developmental outcomes for all nurturing options. In positive circumstances adopted children will do as well as children raised in a stable two parent family. Both of these situations are associated with less morbidity than a single parent family context.

Research into health/development outcomes confirms that kinship adoption at any stage is more likely to have a better outcome than other contexts of care. Placement in kinship foster care should be considered as a viable possibility. Children in kinship foster care experience better behavioural development, mental health functioning and placement stability than do children in non-kinship foster care.

A 2009 paper by Zeanah *et al* confirmed that "institutional rearing was associated with substantial psychiatric morbidity. Removing young children from institutions and placing them in families significantly reduced internalising disorders, although girls were significantly more responsive to this intervention than boys".

Another study involving Zeanah in 2010 demonstrated that foster care is an important intervention to reduce the adverse effects following early deprivation in children institutionalised since birth.

Research such as this should make us circumspect about the outcomes for children in orphanages and child sponsorship programs in low income countries. Their popularity may be misplaced.

Christian professionals need to maintain a critical insight into all models of nurturing as reform is often a necessity in the context of universal human sinfulness and the narcissism of our age.

An article in *The Journal of Paediatric Psychology* in June 2010 identifies that foster children report very high rates of exposure to maltreatment including neglect, physical and sexual abuse. Professionals have a challenging role to support foster carers and also monitor for such problems.

Excellence in clinical assessment of problems will also recognise that genetic factors and life experiences prior to late adoption/foster care are also measurable contributors to morbidity. In a

Table 1: Rates (%) of adolescent problem behaviours (14-16 years) and disorders by birth placement

Problem/disorder	Adoptive Family *N = 32*	Two Parent Family *N = 842*	Single Parent Family *N = 60*	*p*
Internalising				
Major depression/dysthymia	12.5	13.4	15.0	NS
Anxiety Disorders	18.8	11.8	16.7	NS
Low self-esteem	12.1	10.2	21.5	<.05
Suicidal ideation/behaviour	9.4	14.6	18.0	NS
Externalising				
Conduct/oppositional disorders	21.9	14.2	36.7	<.0001
Attention deficit/hyperactivity disorder	9.4	5.6	15.0	<.05
Self-reported offending (>10 offences)	28.1	20.3	42.6	<.001
Police contact	7.7	9.0	17.0	NS
Alcohol problems	12.5	6.6	11.5	NS
Daily cigarette smoking	21.9	14.0	31.7	<.001
Cannabis use	25.0	19.9	35.0	<.05

By **Dr Paul Mercer**
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Adoption

Table 2: Rates (%) of adolescent problem behaviours (12-17 years) and mean total problem behaviour scores by pre-placement care experience

Problem behaviour	Baby Adoptions *N = 122*	Good Start/Late Adoptions *N = 20*	Poor Start/Late Adoptions *N = 69*	*p*
Self-mutilation	2.5	0.0	5.8	NS
Eating problems	1.6	10.0	10.1	<.03
Lying	10.7	5.0	34.8	<.001
Truancy	7.4	10.0	17.4	.10
Expulsion from school	3.3	10.0	18.8	<.001
Running away from home	9.0	0.0	20.3	<.02
Drug use/alcohol abuse	4.9	5.0	10.1	NS
Thefts from home	9.0	5.0	32.0	<.001
Crimes outside home	13.9	0.0	32.0	<.001
Domestic violence	5.7	10.0	23.2	<.01
Mean total problem behaviour score (out of 10)	0.66	0.60	2.22	<.001

Table 3: Rates (%) of anger/hostility: referral to a mental health specialist; and insecure behaviour, poor concentration and academic performance during adolescence reported by adopters compared with type of adoption

Measure	Baby Adoptions *N = 122*	Good Start/Late Adoptions *N = 20*	Poor Start/Late Adoptions *N = 69*	*p*
High level of anger/hostility during adolescence	18.0	20.0	43.5	<.001
Referral to a child psychiatrist/psychologist	15.6	15.0	39.1	<.001
Upset/anxious reaction to major life change(s) before the age of 9 years	17.2	75.0	66.6	<.001
Poor concentration and learning problems at school	19.6	45.0	84.1	<.001
No passes at either GCE or GCSE exams before 17 years	18.9	35.0	64.0	<.001

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literature review Landsverk identified that between ½ and ¾ of children entering foster care exhibit behavioural or social-emotional problems warranting mental health care.

A 1998 paper by Collishaw *et al* documents and compares a range of problems from mental health to social pathology and poor education outcomes around adoption/fostering. *(See Table 1)*

While these problems require a team approach to support and heal, there will remain for many adoptees, existential stress. Who am I? Where do I come from? These are genuine questions where 'genealogical bewilderment' and low self-esteem from early attachment dysfunction play out.

"Best practice care today includes the thoughtful application of evidence in the context of a patient centred approach. For adoption/fostering this means considering the needs of the whole family unit."

With falling rates of children available for adoption in Western societies there has been a mirrored rise in the international adoption of children. These children can present unique physical and emotional health challenges. It is true that families preparing to adopt internationally should pay attention to infectious disease they may encounter and what precautions should be taken. Immunisation status can be unreliable depending on country of origin. Children may have TB, hepatitis B or C, measles, internal parasites, pertussis and even HIV. Many such children will also be under nourished.

The most common long term problems are "developmental and scholastic delay especially if these children come from long and severely deprived institutional settings, precocious puberty and during adolescence depressive disorders as well as anti-social behaviour.

It will be clear from the information provided that stress and the neuro-adaptive response required contribute significantly to the range of problems identified for children in care.

The impact for children caught in slavery or restricted to detention centres when part of an asylum seeking refugee family are distressing to contemplate.

As Bruskas has noted "most children in 'foster care', if not all, experience feelings of confusion, fear, apprehension of the unknown, loss, sadness, anxiety and stress." The author continues "such feelings and experiences must be addressed and treated early to prevent or decrease poor developmental and mental health outcomes that ultimately affect a child's educational experience and the quality of adulthood".

All experienced professionals will recognise this is true to experience.

Tarren-Sweeney adds these wise insights.

> *"Children in care have complex symptomatology that is not well represented in present classification systems. There is a need for research into the characteristics and meaning of these complex presentations, and some re-appraisal of present taxonomies. Clinicians should consider these difficulties in their entirety, rather than as discrete disorders. It is recommended that assessment and intervention are provided by clinical teams that have specialist knowledge of children in care, and that use an ecological approach to assessment."*

Best practice care today includes the thoughtful application of evidence in the context of a patient centred approach. For adoption/fostering this means considering the needs of the whole family unit. Evidence supports this with researchers finding that 'psychological support for the children and their carers is an essential secondary prevention strategy.' Others have shown that therapeutic intervention can 'simultaneously impact caregiver stress and buffer children from the negative impacts of care giver stress on HPA axis regulation.' Christian professionals seeking the integration of work and faith in love will want to intervene in this whole sense as Gramkowski *et al* have also shown that good intervention leads to harm reduction and the development of resiliency.

Many clinical challenges have been raised by the assembling of this evidence.

How should clinicians respond?

I offer some tentative suggestions.

- Get to know the nurturing and social context of all patients but particularly children.
- Practice patient centred care on the basis of the evidence available to us. This includes proactive care.
- Recognise the benefit of reframing adoption/fostering as a metaphor for life and be willing to gently explore this with patients.
- Team care is essential. Take time to understand referral pathways, be involved in case conferencing and advocacy as necessary.
- Include carers/parents in the circle of support.
- Maintain a gracious and hopeful presence whatever the problems or challenges to be faced.

By Trudy's Father
Name withheld to
protect her identity.

Stories & Questions

In 1973 I was a country GP. We had three children but with my wife's stormy obstetric history, it seemed wise to attempt no more, so we applied to adopt a Vietnamese child – as there had been many such children needing adoption. After a not very rigorous assessment (by present standards) we drove up to our state capital for a final interview, taking our two older children with us. On arrival we were asked "Do you still want to adopt a Vietnamese child?" We replied that we understood that the demand and opportunity were diminishing, and we had thought instead about adopting a child with a handicap (my wife being a physiotherapist we believed we could cope.) "Well, Trudy is a four-year old child who has been fostered. Her foster parents can no longer keep her – the wife had told her husband, "Either Trudy goes, or I do." The detection of a heart murmur in infancy had delayed arrangements for adoption. In fact for the first six months of her life she had been in a babies' home. For the last week Trudy had had her bag packed, waiting for someone to take her in. Would we like to take her home for the weekend, and see how we got on?

The idea of a child on approval was abhorrent, and in a step of faith we believed that though we had only come for an interview, the Lord had surprised us with a child. "Come back in half-an-hour and she will be here, with her case-worker." And so it was. As we went to the car the case-worker – whom we had discovered was a Christian, told us how she had been praying for a Christian home for Trudy. That conversation was an immense source of encouragement as we adopted Trudy into our family, and faced a long series of crises that tested our faith, our emotions and the strength of our marriage. After several consultations the child psychiatrist told us he thought she would be OK, so long as nothing happened to either of us. Then my wife died suddenly. There were further crises: twice she ran away, we had frequent calls from her high school, I recall an episode of drunken vomiting… until one day Trudy walked into the church office, and told our pastor she wanted to become a Christian. Much rejoicing!

In due time Trudy married a young man, the Youth Leader in his local church, and they had three children, the youngest of these now sixteen. At one stage she started to investigate her past, but did not have the emotional resilience to go through with it. It is another story about how the family stopped its active Christian involvement, and the marriage ended in divorce a year ago. But Trudy loved children, and had great skill in managing little ones.

Nearly two years ago she fostered a five-year-old boy of Aboriginal descent, who had suffered severe emotional and physical abuse. He could be a charmer, but his frequent destructive violence was more than she, her other children and the local school could cope with and recently she had most reluctantly to surrender him to state care – in this case shifts of workers in a motel room.

One of my sons has also fostered three children – taking them in middle childhood, and each of them showing the damage of early neglect or abuse – though details from the government department have been minimal. Discussions my son had with the Minister for the responsible government department were he felt, treated by the Minister purely for political point-scoring.

"We adopted Trudy into our family, and faced a long series of crises that tested our faith, our emotions and the strength of our marriage..."

Why do I tell these stories, (even though I have omitted so much detail)? Firstly to point out how many children there are who have been neglected or abused and who need to find a home where they can find consistent love and care.

Secondly to point out that there is a great emotional cost in undertaking such a task, but that it is a challenge to Christian families in line with the biblical injunctions about care for the needy, and for the 'little ones.'

Thirdly because our experience has shown there is serious under-funding and under-resourcing by at least this state government to deal with children in need.

Fourthly because I have been driven to wonder about the nature of the damage done in early childhood and its consequences. Increasingly there is evidence that there are changes in brain structure and working associated with poor early parenting. Is the damage reparable? Should we think of it as a neuro/psychological equivalent to more obvious physical handicap? What is the role of Christian faith and of conversion – especially in children who have never learnt trust, but only manipulation? Can we expect Christian faith to heal the scars, or are the children doomed always to be handicapped behaviourally and emotionally? Are these above all situations where we should seek divine-healing and not rest until it is enjoyed?

For me this is now largely academic. Trudy still shows some weakness that can be put down to her early life experience. She still finds it hard to face up to certain issues in her own life – and they are significant. She herself acknowledges she lives in denial. I can only love and support her as best I may – and rejoice that a mutual friend of long standing has recently been able to have input into her life with understanding.

Attachment – The

Recently I excised a skin lesion from one of my weather-beaten patients. 'Phillip' lives at a local marina. He has retired from a lifetime of getting mines and other projects to 'work'. He had a knack with big machines and an eye for suitable modifications. Phillip made a comment about his mother which prompted an enquiry about 'Christmas'. This had been spent alone. Hearing of this I told Phillip of my discovery of a new phrase 'genealogical bewilderment'.

As I excised the lesion, swabbed the blood and sutured the margins, Phillip told me of his family history. He loved his mother but had been unsuccessful in love himself. His parents had separated and Phillip's step-dad was angry and often violent. Phillip stood up to him so he was sent to boarding school. He now has no enduring relationship with siblings or step-siblings. Mum is dead. Phillip on one occasion discovered his father was in another city but a crisis for his mother overtook things. A deep unfulfilled longing for his father remains. Phillip's loneliness is the outcome of the many 'attachment' failures in his early life. 'Attachment' is crucial for human development. It is the glue that allows love to flourish.

Attachment is how we describe the relationship bond or connection between one person and another. It involves soothing comfort and pleasure between a child and a parent. Loss or threat of loss of such an adult evokes distress in the child. The child finds security and safety in the context of this relationship. Conversely 'empathy', caring, sharing, inhibition of aggression, capacity to love and a host of other characteristics of a healthy, happy and productive person are related to the core attachment capabilities which are formed in infancy and early childhood."

Bowlby (1982) provides us with a definition:

> *"to say of a child that he/she has an attachment to someone means that he/she is strongly disposed to seek proximity and to contact with a specific figure and to do so in certain situations, notably when he/she is frightened, tired or ill".*

60-75% of children in biological or adopted families demonstrate healthy attachment patterns. Studies also show 67% of foster families exhibit healthy attachments.

Dr Mary Ainsworth was a pioneer in the classification of attachment. The following table helps with clarification. *(See Table below.)*

Perry has noted other factors important in the development of attachment.

- Infant factors – the child's personality is important. An irritable child will interfere with bonding as will medical conditions.
- Care giver is critical, rejecting and interfering parents tend to have children that avoid emotional intimacy. Abuse, depression, substance abuse etc. are important factors.
- Environment fear in the context of violence, war, refugee status and chaos predispose to attachment problems.
- Fit. The fit between the temperament and capabilities of infant and mother are crucial. This can be described as 'attunement' and includes the reading and responding to the cues of another, synchronous and interactive, can be taught and helps prevent a mismatch between need and provision.

When children have been mistreated by adults they can see adults as being scary, keeping secrets and unsafe. This might mean that the child sometimes behaves in a rejecting, hostile or withdrawn way toward an adult (doctor/dentist).

Van den Dries *et al* observe that "children whose attachment signals are met by sensitive care givers

Classification of Attachment	Percentage at one-year	Response in strange situation
Securely attached	60-70%	Explores with M in room; upset with separation; warm greeting upon return; seeks physical touch and comfort upon reunion.
Insecure: avoidant	15-20%	Ignores M when present; little distress on separation; actively turns away from M upon reunion.
Insecure: resistant	10-15%	Little exploration with M in room, stays close to M; very distressed upon separation; ambivalent or angry and resists physical contact upon reunion with M.
Insecure: disorganised disoriented	5-10%	Confusion about approaching or avoiding M; most distressed by separation; upon reunion acts confused and dazed – similar to approach-avoidance confusion in animal models.

By **Dr Paul Mercer**
Paul is the principal GP at Manly in Queensland. His practice is situated in the context of a Christian family welfare organisation called Silky Oaks Children's Haven.

Glue of Love

develop an internal working model of a safe and responsive world. In contrast, children who are responded to in an insensitive way may picture the world as an unpredictable place and they may not feel worthy of love." The author goes on "adoption may be seen as an effective intervention offering children who lack the care of their birth parents the chance to develop more secure attachment relationships".

On the negative side "disorganised attachment in infancy was the best predictor of adjustment in adolescence and at the beginning of adulthood, even after taking into account SES, parental adjustment and other factors." *(Minnesota Longitudinal Study).* In addition Moss *et al* has shown that disorganised attachment in preschool age is particularly resistant to change.

In practice, attachment difficulties appear to have an intergenerational transmission. There is solid research to substantiate this. Indeed Cole *et al* have demonstrated that "care givers with their own unresolved loss or trauma unconsciously display 'frightened' (over anxious, monitoring/hyper vigilance) or 'frightening' behaviour (faces, tone of voice or actions) when the child seeks the care giver for safety and nurturing, the care giver is perceived as frightening by the child." Problems are likely to ensue.

Spiritual Significance

Many of these facets of attachment have spiritual significance. If God adopts us in Christ, the attachment is vital for healthy spiritual growth. David Augsburger describes our relationship with Jesus as 'radical attachment'. He says "radical attachment to Jesus is not believing something about Jesus (a pietistic experience), or believing in Jesus (a conversionist experience), but believing Jesus (in discipleship) and believing what Jesus believed (in imitation). So, as he believed, love of God, love of neighbour, and becoming one's true self are three indivisible sides of the primary spiritual triangle".

Augsburger draws on important New Testament themes in this definition. Christians understand with the apostle Paul that salvation, new birth, adoption are words which describe our spiritual new creation by grace through faith in Jesus. Through the death of Jesus, God initiates a reconciled relationship with humankind. Attachment to our "adoption" draws us on to imitate Jesus as we accept the call to follow each day.

'Imitation' is a way for Christians to converse about our mutual attachment as brothers and sisters of Christ. New birth is similar in impact to adoption in family life. As we experience the love and faithfulness of God, the Holy Spirit helps us

internalise this as we grow as Christians. The Apostle Paul regularly returns us to this way of thinking by regularly using an 'As-So' paradigm as he exhorts us to 'put off' our old life and 'put on' Christ. Consider these examples.

As God has called each, so let each walk. (1 Corinthians 7:17)

As Christ was raised from the dead, we might also live anew. (Romans 6:4)

As Christ accepted us, so we should accept one another. (Romans 15:7)

As you received Christ Jesus as Lord, so walk in him. (Colossians 2:6)

As God in Christ has forgiven us, so we should forgive one another. (Ephesians 4:32)

As we have worn the likeness of the man made of dust, so we shall wear the likeness of the heavenly man. (1 Corinthians 15:49)

We have arrived at this place. As Christians we recognise our 'adopted' state in terms of God's family. We also recognise that as Jesus lived in imitation of the Father, so our life as disciples is to imitate him. Healthy spiritual attachment should outwork in healthy relationships in our life-work circles. Adoption becomes a powerful way for Christian doctors/dentists and others to think through what it means to integrate our life, work and faith.

Protecting Children

Living and working in this outback town, I have friends who are foster carers to Aboriginal children, and I have looked after Aboriginal patients who are under foster care. I also know of Aboriginal children being taken away by 'Welfare', the name given to the Child Protection Services and put into foster care, and the despair it brings to the family whose child is taken away, bringing back memories of the Stolen Generation. I didn't really understand the despair, the anger, the helplessness and the bewilderment until recently.

It was Sunday morning and I was standing at the back of the church. My friend Mary came to me, and instead of saying hello, she put her arms around me as if to give me a hug, and she whispered to me "Welfare came and took away Johnny and Ben." I didn't think I heard it correctly, but she repeated it: the Child Protection Services had come to take away her two grandsons Ben, aged 5, and Johnny, aged 10. I gasped. I went outside with Mary and I sat and cried with her.

"...the Child Protection Services had come to take away her two grandsons Ben, aged 5, and Johnny, aged 10."

In less than two years, I had gone through a lot with Mary. I cried with her when her cousin died in a tragic car crash near their house. I cried with her nine months later when her sister was killed in a hit and run incident. When Ben was repeatedly turning up at church hungry due to lack of food at home, I talked with Mary about how to shop more wisely. When Mary's daughter attempted to hang herself a few weeks previously, I attempted to counsel Mary. And now, Welfare had come to take her grandsons away, and I was the first person at church whom she told.

When I finished crying, my medical training took over and I snapped into history-taking mode and I began questioning Mary about various aspects of the boys' lives: health, education, safety and nutrition. Mary and I could identify nothing that would trigger the removal of the boys. A few days previously, I had given Mary and Johnny a mini lecture on why he should go to school; he was one of the many kids in this town who regularly skipped school. But if Welfare removed kids who skipped school, then a large proportion of Aboriginal kids in town also ought to be removed from their families. Mary's family live in difficult circumstances in the slums of town, with intoxicated adults around all the time, and where violence is not uncommon. But if Welfare removed kids who lived in those circumstances, then probably half of all the Aboriginal kids in this town ought to be removed from their families.

Mary then told me on Monday at 9:30am there would be a meeting at the Welfare office. I immediately offered to attend with her.

Soon the pastor came to find out why I was crying and then talking intently with Mary. Mary explained the situation to the pastor, and he also offered to attend the meeting with Welfare the following day.

I told Mary: "make sure everyone in the family takes a shower and wears clean clothes for the meeting". It is the twenty-first century, and I was disgusted that I felt compelled to give this advice to an Aboriginal family in hope of their being deemed worthy to raise their own children.

That afternoon, after emailing my prayer supporters, I went online to read the child protection legislation, which I then emailed to the pastor. I couldn't see how the removal of the boys met the legal criteria for allowing such an event to occur. And I prayed as I went through my usual Sunday afternoon activities.

The next morning, after a quick explanation to my colleagues about why I was ducking out for a while, I met the pastor and we drove to the Welfare office – the Child Protection Services. The pastor and I did not know what to expect, but we tried to discuss some vague strategies to attempt to get Ben and Johnny back to their family.

We were relieved that the family had all shown up: Mary was there with her husband Richard, and their two daughters; one of their daughters is the mother of the two boys, and the other also helps raise them. I suspected that probably no family had ever brought a pastor and a doctor along to a meeting with the Child Protection Services.

We all waited outside the building until we were called in to the conference room. The room had no windows and the door had a security lock so it could only be opened from the inside. Richard looked curiously all around the room, clearly showing that he had never been inside such a room before. The family, flanked by the pastor and me, sat on one side of the large conference table, and the two child protection officers sat on the other side.

The officers first asked all of us to introduce ourselves. When my turn came, I said that I was a doctor, but I emphasised that I came in my personal capacity as a family friend who had never been a doctor for anyone in the family. Once the introductions were over, one of the officers noted that the pastor was present, and asked him to open the meeting in prayer; I was pleasantly surprised.

The officers described the circumstances leading to the removal of Johnny and Ben. Johnny had told his teacher that a teenage cousin had pushed him over,

from Whom?

By **Dr Nyalpi Nungarai**
Nyalpi is a member of CMDFA who lives in a remote outback town and works in the public healthcare system. She would be pleased to be contacted through the editors of Luke's Journal.

causing a little bleeding to his knees and lip. The teacher informed the Child Protection Services, who began to investigate what they termed an 'assault'.

I was horrified. **How could a case of an older boy pushing over a younger boy be labelled an assault? How could a teacher report a case of rough play between two boys to the Child Protection Services? How could this lead to the boys being removed from their family?**

The officers continued. While the Child Protection Services were investigating the case of 'assault', they discovered that Johnny and Ben had contact with someone who had a criminal history against children. So the Child Protection Services decided on that Friday afternoon to remove the two boys from their family and put them into foster care.

The pastor asked who this person was. The officers revealed that he was Mr. Z, who is not related to the family. Both the pastor and I knew him. Mary and Richard stated that Mr. Z had been living in their house as part of the family for about twenty years, and they were confident that Mr. Z was kind to the boys. They knew that he had a criminal history, although no one in the family, nor the pastor, nor I knew the details of the crimes, nor when they were committed. I was surprised that even the child protection officers did not seem to know any details of the crimes.

Mary and Richard volunteered information about their living circumstances. They spoke clearly about their long-term positive relationship with Mr. Z, and they recognised that though he sometimes went through difficult periods, they never saw him as a

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threat to the boys. The pastor and I chimed in as often as we could to attest to the fact that Mary and Richard are responsible heads of the households, who abstain from alcohol, who regularly participate in church activities, and who know to seek help from me, the pastor, or other people if ever they have concerns about the family.

Mary had tears in her eyes as she told the officers how upset she was that her grandsons had been removed without consulting her.

Throughout all of this, the child protection officers spoke fast and used jargon that clearly Mary and Richard did not understand. At one point I stopped the conversation and then explained some things to Mary and Richard using my best Pitjantjatjara and simple English.

"The Child Protection Services are constantly advertising for more foster carers, but yet here was an instance where two boys were unnecessarily removed from their loving family and put into foster care for three nights."

After much talking around the table, the child protection officers determined that Johnny and Ben were safe to be returned to their family. To my surprise, I was asked to close the meeting in prayer. We were let out of the conference room and we waited outside while one of the officers went to pick up the boys from the foster carer.

Finally, the car pulled up and the two boys got out. We were all relieved to see Johnny and Ben again, and Mary was the most overt in her relief, giving me and then the pastor a hug. Mary tried to have her grandsons say 'thank you' to the pastor and I, but they were too shy and also too interested in climbing a tree. I noted that Johnny showed no signs whatsoever of his alleged 'assault' – knee and lip lacerations from being pushed over – that triggered all of this.

So Johnny and Ben were now reunited with their family after over two and a half days apart. I felt that we had won the case after the one and half hour meeting. But I was fuming inside.

Both these boys are very shy – they hardly speak to me even though I see them almost every week. I cannot imagine what fear must have gone through their minds as they spent the weekend in a complete stranger's house, and I worry about what long-term psychological damage might result. As upset as I was, what I felt must only have been a fraction of the anguish of what Mary, Richard and the rest of the family felt that weekend without the boys.

I could not – and I still cannot – believe that on a Friday afternoon the Child Protection Services removed the boys from their family without any strong evidence of harm or potential harm. I have read the legislation that allows for children to be removed from their families urgently if certain conditions are met, and in Johnny and Ben's case, I am not at all convinced that those conditions were met. All the concerns they had about Mr. Z's involvement with the family were quickly dispelled in that Monday morning meeting – if Mary and Richard had been asked their opinions on Friday, then probably the Child Protection Services would not have seen the need to put the boys into foster care.

I am angry that during the meeting, Mary and Richard would not have understood what was being said to them if I had not been there to translate. Interpreters should have been offered, though I am well aware that Aboriginal interpreters are in extremely short supply.

I am in disbelief that the Child Protection Services are constantly advertising for more foster carers, but yet here was an instance where two boys were unnecessarily removed from their loving family and put into foster care for three nights.

Even if the Child Protection Services had sufficient reasons to remove the children, there were better options: the pastor and his wife or another family from our church would have gladly looked after the boys for the weekend, and they need not have stayed with complete strangers.

I shudder to think how many children are removed from their families unnecessarily every week, where the family struggles to understand why it is done. I am disgusted to think what happens when the family does not have a doctor and a pastor to vouch for them.

I have heard about the inadequacies of Child Protection Services in various parts of Australia, and now I have had a first-hand glimpse of those inadequacies.

I am still upset that all this has happened, though I have refrained from revealing my thoughts to Mary and Richard who are illiterate and would not read the child protection legislation. I feel they have been traumatised enough by this event, and pursuing a complaint against the Child Protection Services would probably force them to relive their pain and divert their energies from providing a loving home for their grandchildren under difficult circumstances.

As for myself, I see so much injustice here and I see such a huge need for advocacy that often I don't really know where to start or where to stop. I need to ration my own time and energy outside my paid work as a doctor to do other things – at the moment I am pursuing a complaint on behalf of another Aboriginal friend who has been treated appallingly by another government entity. And I'd better focus my time and energy on somehow assisting Mary, Richard and their family in bringing up Johnny and Ben to be healthy and responsible Christians in a dysfunctional society.

Lord have mercy.

All the names have been changed to protect the people mentioned in this story.

Stolen Generation

By **Robin Young**
Robin is an Aboriginal Mental Health Worker. She is an Aboriginal artist and a volunteer Aboriginal community worker. She has a BA in Community Welfare.

The forced removal of Aboriginal and Torres Strait Islander children from their families has had, and is still having, a profound psychological impact on these communities. The 'White Australian' assimilation policies were practiced from 1909 to 1969. However, the practice took place both before and after this period, and involved governments, churches and welfare bodies.

Under the White Australia and assimilation policies, Aboriginal and Torres Strait Islander people who were 'not of full blood' were encouraged to become assimilated into the broader society so that eventually there would be no more Indigenous people left. At this time, Indigenous people were seen as an inferior race.

Children taken from Aboriginal parents so they could be brought up 'white' were taught to reject their Aboriginality. They were placed in institutions and, from the 1950s, began to be placed with white families. Aboriginal children were expected to become labourers or servants, so the provision of education was poor. In particular, Aboriginal girls were sent to homes established to be trained in 'domestic service'. It is estimated that 100,000 Indigenous people have been affected by the policy of removal.

The practice of talking babies from their mothers soon after birth demonstrated a lack of concern for the mothers who had carried the babies for nine months. What an emotional and devastating effect this would have on these poor young women, as well as the fathers, siblings and grandparents! There was little or no hope of ever seeing their loved one again. If anyone tried to hide their children the government would use all means to hunt down and collect the children, and take them to centres thousands of kilometres away. Families would even be divided up so that connection would be difficult or even impossible. Because of this policy, the Australian Aboriginal and Torres Strait Islander people had become one of the most disadvantaged groups in Australia.

The impacts of these policies were acknowledged in a public apology by the Prime Minister Kevin Rudd's motion to parliament on February 12th, 2008:

> *"We apologise for the laws and policies of successive parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians".*

The psychological impact of these massive traumas can be seen from the loss of secure attachments for a child, to loss of identity, language, rituals, sense of belonging and customary life style.

Given the distressing history of these laws and policies, Aboriginal people can find it difficult to trust a non-Aboriginal person in disclosing their personal stories. In particular, Aboriginal children are often taught not to trust government services and to keep family secrets from 'White Australia'.

From the perspective of Indigenous Australians, mental health, and social and emotional well-being are part of a holistic understanding of life that encompasses not only the well-being of the individual, but also the well-being of their family and community. Social and emotional well-being refers to more than simply the presence or absence of illness. It also incorporates a 'strengths' perspective that refers to the wellness of the individual, encompassing mental, physical, cultural and spiritual health. When this harmony is upset we experience ill health and the many associated problems.

Aboriginal people relate to the land, the country and their genealogy, so when dealing with them it is important to be aware of these connections. Most important is the art of empathic listening to gain the trust of individuals and their families. Confidentiality builds confidence in the health team as we all work together for the person. Follow up can win the respect of one's clients. For a person with mental health problems, little things can help, such as transport to doctors, hospitals, ensuring adequate food and housing, and making sure the individual takes their medication regularly.

The concept of 'sharing and caring' is an integral part of Aboriginal culture, and connection to the community is important.

These practical hints can be helpful in dealing with Aboriginal Australians:

- don't use direct eye contact – they may consider it rude.
- self-disclosure (in the best interest of the client) can develop trust and a good therapeutic relationship.
- refer to older persons as 'Uncles' or 'Aunties' – ask permission first.
- their spirituality can be an important part of their recovery.
- use simple and plain speech and be more informal.
- explain medical and psychological language to them.
- don't get offended if they swear.
- ask if they would like someone with them while you converse with them.
- Aboriginal people have Men's business and Women's business.
- walk with the person who is sick.
- don't promise things that you cannot deliver, have boundaries.
- don't use a dead person's name without permission.
- help families with 'sorry business'.
- help people to find their families through 'Link-up'.
- observe Aboriginal ways of dealing with death.
- help families to attend funeral.
- practice holistic mental health care with a focus on prevention as well as treatment.
- arrange for home visits.
- make arrangements for people to meet with other people – to have a 'yarn up'.

The Stolen Generation

The long-term factors associated with removal from parents amongst Indigenous prisoners in NSW

Recent interest in the 'stolen generation' has focused on estimates of the numbers of children removed from their parents and the long-term consequences of removal.

In 1996 we collected physical and mental health information on a representative sample of 789 inmates in NSW correctional centres. Participants underwent infectious diseases screening and an extensive face-to-face interview examining a wide range of physical and mental health variables. Included in the sample were 235 Indigenous inmates who were asked whether they had been removed from their parents as a child. Information on removal from parents was available for 198 of the 235 (84%).

Sixty-eight inmates (34%) reported that they had been removed as children. The median age of removal was 5 years (range = 0 to 15), with 82% reporting removal under 10 years of age. A higher proportion of female Indigenous prisoners had been removed than males (56.5% vs. 31.4%), and removed Indigenous prisoners were more likely to be in the 25 to 40 years age range than not removed prisoners.

Table 1 compares the findings from Indigenous inmates removed as children with those who were not removed. In terms of long-term social and mental health indicators, the removed prisoners were significantly more likely to have been imprisoned on more than 5 previous occasions (35.8% vs. 17.1%), to have been subject to child sexual assault (30.9% vs. 11.5%), and to have attempted suicide in the past (38.2% vs. 20.8%).

"...separation from parents during childhood may be an additional and important factor to be taken into account in assessing the relationship between the economic, social and cultural disadvantage experienced by Indigenous Australians..."

These data do not allow firm conclusions to be drawn as to whether the policy of removing Indigenous children from their parents caused these adverse long-term findings. However the significant association does at least suggest that separation from parents during childhood may be an additional and important factor to be taken into account in assessing the relationship between the economic, social and cultural disadvantage experienced by Indigenous Australians and adverse physical and mental health outcomes.

These findings are consistent with other research. The findings on imprisonment are consistent with the findings from the ABS survey which found that Indigenous people removed in childhood had almost double the imprisonment rate of those not removed. The proportion of removed children in the present study (34%) is consistent with the proportions reported in the research reviewed in the Human Rights and Equal Opportunity Commission (HREOC) report (30-33%). The inflated levels of child sexual assault and suicide attempts found in the present study are almost in agreement with the findings reviewed in the HREOC report.

The present study sheds no light on the reasons for the separation. The fact that 82% of the removed Indigenous prisoners were removed before the age of 10 years suggests that juvenile justice proceedings were not a primary reason. The age of criminal responsibility in NSW is 10 years. The HREOC report documented the over-representation of Indigenous children in removals for welfare reasons which in most jurisdictions were not subject to adequate legal review. The report noted that even as late as the 1980s Aboriginal children were being separated from their families in large numbers, although the dominating force has shifted from assimilation policy to contact with the child welfare and juvenile justice systems.

The findings from the present study suggest that the possible long-term consequences of such policies may be far reaching in terms of the effect on the health of Indigenous Australians and clearly indicate a need for further research.

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By **Sandra J Egger** *(Law School, University of NSW, Sydney)*
and **Tony Butler** *(AIDS and Infectious Diseases Branch, NSW Department of Health)*

– Consequences

Table 1: Univariate odds ratios for factors associated with removal from parents as a child in NSW Indigenous prisoners.

Risk factors	Removed n	Removed %	Not Removed n	Not Removed %	Odds Ratio	p-value
Age <25	20	29.4	59	45.4	1.0	
Age 25-40	37	54.4	49	37.7	2.2	0.02
Age <40	11	16.2	22	16.9	1.5	0.4
Education status – No schooling	41	64.1	79	63.2	1.0	
Education status – School certificate/Trade qual.	16	25.0	42	33.6	0.7	ns
Education status – Tertiary/Professional qual.	7	10.9	4	3.2	3.4	ns
Previous imprisonments 1-5	43	64.2	107	82.9	1.0	
Previous imprisonments >5	24	35.8	22	17.1	2.7	0.003
Psychiatric treatment – No	40	58.8	92	70.8	1.0	
Psychiatric treatment – Yes	28	41.2	38	29.2	1.69	ns
Suicide attempts – No	42	61.8	103	79.2	1.0	
Suicide attempts – Yes	26	38.2	27	20.8	2.36	0.008
Self-harm – No	51	75.0	105	81.4	1.0	
Self-harm – Yes	17	25.0	24	18.6	1.5	ns
Depression – Nil	40	61.5	79	63.7	1.0	
Depression – Mild	16	24.6	26	21.0	1.2	ns
Depression – Moderate/Severe	9	13.8	19	15.3	0.9	ns
Alcohol consumption – Safe	3	6.1	17	16.5	1.0	
Alcohol consumption – Harmful/hazardous	46	93.9	86	83.5	3.0	ns
Injecting drug user – No	9	20.9	24	30.8	1.0	
Injecting drug user – Yes	34	79.1	54	69.2	1.7	ns
Childhood sexual abuse – No	47	69.1	115	88.5	1.0	
Childhood sexual abuse – Yes	21	30.9	15	11.5	3.4	0.001
Self-assessment of health – Good/very good/excellent	50	73.5	97	74.6	1.0	
Self-assessment of health – Fair/poor	18	26.5	33	25.4	1.06	ns

Healthy, Wealthy and

Business Ethics and Healing Professions

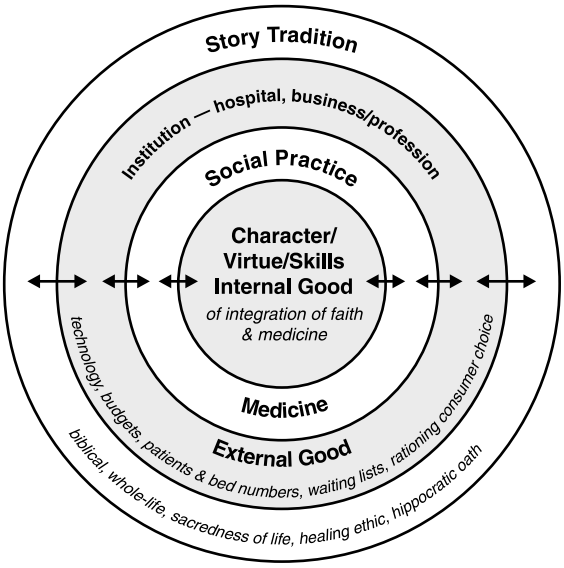
Many in the professions feel tension between business imperatives and their professional identity. Lawyers' jokes aside, a classic case of abandonment or subordination of professional identity to commercial imperative is the ambulance-chasing lawyer. And there are enough, especially in the US, to justify the stereotype, for there is a certain connivance between the medical, legal and insurance industry professions. Yet where would the ailing James Hardie workers be without Slater and Gordon?

Another question in increasingly commercialised professions and internet democratisation of knowledge is, is the customer/consumer always right? I am well-informed that in mental health in Victoria, consumer is the preferred term to patient and client, seen as too passive and patronising and unequal. But where does that leave the professional? What is it to be a professional or a patient/consumer in an increasingly commercial context where you can always shop around?

To answer these questions we will first ask what is medicine and what is business? And what are the constitutive virtues or character traits of these respective institutional contexts? For without examining this, talk of the calling or vocation of the Christian health professional may be mere whistling in the dark. To do so we will look at what leading ethicists like Alasdair MacIntyre and Hans Reinders say about these institutional issues and apply their theoretical framework to contemporary case studies like the James Hardie case and the challenges facing Christian health professionals and the Catholic health system in general as well as specifically in relation to the consumerising of health care in the absolutising of choice in relation to e.g. euthanasia by a Philip Nitschke.

I will assume what I wrote in *Luke's Journal* in August 2005 refuting the Sunday-Monday gap between the professional's faith and work. This sacred-secular divide can lead to the situation captured well in the doggerel: 'Mr(s) Business went to church, that's what they did on Sunday, Mr(s) Business went to hell for what they did on Monday'. Increasingly, Mr or Mrs Business may wear a medical mask.

Alasdair MacIntyre seeks to unmask those who practice economics or emotivist manipulation in the guise of ethics. He is a former Evangelical, Marxist, Aristotelian now Thomist (after St. Thomas Aquinas) Catholic philosopher. MacIntyre's seminal *After Virtue* has brought the Aristotelian and Christian virtue tradition, back into centre-stage since 1982. This is particularly significant for medical ethics, opening the way to an ethos of character, derived from its story or narrative, in a profession increasingly caught between the ethics of principles (Beauchamp and Childress)[1] or of utilitarianism (Peter Singer).[2] MacIntyre sees that the ethics of any human practice, from playing chess to medicine, can be seen in terms of the internal goods or virtues it generates as part of a social practice, and the necessity for, but tension with its institutional context of external goods like budgets, numbers of using services etc. It is the classic interplay between ethical ends and sometimes unethical means. What is needed to maintain the integrity of a professional practice is repeated ritualistic and rational reference to the narrative or tradition in which individuals, professions and institutions find their character, not as mere choosing individuals in a whirlpool of consumer choice. MacIntyre's model is simplified and applied to the practice of medicine in the diagram below.



The James Hardie asbestos case shows in extreme form the evil effects when a business is so fixated on its institutional end of giving good returns to its shareholders that it ignores the health needs of its stakeholders. Hardies could not plead ignorance: "the pathological effects of asbestos had been observed in Europe as early as 1912, and by 1960 British health authorities had confirmed that blue asbestos caused mesothelioma". The 1999 Dust Diseases Tribunal found that Hardies knew from 1938 that asbestos dust was a health danger. Hardie director Jock Reid received that article with a company officer's note on it "I do not think there is anything in this which we do not already know." Yet it was not until 1977 that appropriate warning labels

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Wise?

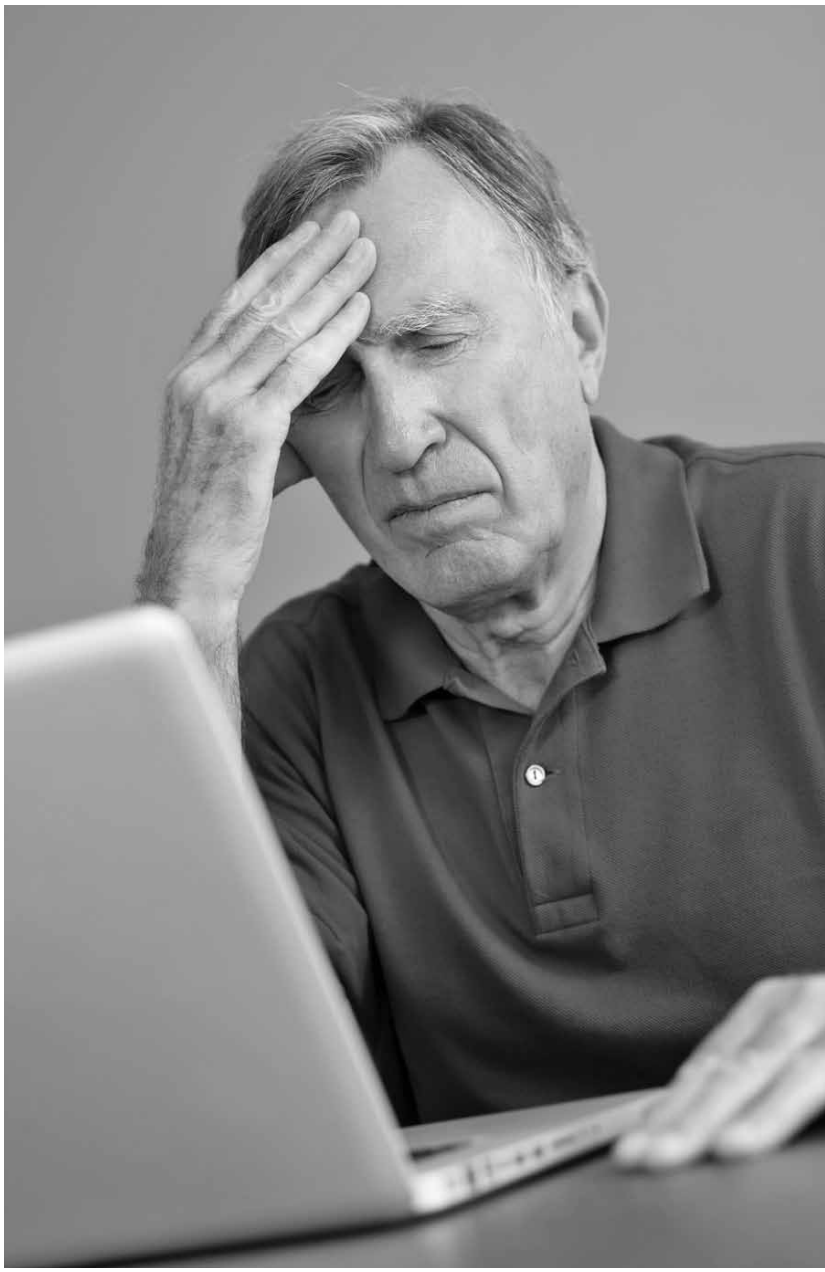
… cautioned that "breathing asbestos dust may cause serious damage to health including cancer". The first public liability claim was heard in 1980.[3] As Red Herrick says: "The truth about asbestos has been clouded for decades by vested interests and by paternalistic authorities... The asbestos issue has been just another industrial status-quo time bomb, tolerated and ticking for far too long… The current focus on a handful of red-handed scapegoats should not reduce the culpability of governments and medical authorities in a systemic industrial crime."[4]

The Hardie case highlights the paradox of modern corporations, capable of doing enormous good, providing innovative products, jobs, wealth and doing immense harm by being focused on their external, economic goods. As Leon Gettler writes: "if James Hardie was a person it would risk being diagnosed as a psychopath."[5]

Dr Hans Reinders of the Free University of Amsterdam shares many of MacIntyre's concerns expressed above. For Reinders, the contemporary commercialising of the professions, and in particular medicine, makes the professional into a mere cipher of the consumer's choice – the customer always knows best. With the power to shop around for medical knowledge either on the Net or among a vast array of alternative therapies, the position of the all-powerful professional as part of a monopolistic profession has been weakened. In medical ethics as MacIntyre noted, the axiomatic position of autonomy – the consumer's choice – has been used as a safeguard to protect us against unbearable burdens such as all-powerful professionals and technologies keeping us plugged in as 'vegetables' as part of a doctors' narrative to never be beaten by death or an inopportune or unchosen pregnancy interrupting our life or career plans.[6]

The more obvious recent examples are of Catholic doctors in Victoria having their consciences compromised by not being allowed to refuse to do abortions. This was partly due to the Catholic Church opting out of the Charter of Human Rights and Responsibilities which would have safeguarded doctors' rights to refuse to abort under freedom of religion and conscience provisions. But these are merely the more extreme examples of the marketisation of medicine increasingly absolutising the autonomy of the consumer at the expense of the professional.

Another example, fortunately outlawed by the Howard government, was euthanasia zealot Philip Nitschke's attempt to sell suicide pills on the net,



"…the customer always knows best. With the power to shop around for medical knowledge either on the Net or among a vast array of alternative therapies, the position of the all-powerful professional as part of a monopolistic profession has been weakened."

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regardless of whose under-age hands they might fall into. Michael Cook correctly depicts Nitschke as having adapted to the new market environment. Now he services people who are simply tired of life and wish to die. In effect, he has reinvented himself as a universal suicide provider. Nitschke seized an opportunity to market his weird gizmos over the internet: the Deliverance Machine, the Exit Bag, the CoGenie and the Peaceful Pill. Nitschke is… another huckstering prophet of consumer technology. Instead of doctors – or politicians or legislation – calling the shots, dying will become democratised... This heightened level of autonomy will open up new choices to the ordinary person…. At the heart of Nitschke's proposals is a notion of personal autonomy that is remarkably like the Cloud Cuckoo Land of the perfectly rational consumer…"[7]

"Balancing the imperatives of medical profession, tradition and character versus the institutional constraints of commercialisation, efficiency and cash is an increasingly difficult but not impossible act."

Behind these more borderline cases that Christians often focus on are examples drawn from the commercialisation of everyday institutional practice of medicine that can lead to a loss of Christian and professional character. About fifteen years ago a Christian doctor and friend told me of the unsatisfactory process, from his perspective, of the changes to a leading Catholic hospital where he once practised. He described how in the takeover of the hospital administration to rescue it financially, the gold-framed paintings of the hospital's founders were removed from prominence to gather dust elsewhere on the grounds that they didn't match the new corporate grey of the re-painted walls. For him this was symptomatic of the hospital having lost its tradition or narrative embodied in the character of its founders.

I have often compared this negatively with my orientation experience at Fuller Seminary in 1990 in Pasadena where its renowned President, David Hubbard, had all the paintings of the founders of Fuller taken down from the walls where they were prominently displayed in the McCallister Library. They were not deposited in some dusty cupboard however. He used them to give an inspiring but warts-and-all narrative of Fuller that made me proud to be part of such a saintly but self-critical place of learning.

But before leaving you the sense of simplistically lambasting that Catholic hospital I must say that Ridley College Centre for Applied Christian Ethics, which I directed, put on a conference on healing the health system at which we had the CEO of that Catholic hospital speak and where my doctor friend was present and asked questions. It was, he said, a healing experience. Both sides of the story began to be heard, the maintenance of a medical tradition and the business imperatives of survival.

Another time, in Adelaide, when speaking of the significance of narrative and character against the monotone of market voices, I was using Michael Goldberg's helpful question-based approach of tracing the traditions and the founding saints which shape our story and character across different contexts.[8] A group of nursing nuns said that's exactly what they do in their hospital. When interviewing prospective nurses, those who knew its story and values when founded by Mary Potter were those who were employed and charged with carrying on its story of compassion for the poor and mercy to the dying. Balancing the imperatives of medical profession, tradition and character versus the institutional constraints of commercialisation, efficiency and cash is an increasingly difficult but not impossible act.[9]

Conclusion

I have only touched on a sample of the tough issues at the intersection of business and healing. If I have put more emphasis on maintaining the practices and profession of medicine in this context I would not want to give the impression, especially as the son of a small businessman, that I somehow think that business is intrinsically bad. Far from it as my book on *Christianity and Entrepreneurship* shows.[10] In fact there I argue that business should not be looked down upon by the 'higher' professions, because it is tainted by filthy lucre, but should be made more professional, for Christians in the light of the profession of Christ. Like all human institutions and principalities and powers business needs to be framed within the creation, fall, redemption and transformation narrative of scripture to find its servant character as do the established professions, especially the most sacred, like medicine. They too can be too heroic, utopian, failing to see that they are frail and fragile, necessary for this fallen world, enabling us to be patients, not consumers experiencing heavenly autonomy now, while we patiently await the day when every tear will be wiped away.[11] Because of this the term patient is far preferable to consumer or alternatives, as long as doctors also practice it.

References

1. *Principles of Biomedical Ethics (Principles of Biomedical Ethics* by Tom L. Beauchamp and James F. Childress, 5th ed. Oxford University Press, New York, 2008.
2. See G.R. Preece ed, *Rethinking Peter Singer*, IVP, Downers Grove, 2002.
3. *The Age*, Sept., 2004, Business, 4. *The British Journal of Industrial Medicine* reported in 1966 on an epidemic of 76 deaths by mesothelioma, a rare lung cancer, at a London hospital, mostly of asbestos workers.
4. Ibid.
5. 'Oedipus wrecks', *The Age*, 28/8/04, Review 1-2. Now in Leon Gettler, *Organisations Behaving Badly: A Greek Tragedy of Corporate Pathology*, Milton Qld: John Wiley & Sons, 2004. The book, now documentary *The Corporation* ed. and directed by Joel Barkan *et al*, systematically applies the WHO description of a psychopath to the corporation, but giving the false impression that corporations, not other institutions, are uniquely evil.
6. Hans S. Reinders, 'The Commodity of Care', *Zadok Paper* S117, Autumn, 2002.
7. See Michael Cook, 'In Nitschke's Hands: Has voluntary euthanasia been transformed from a philosophy into an open-source business venture?' *Arena Magazine*, no. 80, Dec-Jan 2005-6, 36-39.
8. M. Goldberg, ed. *Against the Grain: new Approaches to Professional Ethics*, Trinity Press International, 1993, 193-94.
9. See Sisters Mary Byrne and Maria Cunningham, 'Health Care and the Market', on St. Vincent's Sydney to hear a group of nuns administrators valiantly juggling their Christian values and institutional constraints, both business and ecclesiastical, in Simon Longstaff and Gordon Preece ed. 'Compassion, Charity and Conscience', *Interface*, vol. 3, no. 2, Oct. 2000, ATF, 50-69.
10. With Samuel Gregg, Centre for Independent Studies, St. Leonards, 1999.
11. See Stanley Hauerwas's wonderful essay 'Practising Patience: How Christians Should be Sick' in part II, *The Hauerwas Reader*, Duke University Press, 2001.

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The Phone Rang

The phone rang. My health worker colleague conferred that the daughter of a well-known patient was distressed and wanted to talk. The patient, who had been unwell for several years, was recently admitted to hospital. Both the father, who was the patient, and his daughter had struggled on with admirable courage and a quiet dignity. Both held a deeply rooted determination to live the life that they shared to its fullest while recognising the limitations and restrictions imposed by the significant medical challenges faced by the father.

My thoughts returned to an earlier conversation held with a colleague only a few days before. We were reflecting on the paucity of stories related to courageous, loving and supporting families that continue to provide compassionate care to valued family members while their illnesses and frailties were increasing.

End of life is a time of uncertainty and ambiguity. Great changes are taking place in the lives of all affected by the deteriorating health of a family member or friend. Some manage these changes with great difficulty and confusion. Others are able to reflect on their own personal life lived in its completeness and continue to be gracious, stoical, funny, amusing, obtuse, difficult or quiet according to their natural way. They will live their last days much as they have lived their middle days and their early days.

And so I reluctantly picked up the telephone. The daughter was distressed. Her father's admission for a recurrent infection had this time ended in a different outcome to all previous admissions. Her father had died. The daughter was proud of her father's courage and determination. I was able to reassure the daughter that she had done all that was possible. And now a time was beginning of grieving and pain associated with the death of a family member who had been unwell for a long time, who had struggled on with perseverance, determination and grace and had finally reached the end of his race.

Medicine has for hundreds of years been influenced by Hippocratic and Judaeo-Christian underpinnings. These underpinnings highlight the call to do no harm, and the ideal of compassionate and competent care. Our new medical technologies bring many complex possibilities into the trajectories of illness and death. The rise of patients' rights and strengthened awareness of patient autonomy are valuable additions to the challenges of optimising both individual and community health. Yet as a society we are accountable to each other for how we care for those who are frail, ill, disabled or diminished in their capacities.

"We were reflecting on the paucity of stories related to courageous, loving and supporting families that continue to provide compassionate care to valued family members while their illnesses and frailties were increasing."

Mission & Healing in

Healing has been an important element in the proclamation of the Gospel from the very beginnings of Christianity...

Jesus healed and ordered his disciples to do likewise in order to make the presence of the kingdom of God known, seen, and experienced (Matt. 10:8; Luke 9:2; 10:9). Healing was also one of the dominant features of spreading the Good News during the first centuries of the church's existence. Summing up his findings on medical matters in the early church, Adolf von Harnack remarked: "Christian religion and the care of the sick have travelled a long way together in the course of history; as a result, they now are inseparable... The influence and future of the church depend on her caring for those who suffer spiritually *and physically...* This is definitely the meaning of the Gospel of the Saviour and of salvation. The Early Church understood this comprehensively. And the only way that the Old Church remains young and the Young Church remains the old is that it keeps and preserves this understanding of the Gospel in its fullness."[1]

"Medical missions became a means to various ends and highly suspicious for those interested only in straightforwardly religious goals."

Despite the biblical mandate regarding healing and its early importance in spreading the good news of salvation for all (Mark 16:20),2 healing did not generally become a topic of concern for Christian missions until the advent of medical missions in the nineteenth century. There are two reasons for this delay: the disciples were explicitly charged not to make their living by healing (Matt. 10:8), and it took long centuries for medicine to become scientific. Early medicine, suffused with religion, was virtually indistinguishable from the cults of Asclepios and the Greco-Egyptian Serapis, which were extremely popular in Hellenistic times (approximately 300 b.c.e.–300 c.e.). Noted for their greediness and (not unlike today's health-care system!) their constant demands for more and more donations, early medical practitioners made healing very expensive and thus unaffordable for desperate commoners. To become actively engaged in healing in this context would have compromised in no small degree the proclamation of salvation for all, which includes the command to provide healing *dorean* (Matt. 10:8), that is, free of charge. The brother physician-saints Cosmas and Damien, who suffered martyrdom during the Diocletian pogrom about 303 c.e. and whose popular cult emerged in the fourth century, were commonly referred to as 'the moneyless' because of their practice of not receiving payment from their patients.

When by order of the Roman emperors Gratian (375–83) and Theodosius (379–95) Christianity was made the official religion in the empire, and when in 391/92 all heathen temples in the empire were closed and their possessions confiscated and handed over to the church, shrines once dedicated to Asclepios oftentimes got 'baptised' by simply turning them into a church or erecting a basilica on their site, which first had to be cleared of any idols worshiped there previously. Recent archaeological digs in Cyprus (Amathous, St. Tychon),[3] at the foot of the Athens Acropolis,[4] and especially at the St. Felix shrine at Cimitile-Nola, near Naples,[5] allow us today to understand the transformations taking place. We have ample proof through texts, artifacts, and remains of buildings that the incubation so typical of the Asclepios cult was also practiced in Christian churches, when desperate people were allowed to sleep in church buildings in close proximity to the tomb of the local saint. Original sources indicate that such a practice continued until at least the tenth century, not only in Gaul or Italy but also, and even more intensely, in the eastern parts of the former Roman Empire, notably in Constantinople and in Syria and Egypt. Much more is to be expected from further digs. The many votive offerings already found and the size of the estates suggest that at certain sites Christ's charge not to take payment in money or in kind for health blessings received might have been disregarded.

In any case, what could be done without compromising the faith was to care for the sick, including those beyond one's own kin, thereby witnessing to God's unconditional love for all humankind, something impressively epitomised in the parable of the Good Samaritan (Luke 10:25–34), which many non-Christian religions view as the essence of Christianity. Caring for the sick—not healing per se, except for occasional testimonies to miracles—eventually became the hallmark of Christianity, fundamentally changing the overall societal attitude toward the sick, while active involvement in the healing arts was not on the agenda, at least not until the nineteenth century.[6]

In fact, the official church developed an increasing dislike for the practice of medicine, especially surgery, during the course of the following centuries. This attitude became clear in 1215 at the Fourth Lateran Council, which ruled that no cleric should practice surgery, for fear of committing unintentional homicide. A priest should never shed blood.[7] Later, even the study of medicine was prohibited for any religious. Yet in cases of necessity and in the

Historical Perspective

absence of other medical help, clergy and religious, moved by pity and charity, did whatever they could under the constraints of the limited means and skills at their disposal, offering their services especially in the monasteries. Benedict of Nursia (480–550) had ordered his monks at Monte Cassino to serve the sick as if they were Christ himself (see Matt. 25:31–46) and to do whatever was needed to restore their health and well-being (Rule of Benedict 36).[8] Several centuries later, during the Crusades, the orders founded to care for the injured and their convalescence brought care of the sick and healing to the forefront. Prominent in this work were the Order of St. John of Jerusalem (or Hospitallers, 1099), the Knights Templar (ca. 1119), and the Antonines (1095). Later, during the sixteenth and seventeenth centuries and despite the official prohibition of the church, healing ministries played a major role in the work of Franciscan and Jesuit missionaries.[9]

Care for the sick became a recognised duty for missions and missionaries once the New World was discovered, heralding the age of patronage missions (1492–1622). Thus the Spanish Consejo de las Indias (Council for the Indies) ruled that 'hospitals'—that is, modest facilities for care of the deserving of every kind, such as lepers, widows, the poor, destitutes, orphans, and sick people for whom nobody cared—were to be built in every area under Spanish rule, notably in Mexico, Uruguay, and the Philippines, or where Spanish priests were active in ministry as in Japan, while in the territories under Portuguese patronage, charitable organisations called Misericórdia societies were established, whose members vowed to care for the needy, as had become a pious practice back home at Lisbon from 1498. In the eighteenth century the early Protestant mission societies such as the Danish-Halle Mission and the Herrnhut Brethren sent out professionally trained physicians to attend to the health-care needs of their missionaries suffering from tropical diseases, especially malaria, and also to treat indigenous people in case of illness. Nevertheless, the impact of such initiatives, which remained only marginal in this period, was severely hampered by the limitations on the kind of medical help that could actually be rendered. Such help was often not much better than the healing practices already in place in the local cultures.[10]

Mission and Healing in the 19th Century

The situation changed dramatically during the nineteenth century, when medicine turned decisively away from its focus on the teachings of classical medical authorities like Hippocrates, Galen, and Avicenna and began directly to study the nature of the human body and its physiology. Such an approach had begun long before, as is indicated

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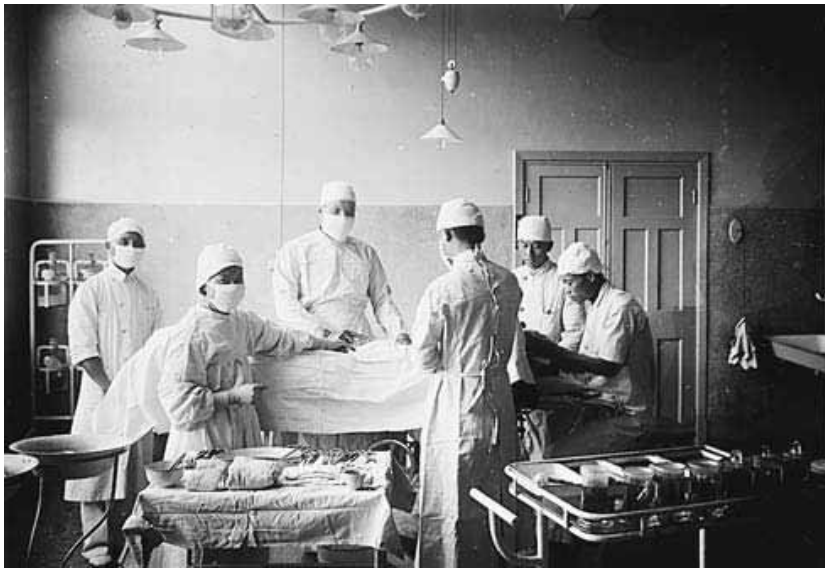

Surgical Team, Wuhan, China, ca. 1937
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by the anatomical drawings of Leonardo da Vinci (1452–1519),[11] by the seven-volume *De humani corporis fabrica* (On the Structure of the Human Body) of Vesalius (1514–64), and by the discovery of the circulation of the blood in 1628 by William Harvey (1578–1657). But this approach gained significant momentum only in the nineteenth century through three developments: first, the discovery of anesthesia (1846) and antisepsis (1847–1867), leading to the previously unimaginable rise of surgery; second, awareness of the importance of public hygiene and sanitation—providing safe drinking water and proper disposal of sewage—for the prevention of epidemics (1854–1859); and third, laboratory-based cellular pathology. This third development led to the age of bacteriology (Rudolf Virchow, 1821–1902; Robert Koch, 1843–1910; Ronald Ross, 1857–1932) and with it the discovery of the disease-causing pathogens of known epidemics, including those common in tropical countries, which led in due course to effective treatment and the development of appropriate measures of prevention.[12] Physicians now could heal diseases previously considered fatal, thereby allowing Christian physicians once again to reconsider the scriptural charge of being sent by their Lord and Master to heal.

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As much as medical missions is thus 'an epiphenomenon of the development of medicine,'[13] with medicine being transformed from an old-fashioned, authority-bound scientia into a modern science, it is also a consequence of the great missionary movement of the nineteenth century ignited by the Second Great Awakening. It first took definitive shape in the Medical Missionary Society in China, founded on February 21, 1838, at Canton (Guangzhou), with Rev. Peter Parker, M.D. (1804–88), its most renowned representative.[14] This society was a joint philanthropic venture by missionaries, professional medics, and businessmen from different countries, different denominations, and even different religions (Parse, Chinese). They joined in this venture to guarantee institutional backing of hospital-based medical services provided by missionary physicians who were trained in rational scientific medicine. They also wanted to provide free treatment of the kinds of diseases that traditional Chinese medicine could not handle, hoping thereby to befriend a xenophobic people. The enterprise thus became a means to various ends, the proclamation of the Gospel being just one among others, rendering it highly suspicious in the eyes of those who were interested only in the pursuit of straightforwardly religious goals.[15]

As medicine was becoming more and more powerful and as an ever-increasing number of pious physicians determined to serve as missionaries yearning for "the evangelisation of the world in this generation," medical missions became "the heavy artillery of the missionary army," as Herbert Lankester, then secretary of the Medical Committee of the Church Mission Society, London, characterised it in 1900.[16] By the turn of the century, medical missions was deemed so essential that the Ecumenical Missionary Conference, held in New York in 1900, could declare that no mission could "be considered fully equipped that has not its medical branch."[17]

While these statements suggest that medical missions was being universally recognised, the reality was different. Only about one-fourth of all Protestant missionary societies were engaged in medical missions. The percentage of Protestant medical missionaries and their staff, both male and female, foreign and indigenous, reached its high point in 1923, when 5.6 percent (1,157 out of 20,569 total missionaries) were practicing medicine.[18] Figures for later years dwindled.[19] Despite these relatively modest figures, we can say that, by the turn of the twentieth century, medicine had become a topic of genuine concern for Protestant missions, albeit a controversial one.

With the exception of a remarkable initiative on the island of Malta during 1881–96 by the visionary Cardinal Lavigerie, a Frenchman and founder of the missionary order of the White Fathers, dedicated to missions in Africa,[20] Roman Catholicism, bound by the decrees of the Fourth Lateran Council, was remarkably hesitant to embrace medical missions. This situation changed dramatically in 1925, however, with the founding in Washington, D.C., of the Society of Catholic Medical Missionaries (Medical Mission Sisters) by the Austrian Anna Dengel, M.D., and with changes the Vatican announced in 1936 in its approach to the study and practice of medicine by religious.[21] Soon thereafter medical missions underwent a process of radical transformation, bringing about basic changes in former attitudes toward medicine by medical missionaries, nurses, and home boards.[22]

Health Care as Focus of Medical Missions Today

The transformation of medical missions was mainly caused by the rapid advances in medical science, which demanded not only expensive high-tech equipment but also intensive-medical care. These advances constantly required more adequate facilities and thus a corresponding financial and action-driven medical model. This trend provoked critical questioning of the goal of medicine. But the shift in emphasis of medical missions also reflected developments in health-care politics on national and international levels (especially the formation of the World Health Organisation [WHO] in 1948, along with national departments/ministries of health), as well as the emergence of indigenous 'young churches,' with their very limited financial resources. These developments prompted a re-evaluation of medical missions across denominational lines and led to the creation in 1968 of the Christian Medical Commission (CMC) by the World Council of Churches (WCC), an ecumenical venture having Roman Catholic representation on its staff from its very beginning.[23] This commission was charged with "responsibility to promote the national co-ordination of church-related medical programmes and to engage in study and research into the most appropriate ways by which the churches might express their concern for... health care."[24] In 1992 the CMC was renamed Churches' Action for Health. Currently, the WCC's program "Justice, Diakonia, and Responsibility for Creation" includes the project "Health and Healing," which focuses on HIV/AIDS and mental health.

Today the healing arts and the task of medical missionaries are seen in a much broader context than before, clearly reflecting the postcolonial situation of a globalised Christianity. Christian medical work could no longer remain content with simply benefiting suffering individuals and running costly hospitals; rather, it needed to address the need for proper nourishment and hygienic living conditions, without which people would continue to become sick. Furthermore, it needed to recognise the rise of private and government health-care enterprises. Priorities had to be set for how best to invest the scarce resources at hand, priorities that of course were to be critically informed by the Gospel. These priorities were identified as promoting life in abundance (see John 10:10) and justice (shalom), both to be accomplished by focusing on the commonly neglected diseases of the poor—that is, the overwhelming mass of people suffering from preventable diseases. This included the practical steps of providing adequate sanitation systems and safe drinking water, giving

special attention to pregnant women and to training traditional midwives in safe methods of delivery, and securing sufficient nutritious foods and basic generic medicines for the most common diseases, all of this calling for cooperation across various disciplines and government departments. In concentrating on providing primary health care for families and local communities, medical missions turned away from hospital-centered medical work reflecting the financial affluence of the technocratic, secular culture dominant in the West. Its health-care program was so effective that the WHO adopted it as official policy in 1978 at the International Conference on Primary Health Care, Alma Ata, Kazakh SSR (Declaration of Alma Ata).[25] Since then, individual nation-states, as well as the WHO, have frequently updated their health-care focus, wishing to show quick results in the interest of securing World Bank funding. The churches and their medical missions personnel continue to pursue the course and vision of primary health care, which has proved to be most effective in coping with the HIV/AIDS pandemic.

In closing, three of the most pressing of many pertinent issues raised by the enterprise of medical missions should be mentioned. Each deserves serious theological and missiological reflection. First, medical missions reminds the church that its own recovery of the ministry of healing cannot be pursued to the exclusion of medicine, as is the tendency in many faith-healing movements. Instead, medicine must be gratefully acknowledged as a gift to humankind.

Second, medical missions challenges the long-held anthropological conviction, dating back to the Neoplatonism of the third century c.e. (see especially Plotinus, ca. 205–70), that the soul is more precious than the body. Most revivalists of the nineteenth century held a similar view. One who was both a revivalist and a physician, however, rejected this conviction outright, stating: "To merely talk piously and tell suffering people of a future state, while neglecting to relieve their present needs, when in our power to do so, must be nauseating both to God and man, and certainly is a libel upon the Christianity Christ both taught and practiced, in which He combined care for the whole being of man, body and soul."[26] At the root of too spiritual a concept of mission or faith healing and too material a concept of health and professional healing lies a misconceived biblical anthropology, one profoundly distorting the church's witness to God incarnate in Christ. As the church father Tertullian (ca. 160–ca. 212) once pointedly stated, *Caro cardo salutis*, The flesh is the hinge of salvation.

Third, the skillful use of medicine for the sake of bringing about life in abundance and preventing untimely death, particularly among those most neglected—the poor, including today especially the victims of HIV/AIDS, notably in Africa and Asia—at once witnesses to the corporeality of salvation and to the proper use of knowledge, skills, and funds for the benefit of all, thereby profoundly critiquing other ways of doing medicine. A genuine missionary task indeed! LJ

References

1. Adolf von Harnack, "Medicinisches aus der ältesten Kirchengeschichte" (Medical topics from the most ancient church history), *Texte und Untersuchungen zur Geschichte der altchristlichen Literatur* 8, no. 4 (1892): 147; emphasis in original.
2. Darrel W. Amundsen and Gary B. Ferngren, "The Early Christian Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Darrel W. Amundsen and Ronald L. Numbers (New York: Macmillan, 1986), pp. 40–64.
3. Tomas Lehmann, "Die spätantiken Kirchenbauten von Amathous (Zypern) und die Wunderheilungen am Grab des Bischofs Tychon" (Church Buildings of Late Antiquity at Amathous [Cyprus] and Miracle Healings at the Tomb of Bishop Tychon), in *Beiträge zur Kulturgeschichte Zyperns*, ed. Johannes G. Deckers, Marie-Elisabeth Mitsou, and Sabine Rogge (Münster: Waxmann, 2005), pp. 23–40.
4. Arja Karivieri, "The Christianization of an Ancient Pilgrimage Site: A Case Study of the Athenian Asklepieion," in *Akten des XII. Internationalen Kongresses für Christliche Archäologie (Bonn 22.–28. September 1991)* (Münster: Aschendorff, 1995), pp. 898–905.
5. Tomas Lehmann, "Die Kirchenbauten in Cimitile/Nola: Ergebnisse der Forschungen der letzten 15 Jahre" (Church Buildings in Cimitile/ Nola: Findings of Research of the Past Fifteen Years), in *Cimitile e Paolino di Nola: La tomba di S. Felice e il centro di pellegrinaggio*, ed. Hugo Brandenburg and Letizia Pani Ermini (Vatican City: Pontificio istituto di archeologia cristiana, 2003), pp. 95–127. See also Dennis E. Trout, *Paulinus of Nola: Life, Letters, and Poems; The Transformation of the Classical Heritage* (Berkeley: Univ. of California Press 1999).
6. Henry E. Sigerist, *Civilization and Disease* (Ithaca, N.Y.: Cornell Univ. Press, 1943; repr., College Park, Md.: McGrath Pub., 1970), pp. 69–70.
7. Namely in constitution 18 (Clerics to dissociate from shedding blood); see *Decrees of the Ecumenical Councils: From Nicea I to Vatican II*, ed. Norman P. Tanner (Washington, D.C.: Georgetown Univ. Press, 1990), 1:244.
8. *The Rule of St. Benedict*, trans. Leonard J. Doyle, ed. David W. Cotter (Collegeville, Minn.: Liturgical Press, 2001).
9. Roy Porter, *The Cambridge Illustrated History of Medicine* (Cambridge: Cambridge Univ. Press, 1996).
10. See Christoffer H. Grundmann, *Sent to Heal! Emergence and Development of Medical Missions* (Lanham, Md.: Univ. Press of America, 2005), pp. 22–37.
11. *Leonardo da Vinci on the Human Body: The Anatomical, Physiological, and Embryological Drawings of Leonardo da Vinci*, ed. Charles D. O'Malley and J. B. de C. M. Saunders (New York: Gramercy Books, 2003).
12. Erwin H. Ackerknecht, *A Short History of Medicine*, 2d ed. (Baltimore: Johns Hopkins Univ. Press, 1982), pp. 145–74.
13. Andrew F. Walls, "'The Heavy Artillery of the Missionary Army': The Domestic Importance of the Nineteenth-Century Medical Missionary," in *The Church and Healing*, ed. W. J. Sheils (Oxford: Basil Blackwell, 1982), p. 287.
14. See Gerald H. Anderson, "Peter Parker and the Introduction of Western Medicine in China," *Mission Studies* 23, no. 2 (2006): 203–38. For a more general overview, see Harold Balme, *China and Modern Medicine: A Study in Medical Missionary Development* (London: United Council for Missionary Education, 1921).
15. See Grundmann, *Sent to Heal!* pp. 65–71 and 92–95.
16. Walls, "Heavy Artillery," p. 290. See also Stanley G. Browne, ed., *Heralds of Health: The Saga of Christian Medical Initiatives* (London: Christian Medical Fellowship, 1985).
17. *Report of the Ecumenical Missionary Conference on Foreign Missions, Held in Carnegie Hall and Neighboring Churches, April 21 to May 1, 1900*, 2 vols. (New York: American Tract Society, 1900), 2:199.
18. James S. Dennis, *Centennial Survey of Foreign Missions: A Statistical Supplement to "Christian Missions and Social Progress," Being a Conspectus of the Achievements and Results of Evangelical Missions in All Lands at the Close of the Nineteenth Century* (New York: Fleming H. Revell, 1902); Grundmann, Sent to Heal! pp. 150, 159.
19. Harlan P. Beach and Charles H. Fahs, eds., *World Missionary Atlas, Containing a Directory of Missionary Societies, Classified Summaries of Statistics, Maps Showing the Location of Mission Stations Throughout the World, a Descriptive Account of the Principal Mission Lands, and Comprehensive Indices* (Edinburgh: Edinburgh House Press, 1925).
20. Grundmann, *Sent to Heal!* pp. 121–24.
21. Anna Dengel, *Mission for Samaritans* (Milwaukee: Bruce Publishing, 1945), pp. 8–29.
22. In the beginning of the medical missions enterprise, nurses did not count as "medical missionaries." If they were referred to at all, it was as "missionary nurses." Only comparatively late, that is, toward the mid-1950s, were nurses, also, regarded as medical missionaries.
23. A. J. van der Bent, *Vital Ecumenical Concerns: Sixteen Documentary Surveys* (Geneva: World Council of Churches, 1986), p. 303.
24. James C. McGilvray, *The Quest for Health and Wholeness* (Tübingen: German Institute for Medical Missions, 1981), p. 41. See also D. Merrill Ewert, *A New Agenda for Medical Missions* (Brunswick, Ga.: MAP International, 1990).
25. McGilvray, *Quest for Health and Wholeness*, pp. 70–80.
26. George D. Dowkontt, *Murdered Millions*, 5th ed. (New York: Medical Missionary Record, 1897), p. 24.

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Aims

- To provide a Fellowship in which members may share and discuss their experience as Christians in the professions of medicine and dentistry.
- To encourage Christian doctors and dentists to realise their potential, serving and honouring God in their professional practice.
- To present the claims of Christ to colleagues and others and to win their allegiance to Him.
- To provide a forum to discuss the application of the Christian faith to the problems of national and local life as they relate to medicine and dentistry.
- To foster active interest in mission.
- To strengthen and encourage Christian medical and dental students in their faith.
- To encourage members to play a full part in the activities of their local churches.
- To provide pastoral support when appropriate.

Origins

Its historical roots are in the Inter-Varsity Fellowship (IVF) and the Christian Medical Fellowship (CMF) that started in the UK. Along with similar groups being set up around the world after World War II, separate Australian state fellowships of doctors and dentists were established from 1949.

These groups combined as a national body in 1962 and the Christian Medical and Dental Fellowship of Australia (CMDFA) became officially incorporated in NSW in 1998. In 2000 the work became centralised with the establishment of a national office in Sydney to assist with growing administrative needs.

CMDFA is governed by state branch and national committees elected at annual general meetings of its financial members.

CMDFA is linked around the world with nearly 80 similar groups through the International Christian Medical and Dental Association (ICMDA) which includes Christian Medical and Dental Associations of the US.

Why join the **CMDFA?**

• Fellowship • Evangelism • Discussion • Mission • Student Work

CMDFA seeks to:

- Unite Christian doctors and dentists from all denominations and to help them present the life-giving Christian message of God's love, justice and mercy in a tangible way to a hurting world.
- Help students and graduates of medicine and dentistry to integrate their faith in Jesus Christ with their professional practice.

Membership is open to students and graduates, who want to follow Jesus Christ as Saviour and Lord. Associate Membership is also available to Christian graduates in related disciplines.

By Joining the Fellowship you can:

- Be motivated in mission for Jesus Christ.
- Be encouraged in your growth as a Christian Health professional.
- Be committed in serving God and your neighbours in the healing ministry.
- Learn from others in integrating your Christian faith and your professional life, drawing on the experience of older graduates as mentors and facilitators.
- Encourage and support other colleagues in fellowship and prayer.
- Share your resources with those in need through special ministries.
- Network with others to effectively bring God's love to patients, colleagues and daily contacts.
- Collectively make an impact for Christ in heath care.