Luke's Journal

of Christian Medicine & Dentistry
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CHRISTIAN MEDICAL
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20 years 50 editions

Luke's Journal

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Living Out Our Faith in the Workplace

Resume of Grace:
Luke's Journal 1996-2016

Healthy Hope

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Luke's Journal

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Vol 20 No 1	Feb 2015	"You are What You Eat"
Vol 20 No 2	Nov 2015	Standing Together in the Public Square
Vol 21 No 1	Apr 2016	Family Matters
Vol 21 No 2	Sept 2016	Life Before Birth

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editorial

Healthy Hope

The Old Testament records 27 times that males of 20 years old and upward were counted as suited for war and the service of the House of the Lord (in our cultural context we should not exclude females).

As *Luke's Journal* now celebrates reaching that 20 year milestone we might ask: "Are we a journal that is either (1) useful for the warfare in which we are all engaged, or (2) which serves God?"

"We have the responsibility to discern the Biblical precepts that underpin our practice."

Most of us receive a variety of medical journals whose articles maybe of special interest to us in our profession. It is well known that prestige, and especially academic progress, is marked by the publications we have authored.

So how and where does a Christian Medical Journal fit in? Do we too go to war? There are several matters to which a Christian journal should give attention – the obvious current ones being "safe schools," euthanasia and abortion. But what about issues of justice:

- fair remuneration in our profession – without being greedy
- opportunities for training of junior doctors and dentists, and the disruption of family life that such training might bring
- the distribution of medical/dental services in underprivileged areas both in Australia and overseas

...to take simple examples.

These are not always easy questions to resolve, and we have had vigorous debates about some of them. But we should not retreat from them. We have the responsibility to discern the Biblical precepts that underpin our practice. John Robinson, pastor to the Pilgrim Fathers on the Mayflower said: "I am verily persuaded the Lord hath more truth yet to break forth out of His Holy Word."

May we as a journal continue both to celebrate what God has done, and seek to discover and then apply what the Lord has yet to teach us how to be true to our motto: *Following Christ, integrating faith and practice.*

John Foley
Editor

Throughout *Luke's Journal* look out for snippets from past editions. **SNIPPETS**

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Theological Reflections on the Practice of Medicine

by Andrew Sloane

Andrew is a Senior Lecturer in Old Testament and Christian Thought and is Director of Postgraduate Studies, Morling College. He initially trained as a doctor before moving into ministry and then theological education. His most recent book is on philosophy and theology of medicine: *Vulnerability and Care: Christian Reflections on the Philosophy of Medicine*, London: Bloomsbury T&T Clark, 2016.

Introduction: thinking Christianly about medicine – the very idea

• Expanding our horizons

Christian doctors care deeply about what they do.[1] For many it's not just a job, it's a calling, a *vocation*, to use an almost outdated term. While they *care* deeply, they don't always *think broadly* enough about medicine and why and how they see it as part of their *Christian* calling, or in what ways being a Christian might impact on their medical practice.

That's not to say, of course, that Christian doctors ignore their Christian beliefs and values in their practice of medicine – at least, not those doctors who tend to join CMDFA. Members of CMDFA are concerned to practice medicine within appropriate ethical limits – hence the extensive discussion of matters of the beginning and end of life, for instance, or questions around conscientious objection in medical practice. Equally, members of CMDFA don't limit their concern for their patients (or their colleagues) to their physical and mental and emotional well-being, but have an abiding concern for their spiritual well-being, as evident in the *Saline Solution*.

But that, it seems to me, is too narrow a focus. There are other big issues that we as Christians in medicine ought to be addressing. We need to think *Christianly* about the *whole* of medicine – and we need to do so with the same depth with which we care about it, and the rigour with which we practise it.

Recognising the importance of theology of medicine

Let me start in familiar territory, briefly noting that many of the questions that Christian doctors already think about would benefit from explicit and broad theological reflection. Medicine is a rich and complex practice in which questions of what it *is* and what it is *for* have great bearing on what we do and how we do it.

• Euthanasia

I will start in a fairly obvious place: the current debate surrounding euthanasia, 'assisted dying' and end-of-life care. The growing prominence of the issue, and the arguments for and against it, have been well-documented elsewhere.[2] I would like to consider, instead, some of the underlying questions of the nature and practice of medicine that are assumed or entailed in the debate.

The pro-euthanasia position implies that medicine's primary aim is to enable people to choose the treatment that will alleviate their suffering (or enable them to pursue their life goals). Suffering and autonomy are what it's about. And so, when a patient's suffering (of whatever kind) becomes intolerable and they determine that they would like to end their life, the doctor's job is to provide this last service.

The anti-euthanasia position presupposes that medicine is about human communities providing *care* for vulnerable people. At the heart of that care is a needy person whose inherent frailty is exposed by their physical or psychological condition and whose capacity to act in the world is limited by it. In this case, doctors are entrusted with the knowledge and skill to care for them.

Christians provide this care because we are aware of our limited creaturely existence, our fractured fallenness, and of the infinite care of our Triune God who sustains us and draws us to his

"[Medicine] is itself a sign of God's compassion and a foretaste of the coming Kingdom."

desired end. We respond to God's call to mirror that compassion and provide brief glimpses of that destiny.

• Medicine and the Kingdom of God

So, medicine has inherent, not merely instrumental, value in the Kingdom of God – that is, it is more than a good way to make money and evangelise people. It is itself a sign of God's compassion and a foretaste of the coming Kingdom. And that, in turn, makes medicine a deeply moral (and even theological) practice. For as soon as Christians see capacity, skill, knowledge, power, they see responsibility to use it for the benefit of the vulnerable for whose sake it has been entrusted to them – by God and the community. Medicine is a *profession*, an *inherently* moral practice.

• The nature and goals of medicine

This has implications for much more than the question of end-of-life care. Recent scandals in the NHS in Britain, nursing homes in Australia and veteran care facilities in the US have echoed around the world. While there are complex issues relating to organisational culture, government investment in large social enterprises, and the role of bureaucracy and corporate management in health care institutions, these scandals raise issues of the nature and goal of medicine.

Some issues are obvious: we are rightly appalled when vulnerable patients are neglected and abused by a system that is meant to be *caring* for them. How did these institutions develop the kind of culture in which that kind of treatment was *imaginable*, let alone normative? What kind of institutional culture *should* be normative? That is, what kind of practice is medicine?

Other issues are less obvious. What role should bureaucratic control and a focus on 'patient outcomes' play in the practice of medicine? We want our social resources to be used wisely and as effectively as possible; however, are *efficiency* and *maximized health outcomes* the aim of the medical game? While we want to make sure that the drugs we give work and the surgical procedures do the job they're intended to do, do outcomes really capture the 'heart' of medicine?

For instance, what does 'efficient' geriatric care look like? What kinds of 'health outcomes' can palliative care produce (other than ones manufactured to satisfy health bureaucrats – as Jeffrey Bishop has devastatingly shown)?[3] We need to think better of medicine if we even consider that 'outcomes' are the right yardstick by which we should measure geriatric or palliative care.

We should be concerned when the burden of reporting make General Practice more a managerial than a medical practice. In all these areas, we need to reflect on the nature of medical practice and what it exists to do.

The role of 'conscientious objection' in medical practice raises similar questions. Outspoken critics like Julian Savulescu say that a doctor has no right to refuse treatment to a patient if that patient has exercised informed consent and the procedure is legal and available to them.[4] This

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raises important questions about the moral agency of doctors, but deeper questions about the nature of medicine are also at stake. Raising questions about the legitimacy of a treatment is not a matter of importing our moral qualms into the practice of medicine or imposing our contested, 'religious' judgements on those who do not share our faith. Medicine is an *inherently* moral enterprise.[5]

This moral dimension emerges from the nature of medicine itself: at its heart is the exercise of knowledge and power by doctors for the patient's benefit. As Christians we see the holding of power as ethically loaded, and the notion of beneficence as deeply moral. Again, however, this depends upon a particular philosophy of medicine, a vision of what it is and is for – and so for Christians, a *theological* vision.

The more we think about it, the more the moral and theological issues multiply – an ageing population and projections of increased healthcare costs; growing emphasis on sophisticated medical technologies, often at the expense of patient *care*; and so on and so forth. These questions demand that we bring philosophy and theology to bear on the complex world of medicine.

Outlining a theology of medicine

Most theological discussions of the nature of medicine are framed in terms of health and healing, and the alleviation of suffering. I think that is mistaken; but exploring the relevant conceptual and practical issues would take us too far afield.[6] So let me articulate how I think we *should* frame a philosophy and theology of medicine.[7]

• The thesis

Medicine is primarily an expression of care for vulnerable human beings whose finitude and frailty has been exposed by physical or psychological ailment and whose ability to function in meaningful relationships has been compromised. Its goal is to care for such vulnerable people so as to demonstrate our solidarity with them as suffering persons and seek to enable them to return to a reasonable level of functioning in relationships. Theologically, medicine is an appropriate expression of a well-formed community's care for vulnerable members of the community, a reflection of the character of God and an anticipation of the final transformation of all things to which God is drawing us and all things. Such a view emerges, I believe, from the shape of the biblical story.

• A (biblical) theological rationale

Creation grounds our quest for knowledge and skill in the orderly character of God and the world. It establishes limits on the kind of technical mastery we should seek – we are finite creatures and always will be; there is no faithful escape from the exigencies of creatureliness.

"The goal of [theologically-informed medical practice]... is to embody that care-in-solidarity that a properly functioning human community owes its vulnerable members."

The brokenness of the world as it is now limits our capacity to know truly and to care faithfully, for we are as broken as the world we seek to understand. Yet it necessitates our attempt to understand the world and shapes our efforts to change it – for the God who both made and judges the world also seeks to redeem and transform us and calls human creatures to be agents of God's work of fixing a broken world.

In Jesus we see both the clearest expression of that transforming work and the anticipation of its final state. In Him we also hear the call to be transformed and mobilised in God's great free-making mission as we work to see glimpses of our final destiny and His perfect future in our fleeting and flawed projects.

Such a theological perspective requires that we understand the limits of our endeavours – any change we make to the world or needy people in it will be partial and temporary at best; we are still subject to death and the world will only be made new by the sovereign work of God, not the labour of our hands. We build signposts to that final transformation, and occasionally plant oases on the road towards it; the garden-city for which we long, and to which we seek to witness by word and deed, will be the gift of God.

• A Christian vision of medicine and its practise

Physical and psychological illness, injury or disability are problems because they adversely affect people and interfere with their ability to function in relationships, exposing their vulnerability and diminishing their flourishing. Patients are in a position of relative weakness, requiring the doctor's knowledge and skill in caring for their frail flesh. This power differential generates a moral call, for in a Christian view of the world, power and privilege generate a corresponding responsibility to serve (Matt 20:25–28). Medicine as a social practice exists in and for a given community and aims to care for people in their weakness and vulnerability; deal with the disruption caused by disease processes, injury or deformity; and return people to proper functioning in their relationships and as persons, as far as this is practicable.

This both justifies the existence of medicine and establishes its goal. While fighting disease and improving a community's health are important, they are the *means* rather than the *ends* of medicine. Medicine is a matter of health *care*, not of *health* care. Medicine's *telos* is to provide care for 'this frail flesh' and, where this is possible and as far as this is practicable, to remove impediments to human

flourishing, restoring people to proper personal and relational functioning. It is a primary expression of a community's commitment in solidarity to our vulnerable fellow humans, rather than abandoning them in their frailty.

Such a perspective both articulates and enhances the **moral character of medicine and enables us to resist the 'technological imperatives' which can overwhelm personal concerns for the sake of technical possibilities.**

Exploring some implications.

What then might this theologically informed medical practice look like?

It would re-centre the relationship between a medical practitioner and their patient. It is in the context of that relationship that problems are identified, possible solutions explored and, most importantly, medical knowledge and skill are used to care for human frailty. This challenges current pressures to reduce consultation times for the sake of greater efficiencies, as well as reorienting the clinical relationship towards basic history-taking and physical examination and away from investigations.

The aim of the consultation is then not to establish a definitive diagnosis, as if the knowledge of pathophysiology is the goal of the clinical encounter (an anticipatory autopsy so to speak); rather, it aims at furthering the care of this vulnerable person. The information it delivers is only of value if it leads to knowledge that informs care: that is, if it bears a reasonable likelihood of altering the way in which a patient will be treated. Such a reorientation requires a shift in both medical and patient culture – it would reduce the number of expensive and unnecessary investigations and, more importantly, reorient doctors towards the care of persons.

However, while some shifts might reduce the cost of medical care, that is not the goal of a theologically-informed medical practice. The goal of that practice is to embody that care-in-solidarity that a properly functioning human community owes its vulnerable members. As such, it may be more expensive care, for the focus will shift from technologies to persons, and the time and personnel that person-oriented care requires.

Of course, not all services can be provided for all people, for constraints on resources, time, personnel and even geography limit the kind of care that people can access. Basic care needs to be reasonably available to all; many specialist services will necessarily be restricted. But we need to remember that medicine cannot overcome human mortality or finitude; there is no escape from this frail flesh - only appropriate care for it. This has implications, of course, for both treatment decisions and public policy.

It also suggests that we need to work towards developing an alternative culture of medical practice and 'consumption' that re-humanizes medicine and provides a different framework through which we approach questions of resource allocation, end-of-life care and the moral practice of medicine. But these are large questions that must await another occasion. ●

References

1. This paper began life as an address to the Christian Medical and Dental Fellowship of Australia, NSW Annual Dinner, 17/09/2015. The ideas are drawn from my work on philosophy and theology of medicine, for which see: Andrew Sloane, *Vulnerability and Care: Christian Reflections on the Philosophy of Medicine* (London: Bloomsbury T&T Clark, 2016).
2. See, for instance, Peter Singer, Practical Ethics, 3rd ed. (Cambridge: Cambridge University Press, 2009); John Wyatt, *Matters of Life & Death: Human dilemmas in the light of the Christian faith* (Nottingham: IVP, 2009).
3. See Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power and the Care of the Dying* (Notre Dame, IN: UNDP, 2011).
4. See Julian Savalescu, "Conscientious objection in medicine," *BMJ* 332 (2006). While abortion has been the most prominent procedure involved in this debate, it is not the only one.
5. Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice* (Washington: Georgetown University Press, 1996); *Helping and Healing: Religious Commitment in Health Care* (Washington: Georgetown University Press, 1997); Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, ed. H. Tristram Engelhardt, Jr. and Fabrice Jotterand (Notre Dame: UNDP, 2008).
6. For a recent, helpful articulation of a theology of health, see Neil G. Messer, *Flourishing: Health, Disease, and Bioethics in Theological Perspective* (Grand Rapids: Eerdmans, 2013). For my reservations about that (kind of) project, see Sloane, *Vulnerability and Care*, Ch.6.
7. For more detailed discussion, see "Christianity and the Transformation of Medicine," in *Christianity and the Disciplines: The Transformation of the University*, ed. Oliver D. Crisp, et al. (London: T&T Clark, 2012); *Vulnerability and Care*, esp. Chs.7-9.

Resume of Grace

Luke's Journal 1996–2016

by Paul Mercer

Paul is co-editor of *Luke's Journal.*

When G K Chesterton[1], the quirky English wordsmith described St Francis of Assisi, as 'the only Christian', was he genuinely raising a universal surrender flag? When it comes to integrating life, work and faith, few can stand against the little man of Assisi. Perhaps Chesterton, with his incisive wit, was acknowledging that the integration of life work and faith is a journey that most of us stumble along.

This edition of *Luke's Journal* celebrates twenty years of reflection and grace, generously recorded in material prepared by members of CMDFA and friends over this timespan.

I have spent the past month or so reading and skimming through every past edition. I have experienced the "strange warming" of the Holy Spirit captured in articles by doctors, dentists, students and others who have "put on Christ" and in good work have discerned grace and new creation in their work. To this crowd of witnesses, many still living and working, we owe thanks and beyond this, all praise to the One whose image we bear. The tapestry of work recorded in pieces over the past twenty years is rich and beckons re-reading.

Dr Rod Stephenson gathered and produced the first *Luke's Journal* in January 1996. Rod had honed his skills in a newsletter for CMDFA in Victoria. He then handed the baton on to Drs David and Denise Cooper-Clarke in 1999 and they handed on a more professional type journal to Dr John Foley and I at the end of 2005.

As I made my way through articles, I came to a short piece by Dr Katrina Phillips, who shared something of her role at the Christian Medical College at Vellore in India.[2] She nominated five challenges in the training programme, to be addressed if graduates were to continue on as "ministers of healing" – as doctors who integrated work and faith.

It struck me that these "challenges," capture most of what our journal has been about as well. Katrina's five were:

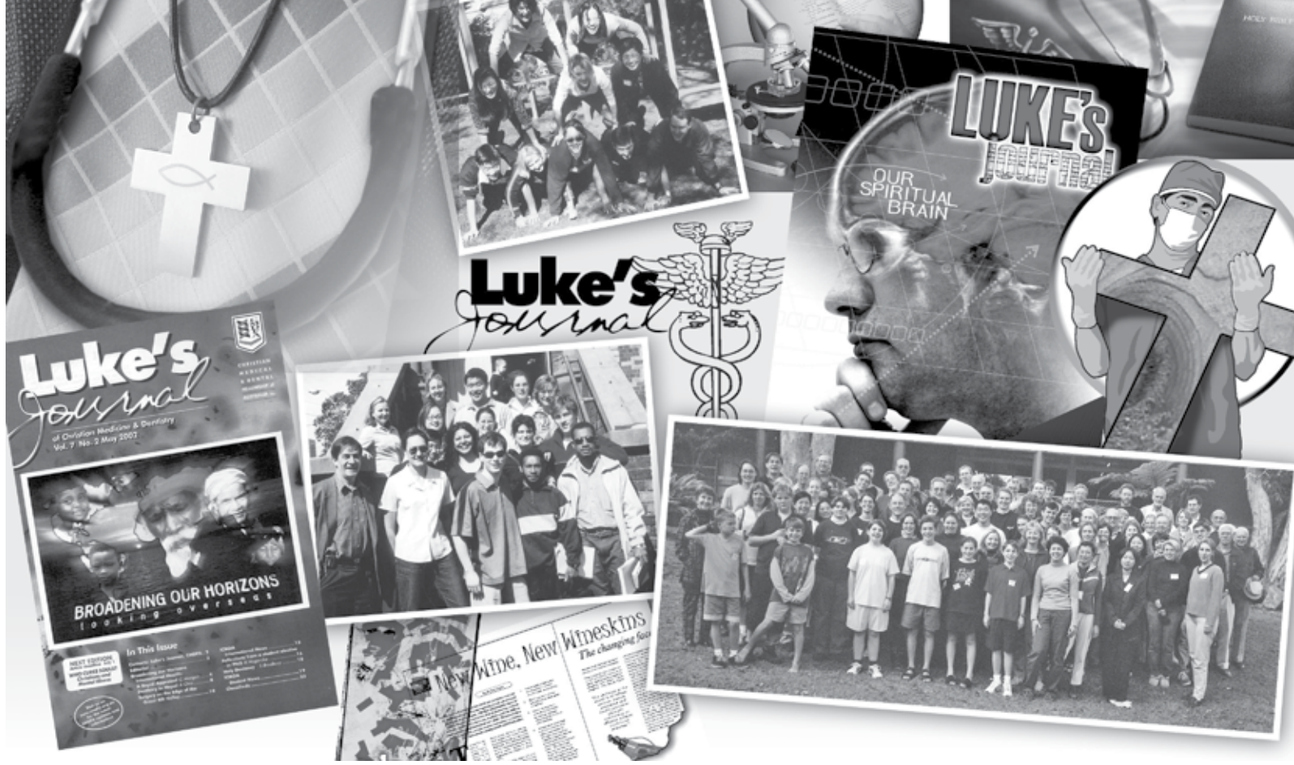
- Finding enough time and people to do all that opportunity presents.
- Striking a balance between high tech medical treatment and low cost primary health care.
- Serving not just in the 'spirit of Christ' but in the' name of Christ' as well
- Arrest the gradual shift from depending on God to depending on one's credentials.
- Empowering people to be witnesses for Christ.

With some certainty, we can discern the integration of faith and life's work in the history of 'brother' Francis. Apparently Francis battled with an eye complaint. Chesterton was impressed with a story around the treatment

SNIPPET

- The goal of my medical practice is the promotion of health and well-being.
- I will maintain great respect for my patient, and for human life from the time of conception, believing that each one of us is created by God in His own image.
- I will offer to my patients those forms of treatment which, according to my training and experience, I consider most likely to benefit each patient. Even under threat I will not use my medical knowledge to cause harm.
- For the benefit of any patient I will refer to or consult with my colleagues when needed.
- I will respect the confidentiality of my patients, and will take no unfair advantage of those who honour me with their trust.
- I will endeavour to follow the example of Jesus in serving the poor, the weak and the vulnerable in our society, including the very young, the chronically ill, the disabled and the elderly.
- While committed to caring for my patients to the very end of their lives, will not, with or without request, by act of commission or omission, intentionally take the life of any patient.
- I will be loyal to my profession, and treat its members fairly. To my teachers I will give the respect that is their due, and I will share my knowledge of the art and science of medicine with my colleagues and students to the best of my ability.
- I make these promises sincerely and with God as my witness. To Him be the glory.

Vol 6 No 1 Feb 2001 – Making a Statement "Themes in Developing Position Statements" by Alan Gjisbers



recommended. Francis was asked to place a burning hot poker against his lateral periorbital margins. It is reported he accepted this calmly and as the poker was about to be applied prayed that 'Brother Fire' would be gentle with him. God undoubtedly used Francis as a source of renewal and reform in the thirteenth Century Church.

Scholars have noted a unique feature of the Bible – God's self-revelation and the purposes for creation are given to us in the events of history.[3] God's self-revelation occurs in the history of Israel and then through Christ, in the history of new creation, and the now (but not yet) Kingdom of God. If we consider the Old Testament book of Genesis, we find God speaking to establish creation. With the rebellion and sin of Adam and Eve, God's direct communication begins to recede. At the same time, God's words are followed by consequences, so that Abraham, Isaac and Jacob, and so on, know that God means what has been said and that God keeps promises.

By the end of Genesis, God's direct speech has disappeared. However, we are left in no doubt that God is involved in human history. In jealousy, Jacob's sons had sold Joseph off into exile as a slave in Egypt, and then lied to their father about his favourite son. When a famine causes the family to seek aid from the 'bread basket' of Egypt, a sort of reunion occurs. Confronted with their sin, the brothers throw themselves at the mercy of Joseph. Joseph is now the Prime Minister in Egypt and he calms them with this testimony: "Am I in the place of God? You intended to harm me, but God intended it for good to accomplish what is now being done, the saving of many lives." *Genesis 50:19-20*

"*Luke's Journal* has developed as a more robust, professional, national journal."

The history captured in the past twenty years of editions of *Luke's Journal* is also God's history being played out in the life and work of a particular group of Christians – members of CMDFA. The year 1999 marked the Jubilee of CMDFA in Australia. The story goes something like this (quoted from a paper prepared by Cliff Smith): Earlier in the twentieth century "There was a tremendous impetus in student Christian work in the UK. From this the Reverend Doctor (medical) Howard Guiness started the Evangelical Union student work in Canada; then in the USA; and later, in 1930, moved to Sydney, Australia. The Christian Medical Fellowship was formed by the vision of Dr John Hercus and others in 1949 in NSW and soon state branches developed autonomously around Australia.

A story is told of a CMF Victoria meeting with the English cricketer David Shepherd. He then arranged for a group of medical students to meet with the whole English cricket team.

Many doctors, and more recently dentists, who have made significant contributions to health care in Australia have also embraced the fellowship of CMDFA. Cliff's paper concludes in this way "sufficient to say that we all pay tribute to those pioneers that have gone before us. Thank you for the heritage that has been given to us. May God be honoured as we seek to build on that and press on toward the prize."

Writing in 2014, Drs Anthony Herbert and Frank Garlick published an article in *Luke's Journal* telling the history of CMDFA in Queensland.[4] They identified a number of important themes in their

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history – Christian unity in the face of an increasingly secular workplace; fellowship and prayer times for renewal and inspiration; the importance of integrity; the value of Christian distinctiveness and an ongoing need to support students and recent graduates.

One of the ways the Journal has 'owned' our history has been to publish obituaries of members who have passed on. In our first edition an obituary for Dr Jean Benjamin was submitted. A sense of the unity of our fellowship is captured in this sentence. "I was in the student Christian movement, so there were many discussions on why the Christian Church was so divided and we took a very ecumenical approach."

I have chosen a few threads of our history as a Fellowship to affirm the work of God among us. We all take the journey of life as Christians in the light of Scripture. Our journal is a simple complement to that richer well. David Simpson prepared the first *Luke's Journal* Editorial. His encouraging words bear retelling: "As our new Journal serves to bind our members near and far, I appeal to you all to seek prayer for your local problems from the whole of the Fellowship through the journal. I would encourage more women and more dentists to be active on our state and national committees – your contributions are needed for a balanced approach to our task." His call for women and dentists to be involved in leadership of CMDFA has been to some extent answered in Dr Judy Fitzmaurice's recent service and now in Dr Ross Dunn's (a dentist member of our Fellowship). God has been good to us.

Various national and state newsletters continue to promote needs for prayer and opportunities for Fellowship and Conference events. *Luke's Journal* has developed as a more robust, professional, national journal. Centralisation was accelerated when Judy became national chair. She has shepherded CMDFA into a more nationally-focused organisation, with a Board of Governance, a very intentional student-support ministry, developments around ethics, an independent HealthServe organisation, a missionary support chapter and so on.

As Judy recently stepped down, I was drawn to a comment made by Paul:"So that I may come to you with joy, by God's will, and in your company be refreshed". *Romans 15:32*. CMDFA is a fellowship. We are drawn together in many ways, including through *Luke's Journal*. Genuine Christian fellowship is about presence, and, while a journal or a Facebook page may sustain us for a while, Paul's words capture the blessing of presence. He says to the Christians of Rome (asking them to join him in the struggle of gospel ministry by prayer) "so that I come to you with joy, and together with you, am refreshed."

What do you hope for?

By choosing the theme *Healthy Hope*, the editorial team recognised that an edition such as this needs to celebrate the past and remain faithfully open to the future. This openness is on the tip of our tongues when we pray "your will be done on earth as it is in heaven." Christian hope, as the title of Tom Wright's 2007 book *Surprised by Hope*[6] suggests, is a surprising hope. Are there clues we can glimpse as we look forward? Wright argues that many of us as Christians have undervalued the resurrection of Jesus. Our spiritualties have often grown from an anxiety about sin and the assurance of salvation in the Cross of Jesus. In the resurrection of Jesus, God has brought the future partly into the present. Jesus is the firstborn of many 'sons and daughters'. Christians receive the power to live a resurrection life as well as participating in the future great resurrection, when all things will be recreated in Christ and Jesus will be Lord of all.

In today's world, many hold a bleak, apocalyptic view of the future. Many others see the future limited to one flourishing life now. Now is all there is. As Wright observes, "Because the early Christians believed that 'resurrection' had begun with Jesus and would be completed in the great final resurrection on the last day, they believed that God had called them to work with Him, in the power of the Spirit, to implement the achievement of Jesus, and thereby to anticipate the final resurrection, in personal and political life, in mission and holiness." Wright points his readers to 1 Corinthians 15 as a seminal text. Here Paul writes that "what we do in the Lord is not in vain". And so Wright reflects "that is the mandate we need for every act of justice and mercy, every programme of ecology, every effort to reflect God's wise steward image into his creation". For dentists and doctors, this would encourage our wholehearted participation in healing work in the world. Healing today is a signpost of resurrection already present in Jesus and caught up in God's new creation for tomorrow.

The future of *Luke's Journal* will depend on the stories of healing coming from members living in and through the resurrection life of Jesus. Another way of saying this is that "nurtured hopes, lead to fruit". For *Luke's Journal*, this in part means the emerging entry of a new development team in Dr Catherine Hollier, Dr Grace Leo and Dr Winnie Chen. Many professional journals are a little uncertain about the balance between the traditional paper-based format and online options. *Luke's Journal* is now available through the ISSUU platform, which is a step towards online access, although still with limitations. IT development will continue to influence our Journal and we will adapt as we progress. Our plan is to be readership-responsive to format.

There are times when the future seems blanketed by the pressure and burdens of the past. We trust that *Luke's Journal* will be a companion for refreshment in such times. The Journal makes a modest contribution to Public Theology in Australia. We hope this continues to grow.

In the first edition in 1995, a hymn written for CMDFA by Dr Ross Langmead was published. Ross is now with the Lord, but his words are, like grace, "a gift that keeps on giving". The third verse is as follows:

> *Sustaining God, spirit arising.*
> *Heal your wounded healers as well,*
> *as with new strength*
> *in a body made whole.*
> *How you move, who can tell?*
> *Come, refresh us with love".*

This twenty year anniversary of *Luke's Journal* is a celebration in words. It is a contribution that has resulted from the unforced rhythms of grace at work in our professional lives and our fellowship. In this journal we can document the joining of work and faith in the power of a 'resurrection life' and so we move forward hopefully.

In June 2006 the life of CMDFA was amazingly enriched by hosting the international ICMDA Conference at Meroo at the base of Sydney's Blue Mountains and Sydney's Darling Harbour. Many wonderful presentations were made, and some found themselves in the third edition of *Luke's Journal* in 2006. Of all my reading through all our past journals, the words of Canon Gideon Byamugisha from Uganda, a world HIV Ambassador for the UN, touched me the most. I share them again as a conclusion:

> *"Love in any language, fluently spoken, heals. Love, fluently ministered, brings health, brings hope."* ●

Paul Mercer
Editor Luke's Journal

SNIPPET

Sexuality Transposed (the Doctrine of the Eschaton)

The biblical drama of salvation has a plot. The movement is from old creation to new; from garden to city; from tragedy to comedy. In the world to come there is no suggestion of endless unembodiment. The Christian does not believe in the Greek notion of the immortality of the soul, but rather in the resurrection of the body as presented in the Scriptures (1 Corinthians 15) and rehearsed in the creeds (Apostles', Nicene and Athanasian).

The question is whether human sexuality and expression continues in the new heavens and the new earth. Jesus cryptically said that in the new world disciples would not marry. They would be like the angels (Matt. 22:30). John writes that in the world to come there will be marriage, but a marriage between the Lamb and his bride, the church (Revelation 19:1-10 and 21- 22). It seems that human sexual expression in one flesh union is now transposed to another plane. Human *eros* now has a Christological focus. Grace has both redeemed *eros* and transposed it.

Vol 3 No 5 Aug 2000
Sexual Orientation and Medical Practice
"Sexuality and it's Expression" by Graham Cole

SNIPPET

The developments in Western medicine that have arisen from embracing the scientific method together with Cartesian dualism have resulted in tremendous scientific progress, as defined by the assumptions of the scientific method, and intensified by logical positivism. It has been offset by deliberately excluding from study many variables that do not easily fit the prevailing paradigm, including the area of spirituality. The multiplicity of medical specialisations now makes it difficult to communicate across from one area of science to another. This has allowed the pressure to attend to patients' spiritual needs to be diverted to a non-medical specialist periphery, attended to by chaplains and other religious or lay figures. Doctors have been spared the need to address spiritual concerns in their patients, or indeed even within themselves, while the nursing profession has had to provide much of the emotional and spiritual care that patients actually long for.

Vol 6 No 3 Aug 2001 – Spirituality and Health
"Spirituality and Health – From Forgotten Factor to Reconciliation" by John H Court and Pemela C Court

SNIPPET

Spiritual issues encompass what is most meaningful and central in human existence. In times of crisis, illness and transition, spiritual issues are likely to come to the fore of human awareness for both patients and professionals. All health care professionals in different disciplines have distinct contributions to make in the way they use their training to assess religious and spiritual issues of patients. All health care professionals need to include the spiritual dimension in assessment and treatment of patients. There is thus a need for inter-professional dialogue and collaboration in order to understand each other's perspective on the spiritual dimensions of care.

Therapists might utilise the patients' beliefs to complement and facilitate the process of psychotherapy. Where appropriate, the patient's spiritual resources can be used to enhance mental, emotional and physical healing. While admittedly this can be difficult ground for the psychiatrist, and indeed physicians, addressing spiritual issues with patients is becoming an increasingly accepted part of whole person care in medicine. While clinicians will differ in the extent to which they decide to utilise and delve into religious issues with their patients, there is a minimal standard that has emerged in this area.

Vol 6 No 4 Nov 2001
Doctors and Disciples
"Do Patients Expect Doctors to be Interested in Spiritual Issues" by Russell D'Souza

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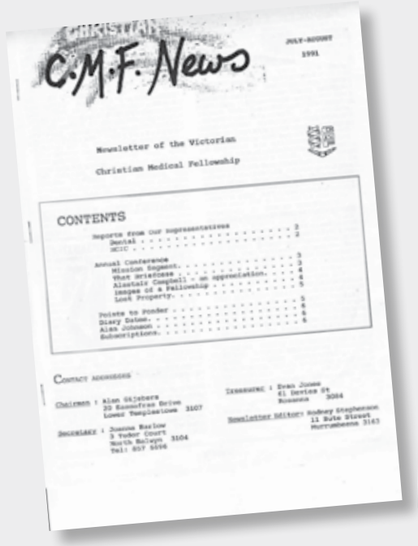
Luke's Journal, 20 years on

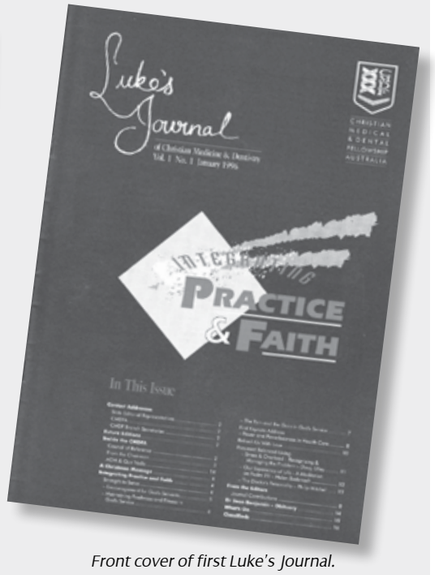
by Rodney Stephenson

Rod is the inaugural *Luke's Journal* editor. He is a GP in Berwick, Victoria, graduating from Monash in 1986. He has 6 adult children. He is a member of St Johns Anglican, assisting on the parish council and music team. He has had lots of previous involvement with CMDFA, including editing newsletters, journals, assisting with the national constitution, and acting as a pastoral worker and mentor for students in Victoria. He is currently on the organising committee for IMPACT 2017.



Front of first Fellowship News (then known as CMF News). August 1991.

Front of Women in Medicine edition. January 1995.



Front cover of first Luke's Journal. January 1996.

Yes, it is now 20 years since the first *Luke's Journal*. The name coming from Luke's House which was the name of the CMF Korea office, and was used with kind permission of the Koreans.

But it didn't just start there. I had been writing *Fellowship News* for 5 years previously. It was at a Victorian Committee meeting in 1991 that Eugen Koh suggested that I help the then secretary, Joanna Barlow, with the newsletter to ease her burden. He thought I would be good because I had been doing the student newsletter for some time. I always find it easier to look in hindsight and see God's hand at work: from a compulsory year of typing at secondary school (which us guys thought was a waste of time), to a friend at Uni who encouraged me to get a computer in 1975 when they were still quite basic tools.

My heart was not just in the technical side of the job, but it helped. With a low budget, I typed out the articles on the word processor. We printed, photocopied and folded the newsletters by hand. The feedback from those who read first the newsletter, then the Journal, was very encouraging. We (because Robyn, my wife, was ever by my side) tried to cover topics inspired by annual meetings, conferences and other areas of interest with titles like "Ethics", "Influencing Our Generation", "Sex and Family".

"How vital this Journal is to the Fellowship in linking upcoming generations of doctors and dentists."

As I now read back through my first attempts, I can't believe I used such an unreadable font. Thankfully, this changed with the inclusion of Ivan Smith, a wonderful graphic artist, who is still doing the layout to this day. It became even more aesthetically pleasing with the introduction of colour in 1993 when we first had the newsletter commercially printed in Warrnambool (yes, it is still printed there), where our growing family had moved because I had the wonderful notion of having a country practice.

Early days: Robyn and Rod Stephenson with three of their children.

Robyn did editing on a fantastic edition on *Women in Medicine* in January 1995 which was very well received.

In 1996 the first *Luke's Journal* came out. Other improvements such as a two-colour cover, peer reviewing in 1998, and employing a sub-editor in 1999 all helped my sanity. However, I reluctantly had to give away the journal and become a more present husband and father to my six children in 1999.

Editing the Journal was as much a blessing to me as others. It was great to be able to encourage members to write articles and it helped me to take in lectures when I was typing summaries for the Journal.

I was grateful that others in their turn were able to take over from me and continue the Journal. Thank you for all the effort in chasing up articles and meeting deadlines to get editions to print. I know how loop frustrating this can be but I also know how rewarding it is to see students and young doctors taking copies of the Journal to read with enthusiasm. How vital this Journal is to the Fellowship in linking upcoming generations of doctors and dentists, and how vital that we continue our Fellowship through the Journal in the face of real secular influence.

May God continue to use *Luke's Journal* for the teaching and nourishment of all in the medical and dental profession. We all need to be able to say with Paul the apostle "I have fought the good fight, I have finished the race, I have kept the faith." (2 Timothy 4:7) ●

Additional Reading:
1. From Small beginnings. *Luke's Journal,* July 1997 p. 15
2. In Appreciation. *Luke's Journal,* Feb 2000 p. 3

SNIPPET

It concerns me greatly that in our own country where we have so many opportunities and resources, the basic principles which we applied to health care in PNG are not followed in a systematic way in the Aboriginal health services. The basic principles of self-reliance are largely ignored. There is inadequate communication between the general health service and the Aboriginal health service with an incredible lack of coordination and standardisation of health care around the country. There are good attempts being made to address some of these issues, but so much remains to be done.

Vol 5 No 4 Nov 2000 – Justice in Health
"A Personal Journal Viewing Indigenous Health Issues"
by Clifford Smith

SNIPPET

As a comfortable rural GP I have a different relationship to the medical world than in my days as a doctor in the developing world. It is easy to be jaded by the drug seekers, the over reliance on medicine and the unreal expectations on us as a profession and consequent litigation fears we all confront daily. It is easy to somehow feel hard done by, put upon, even underpaid, rather than privileged to work in a world where the death of children is a rarity, where if there is a nasty disease it is more often than not treatable with medications that are both available and affordable to the health system.

Much as medical politics, financial returns, medico-legal considerations, the ongoing grind of patients to see, and medical education obligations can keep us occupied, the biblical demands of care for the poor, outlined starkly in Matthew 25 in the story of the sheep and the goats, will always place demands on our energy and attention. I am fairly sure that knowing the needs of the poor overseas puts us in the place of the sheep and goats who asked when they had ever seen 'the King' hungry, thirsty, lonely, needing clothes, sick or a prisoner. God did not give us the role of healers to assure us of comfortable lifestyles, social respectability or even great job satisfaction and the gratefulness of our patients. He will call us as healers to care for the suffering and that care must extend to the under privileged at least to the degree it does to the more privileged within both our society and the world.

"Social Justice and Medical Care Internationally" by Michael Langford

Domains of Enquiry
Enquiry into a patient's beliefs and practices can be a start. We are interested in not just the content of belief but how their beliefs impact on their lives. I often wonder, "What sort of God do you believe in?" Is their God a god of obsessive rules and regulations or an 'anything goes God,' remote, uncaring. Others seem to worship an ogre. We of course long for them to discover the God who loved so much that he sent his Son to die for us.

Under practices we could enquire about a person's religious behaviour, whether formal as in going to worship, meeting fellow believers etc, and informal by way of Bible reading (or of other holy books) or prayer, meditation, alms giving, fasting and pilgrimages. What brings them strength and comfort?

There are lifestyle issues which lie on the border between wise conduct and spirituality. For instance:

- How do they cope with loneliness? There is all the difference in the world between loneliness and solitude. Loneliness is debilitating, solitude is nourishing.

- How do people cope with driven-ness? Some drive clearly is creative and necessary to get things done but there are many patients who are constantly over-driven.

- How do people ensure they maintain balance in their lifestyle? One of the features of addiction is the salience of the thing they are addicted to. This may be alcohol or other substances, or gambling, shopping, entertainment, sexual thoughts or stereotypical behaviour, or even religious behaviour. Why are things out of balance and how can balance be restored?

- What gives them joy and enjoyment? The search for joy was, of course, the drive that led CS Lewis to faith, but have our patients developed the joy of music or painting or a sunset, or the stars or other areas of wonder?

- What skills have people developed to cope with stress and bereavement? Are they able to maintain confidence, poise and equanimity when under stress? What resources do they have? What supports within and from others do they draw on?

- How do people deal with wrongdoing and forgiveness – of themselves and others? This is an important dimension. As the romance of relationships is replaced by cold hard reality, are they able to accept themselves and their partner, warts and all? Are they able to acknowledge wrongdoing appropriately and with proper perspective and are they able to ask for and give forgiveness? Are they able to say sorry?

Vol 6 No 3 Aug 2001
Spirituality and Health Outcomes
"Taking and Evaluating a Person's Spiritual Story"
by Alan Gjisbers

"The church" and "research" rhyme, but they are not spelt the same and many would think they do not fit well together. Yet for me, as a questioning person who has been much involved with both, there is no problem, for I take comfort from Jesus' saying, "Seek and you shall find" (Luke 11.9), and have tried to put it into practice.

Vol 12 No 2 Jun 2007 – Leadership
"The Church and Research" by Prof Charles Bridges-Webb

Finding to Time to Pray
Being a medical student is challenging. Being a Christian medical student opens many doors of opportunity and brings new insight into the inevitable ethical issues doctors face today. Essential to standing firm as a Christian in the hospital setting is a firm relationship with God. This involves making time for God every day, going to church and reading the Bible. I also found that an important part of encouragement for me was meeting with other medical students.

Preclinically this required discipline. Once clinical years started it also required perseverance and organisation. People were in different groups, based at different hospitals with different timetables. Days were often very busy. Finding time was hard – but we did it. We weren't that regular; sometimes only two of us met for prayer, sometimes more were able to meet. I found this especially encouraging during psychiatry and obstetrics and gynaecology when ethics hits the fore.

I would encourage all Medical students to make the effort and find time to meet each week even if it is only two by two. I encourage you to pray, for our fellow medical students need it. They need Christ. It won't always be easy, but persevere. Especially if you are going to start in clinics next year. Start well. If you leave it until later it may never happen.

The other encouraging aspect was meeting medical 'students from other year levels and those from both Monash and Melbourne. This was done through CMDF. These meetings were helpful and gave some perspective as well as putting forth challenges. I encourage you to attend and invite your friends. May God bless you in your study and beyond. (Hebrews 10:23-25 NIV)

Vol 1 No 5 Dec 1996
Around the Campuses
"Finding Time to Pray" by Pieta Collins

Any form of imposition is unethical because it disrespects the autonomy of the other person.

It is true that the concept of autonomy can be overemphasised. It has risen to the surface as a result of the Enlightenment which elevated the individual above all else. I am aware of the philosophical disaster of Descartes' *cogito ergo sum* (I think therefore I am) because this elevated each single human being to be the ultimate arbiter of truth. Such a claim is arrogant and false.

Nevertheless, I believe that there is a Christian justification for the respect of the individual and that disrespect violates the *Imago Dei* (the image of God). Love does not coerce or impose, it respects. The stories of the Garden of Eden, and of God, Cain and Abel have as one of their themes the freedorn of choice (even wrong choices) that God gives God's creatures.

I do not believe that God imposes Godself on us. From what John Patrick said to us at the National Conference, I believe he agrees with this. God leaves hints of God's existence, like lover's flowers on our doorsteps. Because God is the Superb Lover, looking for our free surrender, God never overwhelms us, but woos us into God's care.

"The Tension between Truth and Tolerance"
by Alan Gjisbers

My Peace I Give to You
You could tell she had been very beautiful in the prime of her life, but she would never have admitted this. She was a very private being and as she approached the ninth decade of her life she was again admitted to hospital for the global anxiety and depression that had been with her for years.

No one could pierce the depths. Medication enabled a discharge after 2 months. I gave her a copy of *I Dared to Call Him Father* by Biiquis Sheikh. She wanted more. She read a copy of how I had come into relationship with Christ. As I was taking her blood pressure one day, she asked if she could find Him. We prayed together, a prayer of repentance and commitment to Jesus and invited His Holy Spirit. She knew John 3:16. We prayed the prayer twice because I went too fast the first time.

My prayer partners prayed. She accepted a book of daily Bible readings by Corrie Ten Boom. My House Group prayed because she felt unable to step out into the wider church. They were her unseen fellowship. Eight weeks later she was diagnosed with terminal cancer. She told the Christian specialist she wanted euthanasia.

The nurses sent the work experience student to her bedside to sit with her. The student's father was a Christian priest being persecuted for his beliefs in another part of the world. Somehow she was comforted. She went home. The palliative care team was involved. She wanted prayer every time I visited. We prayed the Bible, especially my peace I give unto you ... and nothing can separate you from the love of God. The anxiety settled. Her devoted family saw something had happened. But would she be in pain and would she make that terrible noise (Cheyne-Stokes respiration) when she died? We prayed again. She said thankyou after every prayer and she just slipped away in perfect peace.

Jesus returned to Galilee in the power of the Spirit ... and he went into the Synagogue ... and stood up to read ... "The Spirit of the Lord is upon me ... He has sent me to proclaim release to the captives ... and to set at liberty those who are oppressed." Luke: 4:14-2.9.

Vol 2 No 4 December 1997
Practice Under Christ
"My Peace I give to You" by Susan Selby

A Christian approach
A Christian approach to health is strongly influential in our world, both historically and currently. This Christian approach to health care is in ways influenced by and influences both traditional and modern approaches to health. Many of the world's health systems have until relatively recent times been founded and greatly contributed to by Christian health services.

A Christian approach always offers a hopeful, compassionate and respectful understanding of the patient. A Christian approach will continue to bring compassionate care into our world. We are called to bring the best of our clinical knowledge based on appropriate evidence and the highest standards of clinical competence which we are continually striving to maintain and improve, to our patient. With respect and sensitivity, we seek to understand the values and expectations of each and to understand how they understand their disease so we can contribute to their better health physically, emotionally and spiritually. Also we bring hope.

Vol 19 No 2 December 2014
Integral Mission or Holistic Transformation
"Understanding Disease: Traditional, Modern and Christian Approaches" by Michael Burke

The Effect of Medicine on my Christian Life

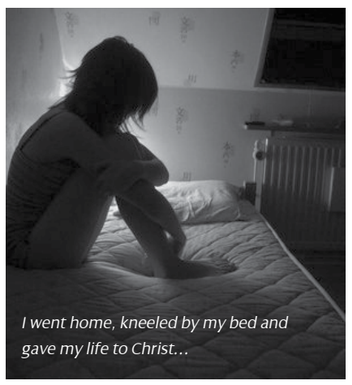
by Peter Ravenscroft

Peter Ravenscroft AM, MD, FRACP,FFPMANZCA,FAChPM is Professor of Palliative Care at the University of Newcastle. His main role now is teaching medical students in the palliative care programme. He is a former Chairman of CMDFA (Qld), of CMDFA (Australia) and of the International Christian Medical & Dental Association.

At an early age, I recognised the importance of church in my life. In relating my life experience, Christianity has been a basic influence – guiding me into medicine which I saw as a way of serving God and others. This journey has not been a smooth one.

Early days

Our family moved from Sydney to Brisbane in 1949 when I was seven years old. At high school, I participated in the church youth group, Sunday school teaching and Crusaders during school terms and church and Crusader camps during the holidays. When I was in the senior boy's class in the Sunday school at Camp Hill Methodist Church, Mr Greaves, our teacher, asked us to consider Christ's call to us to become his disciples. He suggested that if we wanted to do this we could do it in the quiet of our own homes. I did just that. I went home, knelt by my bed and gave my life to Christ. An indescribable joy came into my life that day! I look back on that day as my day of commitment. I have found it a great help to have a point of commitment that I could hold on to when things got tough later in life.



I went home, kneeled by my bed and gave my life to Christ…

In the latter years of high school, the focus moved to obtaining a good enough pass to enter medicine at University. But I had other things on my mind! In my senior year, I was elected Prefect and School Captain, as well as Captain of the Athletics team. I was a member of the Cricket and Tennis teams and an officer in the Air Training Corps. I also developed a friendship with a girl, as you do at that time in your life. On reflection, I would never pass up the opportunities for those sorts of experiences that were so helpful in later life, but I was brought to a grinding halt when the senior results came out. I did not get a Commonwealth Scholarship.

Entering undergraduate medicine

My parents had different views on my future. My father wanted me to go out and get a job – my mother thought we could manage to pay the first year fees provided I worked during the holidays to assist financially. I was in a state of shock because I had not previously worried about examinations – I had passed them well. At that time, the Dean of Medicine at Queensland University was Professor Douglas Gordon. He believed that entry to medicine should be available to all who had the qualifications for entry and the cut-off point should be the end of first year medicine. This would allow students to handle a year of university study before the cull. This we did. This experience taught me the value of adverse situations: helping me to learn the power of prayer and to focus on what I believed was God's plan for my life. I worked hard that first year and, with relief, picked up a Commonwealth Scholarship for the remaining years of the course.

My first contact with Christian Medical Fellowship (Christian Medical and Dental Fellowship of Australia, as it is known today) was when we were doing paediatrics. We formed a Bible study group that met in Professor Rendle-Short's office at Royal Brisbane Hospital. That was in 1965. Medical students were not then invited to the CMF meetings.

The student elective at the end of fifth year saw me heading for Papua New Guinea as a Medical Assistant. I was first sent to Bogia Hospital on the north coast of PNG. I found out that the doctor had just left to have medical treatment in Port Moresby. I was alone, a 5/6 doctor with no functional experience, with the help of indigenous staff. The hospital consisted of a galvanised iron shed the size of a single garage as the "ICU" and a thatched hut as the "ward". The "ICU" had two patients, one had been gored by a wild pig and had about 200 stitches in his lower body and legs and the other had stood on a stone fish and was in terrible pain. What I would have given for the advice of a good pain management physician! However, the worst problems I had to confront were two babies with Falciparum malaria who were in status epilepticus. They arrived *in extremis* and my attempts to save them were futile. The other was a pregnant mother in her last trimester with twins and a Hb of 2 gm/100 ml. My speed to arrange an aerial transfer was matched only by my anxiety. My prayer life grew enormously in Bogia!

Dr Braun and the team at Yagaum, 1965.

"The 'ICU' had two patients, one had been gored by a wild pig… and the other had stood on a stone fish and was in terrible pain. What I would have given for the advice of a good pain management physician!

I was then transferred to Yagaum, a hospital about nine kilometres from Madang. I had often wondered what missionary life for a doctor would be like and this was my chance to observe it. Yagaum was a Lutheran Mission Hospital run at the time by Dr Theo Braun, an American surgeon. He had been in PNG since the early 1930's. He had been imprisoned by the Japanese and released by the Australian Army. He met his wife in PNG – she had been there before him. When I was there, she was in the hospital suffering with tuberculosis.

Yagaum was a series of fibro huts providing inpatient care for about 100 patients in a clearing in the jungle. About 2 km further into the jungle was a leprosarium that had a further 50-100 beds. The equipment for the hospital was provided by General MacArthur who, when pulling his troops out of PNG at the end of the war, gave Dr Braun the contents of the field hospital at Finschhafen. Dr Braun had equipment to do virtually all types of surgery. By using his furloughs and visiting surgeons wisely he had learnt the techniques of them all. I had the privilege of assisting at lists of general surgery, urology, thoracic, eye surgery, neurosurgery etc. Dr Braun's skills as a surgeon and a missionary were remarkable.

The catch for me was that Dr Braun said he did not do medicine, so the medical wards were my responsibility! I did ward rounds when I was not assisting with surgery. I had not thought about the skills of nursing staff until that time, but I was very impressed with the skills of the German nursing staff – probably the inverse of the impression they had of me! The work really stretched my medical knowledge and ability and I found myself reading in the hospital library late into the night.

Dr Braun and I would often sit on his front stairs in the evening and talk about the mission, his love of English literature and his experiences. We worshipped together in the mission church with all the staff. I saw a team committed to the Lord and very focussed on giving the best care possible. When I was about to leave, he gave me a couple of pieces of advice. He said to me, "Peter, you will make a fine doctor". It's a word of encouragement that kept me going through some hard times and I try likewise to be encouraging to my students. He also said to me, "Don't think only of being a foreign missionary, but think of being a Christian influence in the medical school." I have felt that has been my calling, to be a Christian in university departments of medicine, to have close contact with students and to witness to Christian values.

Medical Graduation and beyond

As a first-year intern, I had hoped that the hospital would employ me for a second year, so that I could get onto the medical training programme. Alas, when the list of junior staff who had been reappointed for the following year appeared, my name was not on it. I thought my dreams for the future were dashed. I went to the Medical Superintendent's Office to seek an explanation, and told him my dilemma.

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He picked up the phone and rang the Director-General of Health. "We have left one of the juniors off the re-appointment list. Can I have your approval to appoint an extra one?" Amazingly for me the answer came back in the affirmative. Again, thanks Lord, my career continued!

I married Heather Moriarty in 1976. She was a fine Christian person and a wonderful mother. We, and our two children, Kylie and Simon, left on a National Health & Medical Research Council Research Fellowship in 1976 and settled in San Francisco for 2 years. During that time, we worshipped at Aldersgate United Methodist Church at Terra Linda in California. Here we were introduced to Francis Schaeffer's writings which we devoured enthusiastically. After the research fellowship, we went directly to Huemoz in Switzerland to see how the Schaeffer's community at L'Abri operated. Francis Schaeffer encourages all Christians to take our faith and explore it consistently in all areas of human endeavour – in medicine, science, the arts and family relationships. It was that integration of all these factors that captured my attention and still challenges me today.

Some of the works of the Schaeffer family…

We were not home long when Heather was diagnosed with breast cancer. Surgery, chemotherapy and radiotherapy followed, but were unsuccessful. I grappled with why God had not healed Heather and what I should do about it. One day in the shower, I was crying over the situation when I realised that resolving this situation was beyond me, and I came to realise that I needed to acknowledge my own finiteness before God. For me, the paradox was that I needed to

Francis Schaeffer. He taught us to take our faith and explore it consistently in all areas of our life…

continue to pray for Heather's healing, yet at the same time realise she may not be physically healed. Because of that thought, I felt a great weight lift from me. To live with that paradox was very liberating for me, both during Heather's terminal illness and after her death. Others have also found this so.[1] My faith in God was not affected, though I was at a low point in my life. I felt the Lord was beside me each step of the way.

Heather died in 1986, aged 39 years. The impact of that diagnosis, management and her death were massive on our family. I regret that the children suffered greatly at that time. I did not understand what they were going through. I think I was side-tracked by my own suffering and grief. When I moved to palliative care, children of dying patients had my special attention.

Beth came into my life courtesy of medicine. Beth and I had been in the same group, and in the same year of medicine, so we knew each other well. I had emerged from the confusion of being single after Heather's death, but she was a paediatrician hoping to go back to Korea, so you might imagine the discussions we had! We married a year later. What a joy she has been in my life. Trust God, He can work miracles in the lives of those who trust Him!

Palliative Care

The Lord was working within me. I had seen the value of palliative care in my own life, but I was working at Princess Alexandra Hospital in Brisbane with 1300 beds that offered no palliative care. I was responsible for pain control in the burns unit and we were doing research on opioids. In addition to my role as the clinical pharmacologist, I worked as a general physician, so I had inpatient beds. I suggested that we start a palliative care unit. The Division of Medicine were for it, but the administration were against it. I was able to get the hospital administration to allow me to have a part-time appointment at Mt Olivet Hospice (now called St Vincent's Private Hospital) to learn the practicalities of palliative care. I quietly let it be known that I would see palliative care patients and if necessary admit them to my beds in the University unit. Gradually, my beds filled with symptomatic terminal patients.

The head of the university unit was heard complaining about this and the junior staff gave me the award for the longest ward rounds at the hospital dinner. The final straw came when we decided to make plans to amalgamate the university component of palliative care at Princess Alexandra Hospital with the Mt Olivet Hospice and Palliative Care service led by Dr John Cavenagh on a vacant floor at Mt Olivet Hospice. We produced a grant application and went to the grant interview, even with the Medical Superintendent of PAH attending – that's how keen they were to get rid of us! The Cancer Council did not fund the grant. We were devastated. I decided I needed to think and pray about a move into full-time palliative care, possibly at another hospital.

Newcastle

At that time, David Allbrook, formerly Professor of Anatomy at the University of Western Australia and a friend from CMF, had taken a job in Newcastle as a palliative care physician in their palliative care outreach service. He and others had lobbied for a new hospice to be built on site and work was starting. He told me in a phone call that he had developed leukaemia and felt that his best course of action was to return to WA where he had the support of family. "Would I be interested in a job in Newcastle?" You bet I was! I was very excited.

Beth and I moved to Newcastle in June, 1992 to the Chair of Palliative Care and Director of the Palliative Care Unit, at what is now the Calvary Mater Hospital. We recruited a palliative care team and the new hospice was opened in 1993. In advertising for staff, we saw God's hand in it all. Dr John Cavenagh, applied and got the Staff Specialist job and Dr Jenny Schneider, who had been leading my research team in Brisbane, applied for and got the pharmacy job at the hospice. They both moved to Newcastle and we formed the nucleus of the academic/clinical group that we had dreamt about in Brisbane. I thank God for His hand in this. I felt our dream had materialised!

CMDFA and ICMDA

My contact with CMF (later CMDFA) began in 1965, and in 1977 one of my friends offered to pick me up and take me to a home meeting of the fellowship in Queensland. There began my membership, which later led to becoming the Chairman of the Queensland branch of CMF (1987-1991) until I prepared to move to Newcastle. I was appointed to the Executive Committee of CMF Australia (1990-2000) and later became National Chairman (1991-1995). During my term as Chairman, student work was commenced (there had been only graduate membership until this time) and a mentorship programme was implemented and encouraged nationally. Dentists were included, the name changed to CMDFA and a new logo developed.

Never underestimate God's hand in all your plans…

While on a visit to St Christopher's hospice in London in 1989, I met with Dr Keith Sanders – the General Secretary of CMF(UK) – who was also guiding the development of the International Christian Medical and Dental Fellowship. I felt a real enthusiasm for this work. The following year, Beth and I went to the International Congress of ICMDA in Seoul, South Korea. I caught the vision of the international body and was soon appointed to the Executive. In Taiwan I was appointed Chairman of the Executive Committee (2002-2010), then Chairman of ICMDA (2006-2010).

The connection to ICMDA through CMDFA gave me the opportunity to be part of a world-wide organisation bringing medical and dental practitioners from many nations together to work for common goals and to share missionary aspirations and support. To see God's work in many parts of the world was humbling and inspiring. For the great fellowship fostered through discussion, prayer, sharing the scriptures and the laughter that I experienced through these organisations, I am truly grateful to God. CMDFA and ICMDA have given me lasting memories of how the medical and dental professions can further Christ's kingdom in medicine and dentistry. I would encourage any member of CMDFA to attend ICMDA Congresses and be part of this great organisation.

SNIPPET

The real test of whether 'corporatisation' is good or bad for health will depend on the character of the people working in corporatised medical practice. If these people maintain ethical values that put patient care before personal gain, then it is possible to improve health in the community. As such we can expect good outcomes and bad outcomes. In fact this is not different from what is already occurring outside the corporate world in thousands of small practices across Australia.

Vol 7 No 1 Feb 2002 – The Corporatisation of Medicine
"The Corporatisation of Medicine" by Neville Steer

Current Perspectives

In working in palliative care, I felt that I had found a situation that allowed me to express my whole self in my work. In other words, the work focused on the physical, psychological, social and spiritual aspects of patient care. There was cross-stimulation between the Christian and medical aspects of my practice. The spiritual aspects were often lacking generally in the practice of medicine, particularly in hospital practice, and were rarely taught in medical schools in this country. A group of us have worked to have spiritual care for patients included in the palliative care curriculum of the Royal Australasian College of Physicians and we are working to provide training for supervisors to ensure it is taught well.

The spirituality we talk about in palliative care is defined as follows: "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred".[2] Terminal illness challenges all of us to seek some resolution of these issues in our own lives. Including spirituality in our patient care allows us to share our own faith journey with all people that we care for, not only Christians. To anyone wishing to read how to integrate spirituality into patient care, I can thoroughly recommend "Making Health Care Whole".[3] Evidence suggests that spirituality should rank with pain and symptom control in the medical management of patients, at least in the palliative care context. Medical students are generally receptive to learning about spirituality and I find the challenge of teaching them very rewarding.

In reflecting on my life, I cannot but say with humility, in the words of the hymn writer, "How great Thou art!" ●

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Intermed

Practical Preparation for Vanuatu

by John Fluit

Dr John Fluit, MBBS Uni NSW, has worked in General Practice in Newcastle since 1985. He is married to Anna, who was born in PNG of missionary parents, and considers that wherever we are (Newcastle or New Delhi) we have our own personal mission field provided by God. He is also convinced that there is no such thing as retirement in Christian service but simply changes in our work and environment as we age and follow God's leading.

I'm at a stage in my working life that after thirty years I would like to reduce my general practice load and do short-term work in a developing world area of need. Researching how to best prepare for this I spoke to the late Dr Cliff Smith (who had been a great mentor) who recommended the Intermed course. It's a course designed to introduce health professionals to Christian medical work in developing contexts, anywhere in the world, including our own Indigenous communities.

So, during January of this year I did the four week intensive course at Tabor, Adelaide, a Christian Tertiary College. For the benefit of anyone who is wondering whether they are called to short- or long-term work in the developing world, I thought I'd record some of my observations about the course.

My group consisted of a dentist going to Nepal' nurses and a physician from Texas, USA with experience in and plans to do more work in China, Indonesia, PNG, Sth East Asia; a young man about to commence his medical course and myself with a little experience in Zaire. This year, for the first time, the course was being offered as an accredited Graduate Certificate and Diploma in International Health and Development. Three of the group had signed up to do this. The rest, including me, choose to do the course for audit (no assessments and no formal credit).

The students numbered seven in total (a small group, more often fifteen to thirty) and one of the best aspects of the course was the bonding over the period. Every day commenced with singing, prayer and a time of sharing and devotions in the chapel. The joy of serving Christ, following His leading and seeking first His kingdom pervaded the whole course. Truly a foretaste of heaven!

The coordinators were Dr Doug Shaw and Prof Anthony Radford, both of whom had a wealth of experience in Primary Health Care in developing countries and a godly mentoring attitude towards the group.

The course covered a wide range of subjects – from the common diseases and health challenges in various communities, to strategies for implementing programs in remote communities. We learned about tuberculosis, AIDS, malaria, immunisation, malnutrition, worms and parasites (many lecturers recounted personal encounters with these!). We went to a pathology laboratory and learned to make microscope slides and identify all sorts of nasties. There were talks on mental health, surgical emergencies, resuscitation, suturing, inserting cannulas, how to pull teeth , give anaesthetics, as well as putting each other in plaster casts, etc.

The four weeks were very full and we even had lectures on Australia Day (after a respectful waving of Australian flags and donning of appropriately patriotic hats of course!).

The most helpful aspect of the course was that all the lecturers had significant experience in their fields and were able to present extremely abridged versions of their topics, emphasising the common and practical aspects rather than just inundating us with information.

Following on from the course at Tabor, Intermed lead a team of medical professionals on a **Practicum** to Vanuatu in October. We spent two weeks learning about the culture and delivering health care in context. We visited villages in which we used fact-finding tools (that we'd learned in theory) to best engage with the locals to identify and enable changes that were relevant to their needs and capabilities. We did numerous clinics in unusual places while being taught by the Intermed doctors and nurses already working in Vanuatu. At the same time we passed on some of our skills . Again there was a strong spiritual element. The best example of this that I can recall was a local man having a huge lipoma removed from his neck. Whilst this was happening, the local pastor sat beside him explaining how sin is like a burden on our shoulders that can only be removed by 'specialist' intervention by his loving creator! God worked mightily during the two weeks and the team and locals were blessed.

There's much more I could say. Check out their website www.intermed.org.au. To summarise, I believe I left with a new enthusiasm for God's work in the developing context and the empowerment to be useful! ●

Meet CMDFA Family Members

by Grace Leo

Even though CMDFA encompasses so many members with diverse interests, we are all part of one family in God's great kingdom. Let's meet a few of our members who reflect on what CMDFA means to them and how they have enjoyed being involved over the years:

Dr Lewis works part time as an ED SRMO and joined the NSW state committee this year. Prior to that she worked in Alice Springs for two years as a Tentmaker Encouraging Aboriginal Ministry with AIM before heading to Sydney this year to study a full time Graduate Diploma of Divinity at Sydney Missionary and Bible College. She thanks God for time with her family, refreshment and His amazing creation of shrimp plants!

"As a member of the CMDFA I support the fellowship in what ways I can financially and in fellowshipping with the body of Christ in Healthcare. It is a privilege to participate in blessing and being blessed by the CMDFA family at dinners, conferences and other informal chats. This year I had the opportunity to join the NSW committee as they seek under God to serve the CMDFA in NSW so doctors, dentists and students can be encouraged to live lives that glorify God in the workplace. Officially I'm meant to be helping out with communications but I have also been involved in discussions about how to support students and doctors in training, especially in their first few years in the workforce. As a student, and now SRMO, I am grateful for the ways CMDFA has helped me to work through issues specific to the medical setting with regards medical ethics, career decisions and how to live as a faithful Christian doctor."

Tim Charles is a GP Registrar in Brisbane working with the Army. He is married to Kasey and father to Gabriel (almost 3) and baby Grace (8 weeks).

"I was first introduced to CMDFA while I was dating Kasey and she was in Med school at ANU in 2007/8. Tash Yates was a great leader to us then. We had a group at Flinders in 2009 led by Kelly Chugg (now Peterson) and Tanya Jones. I attended Vision in Jan 2010 and IMPACT / Recent Grads Retreat several times since. I was a student SA board rep in 2010. We assisted with starting a group in Darwin during 2011/12 with Chris Symonds and Phil Morrow + team. We hosted the Intern Boot Camp 2015 with several junior doctors in Adelaide and held a few junior doctor meetings that year. CMDFA has always been a group of like-minded Christians with a passion for service and fellowship with the ability to share and support each other through small groups and the larger meetings like Impact. I look forward to seeing CMDFA continue to grow and to be able to share my experience, especially now I have been working for a few years with those coming through medical school/ junior doctor years. I would encourage them to continue to stay motivated and connected to Christ during those busy years.

A memorable moment from my time with CMDFA would be the connection with Dr Symmonds (the father of Chris who I met at IMPACT in 2011 and we lived in Darwin together in 2012) in Fiji at the Suva hospital emergency department while he was there teaching medical students and I was working with the Army post-Cyclone Winston."

Mimi Xu is a Resident Medical Officer from NSW. She loves curling up with a good coffee, the colour red, found a medical elective in India transformative and is looking forward to starting Psychiatry training next year.

"CMDFA is a family of people just like me who understand the struggles of being a medic and the often-challenging work-life-faith balance that we have to do as Christians. I've mostly been involved in attending IMPACT conferences and other NSW local events such as Intern Boot Camp. I love being encouraged by those older and wiser and being able to encourage those facing a stage of work/life that we have already faced. It's a wonderful community that feels like home. What is the most special is that IMPACT means you get to catch up with people from all over the country that you only really meet once a year, but boy, are those catch ups precious! It's saying hello again to an old brother/sister." ●

Looking forward by learning from past experiences

Tapping into God's Strength as a Junior Doctor

by Lorraine Cheung

Lorraine is currently a resident and will be embarking paediatrics training in 2017. She is a child of God, a child at heart, and prays for a Matt-18:3-child-like, trusting faith every day. As a speaker at the 2016 CMDFA internship bootcamp, Lorraine loves gathering fellow Christians in hospital together, to encourage one another in spreading God's aroma on the wards.

How do we tap into God's strength as junior doctors? In medicine, there are many times when God's strength is needed to carry us and uplift us through both the joyful and sorrowful days at work. Let me share my own experience as an intern on an after-hours shift.

It was the first hour of a 15-hour shift, and I reviewed a gentleman who had suffered from a presumed transient ischaemic attack (mini-stroke) with some residual speech deficits. During this morning review I assessed the patient, answering many questions from the patient's wife as best I could. I then went about my day, performing different ward jobs. Around an hour later, I received a call from a nurse, ringing about the patient. "It's the wife again" she says, "she says his speech is slightly worse." "Is there any weakness?" I enquire. "No, I don't think so," the nurse answers.

I spent the next few hours looking after this man. Each time I entered his room, his wife appeared disgusted at me. It crossed my mind to avoid her, but I knew I had no choice.

"She... began to hurl personal insults, questioning how long I had been a doctor and telling me that if I ever continued my medical career, 'I'd have a lot to learn.'"

In hindsight, there were many things at this point in time that I would have done differently. But in the moment, I was caught up on another ward reviewing another patient and in my distracted state I said, "I'll come and see him when I can." Forty-minutes passed by before I could attend the patient. When I entered the room, I found his wife perched on the edge of the chair glaring at me, "Why have you come round so late!?" I apologised for being caught up on the other wards and started to assess the patient. I tested his power and discovered hemiplegia (weakness) on his left side.

My heart drops, and my stomach flips. Have I delayed the window for thrombolysis? What if it's me who leaves him with a residual hemiplegia? I feel my cheeks flush red, and duck out to activate the urgent stroke call.

I decided to apologise to her formally, acknowledging that I should have come sooner. She was so acutely upset that she was unable to process this and began to hurl personal insults, questioning how long I had been a doctor and telling me that if I ever continued my medical career, "I'd have a lot to learn."

This was the first time I cried during internship. It was the first time I felt the weight of responsibility of being a doctor. And to this day, I would have to agree with what she said – I had a lot to learn.

John Piper says, "Faith is not the boast of the strong. It is the cry of the weak in need of a saviour." It seems obvious, but if you were strong in the first place, why would you need to find strength in God? Finding strength in God calls you to first realise your weakness. In 2 Corinthians 12, Paul speaks to the Corinthian Church about a vision he was granted from God. His opponents were always boasting in their spiritual experiences and Paul is very hesitant to boast of his vision. He writes:

"On behalf of this man I will boast, but on my own behalf I will not boast, except of my weaknesses – though if I should wish to boast, I would not be a fool, for I would be speaking the truth; but I refrain from it so that no one may think more of me than he sees in me or hears from me. So to keep me from becoming conceited because of the surpassing greatness of the revelations, a thorn was given me in the flesh, a messenger of Satan to harass me, to keep me from becoming conceited. Three times I pleaded with the Lord about this, that it should leave me. But he said to me, "My grace is sufficient for you, for my power is made perfect in weakness." Therefore I will boast all the more gladly of my weaknesses, so that the power of Christ may rest upon me. For the sake of Christ, then, I am content with weaknesses, insults, hardships, persecutions, and calamities. For when I am weak, then I am strong."

There are three things we can learn from Paul's letter which can be applied to our work and struggles.

1. What does 'weakness' look like for a junior doctor?

2. Why does God allow these weaknesses?

3. How do we boast in our weakness to display God's glory?

First thing's first. Let's clarify what Paul means when he talks about his "weaknesses." I think some might be tempted to say that weakness refers to "sin," but Paul clarifies what weaknesses are. He talks about "insults, hardships, persecutions and calamities." These seem to infer that there are circumstances that are forced upon you rather than sinful circumstances, which stem from our own hearts.

When I asked some residents what they wish they knew in internship, a recurring theme was, "I was always told internship would be tough, but I never knew what that meant, until I started." Internship can be tough – physically, mentally, spiritually. It might not be tough for everyone, all the time. But, unlike the carefree days of being a medical student, it is easy to feel the burden and weight of the responsibility. There will be times when you have a lower urine output than your patients or you become pre-syncopal with

continued over page

"I was always told internship would be tough, but I never knew what that meant, until I started."

SNIPPET

Most of all, I would like to encourage participation by Christian health professionals in the broader sphere of international health activity. There are many groups in Australia engaging in this in some form or another, including: non-government organisations, both Christian and secular, non-profit institutes, university departments, special interest groups in hospitals, commercial project management companies and others. Christian health professionals have much to offer here. We can unashamedly tap into a special heritage and history of health care. We can offer a counter-culture professional perspective that starts with the worth God places on each individual and does not value the useful over the poor. And all of us will benefit from closer identification with the labour, often sacrificial and saving, of Christians working overseas.

Vol 7 No 2 May 2002
Broadening Our Horizons – Looking Overseas
"International Health – A Rapid Appraisal"
by Chris Morgan

hypoglycaemia. There can be difficult and seemingly unreasonable families to talk with. Even with the best of intentions, we will make the wrong clinical judgements. You will get judgemental glares, when you stand up for a fellow intern who all the nurses are putting down. You will manage to disappoint your seniors. You will get dissatisfied shrugs when you choose not to gossip with your team about co-workers. You may feel overwhelmed by the workload. There will come a time when you get the gut-wrenching feeling that you've made a mistake and realise your incompetency.

You will feel overwhelmed with stress and guilt and inadequacy when you find yourselves in such situations. They make us look weak.

And that's the point.

This is why God grants us these weaknesses in the first place. As people working in medicine or dentistry (many of us with type A personalities), we can be bad at failing or have trouble responding to situations that make us feel and look weak. So, saying, "When I am weak, I am strong," is very radical. There are two main reasons why God allows these "thorns" to pierce us.

Firstly: We realise where our values are held and where our identity is found. When I become upset about an incident, or a failing, I always ask myself, "Why am I feeling this way?" How much of my disappointment is because my ego has being crushed or because I feel like other people are judging me? Tim Keller in *Counterfeit Gods* talks how one way you can identify an idol is by tracking your emotional response to different

"Let me tell you from experience, thankfulness and encouragement is countercultural. It has the ability to change the dynamics of our work day, our team, and even our ward."

situations. He says, "pull your emotions up by the roots and sometimes you will find your idols clinging to them. When I'm upset about a situation, I end up asking myself, where, or in whom, do my security, and hope, and desires lie? And why am I so anxious, upset or disappointed about this situation? Who am I trying to please? Man or God?

Secondly: God says to Paul, "My grace is sufficient for you, for my power is made perfect in weakness." It is in these times when God brings us low, that we realise his height. We realise our dependence on him, for every breath and footstep.

What does Paul do when he receives the thorn? He pleaded with God for Him to take it away from him. Paul's weaknesses are the platform for perfecting and demonstrating the Lord's power. You see, the fact is, our suffering reflects the suffering of Christ. God chose what is foolish in the world to shame the strong (1Cor 1:27). If we were actually "strong," we would retaliate when we face these situations. We might return the insult, we might turn back the hardships, we might cover up the calamities and use our own strength to get out of the distress.

When we get down on our knees and plead to God for our sufferings to be relieved, we demonstrate our dependence on Him. We should pray, not assuming he will take the thorn away, but we pray and trust that God will listen, give us strength to endure and even rejoice in tribulation. By doing so, we display the resurrection power of the Spirit, and Jesus' victory over death. We are set free from the shackles of the guilt and burdens of our weaknesses. We can boast in our weaknesses to bring God the glory, displaying our reliance of God's strength, and grace.

John Bloom, co-founder of Desiring God lets us in on a secret. He says, "the more aware you are of God's grace, the more humble, prayerful, thankful, patient, gracious, content and joyful you will be."

After considering all of this, how can we "boasting in weakness" look like in the workplace? Finding strength in God, amidst tribulation, plays out in 4 ways, and it spells out "T-A-A-A-P" – for "tapping into God's strength." Thanks, Ask, Apologise, Admit. Pray

Thanks – A thankful heart speaks humility. Thankfulness speaks contentment. Thankfulness can be when we "consider it pure joy when we face trials of many kinds" – James 1:2-4. Think about it from the devil's perspective. He wants us to complain, and hurl insults back, to retaliate. But how radical would it be if we responded with thankfulness?

Thankfulness also applies to thanking other people. Philippians 4:8 reminds us "Whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable – if anything is excellent or praiseworthy – think about such things." Just a small word of encouragement to a fellow intern, a med student can express thanks. And giving appreciation to your registrar or even to your consultant can go a long way.

Sometimes I ask myself, why am I so reluctant sometimes to give praise to my colleagues, or to a nurse. When I dig, I find it's my own ugly pride which is stopping me. You see, when we complain or put someone down, it makes us feel as though we've stepped up another step on the pedalstool. And in our heads, we think that maybe when we praise, it will push us down and the other up. But this is ridiculous! We are to be thankful, because that speaks humility. It speaks contentment and appreciation, for the situation we're in. Let me tell you, from experience, thankfulness and encouragement is countercultural. It has the ability to change the dynamics of our work day, our teams, and even our ward.

Ask – Don't be afraid to ask! As we are junior doctors, we are expected to ask. This is our chance to really learn and ask all the questions we have! We are not expected to know everything. This principal extends beyond internship as well. Asking for feedback and accepting criticism humbly shows that you are not someone who covers up their weaknesses, but shows that you are willing to learn, and ultimately, it is because you care and want the best for your patients.

Apologise – Many a time, we will wrong people. In our weak selves, we will succumb to temptation. We will follow the crowd, we'll take short-cuts. When we're tired we will become curt with the nurses or the patient's family. In our weaknesses, we make mistakes. The worst thing we can do is to cover it up. Think about David and Bathsheeba. When we cover it up, one thing leads to another. We should apologise to God, and we should apologise to the ones we wrong.

Admit – Last year I was working in Coffs Harbour and I had a wonderful consultant to work with who has great respect for his patients and colleagues alike. One day, he came across a patient who was a failed discharge. She had a GCS of 3 and needed transfer to a major hospital because this consultant had ceased her immunosuppressants a few weeks ago, and she had a relapse of Hashimoto's encephalitis. I received a phone call from the immunologist with strict instructions to "Please, don't stop the immunosuppressants for at least 3 years, unlike last time." To my surprise, my consultant said, in front of the whole team including our registrar, two interns and a medical student, "Well, that was one of my mistakes of 2015, that's good to know for next time." We were stunned, that this consultant admitted that he was wrong – it was so rare, so radical! What did it show? Humility.

I realised how loudly it speaks when others know you are a competent doctor, but you also are not afraid to admit to your weaknesses, and boast that you are also learning, just like everyone else.

Pray – Not only do we admit to those we might have wronged, but admit our weaknesses, our insults, our calamities to one another. Remember that in sharing in Christ's blood, we share in his sufferings. And we do this together. The act of admitting weaknesses to another, will allow the other person, when they are also faced with weaknesses, to know that they aren't the only one who faces them. By sharing with one another, and praying together, we can be vulnerable, honest to each other. When we share to one another, we share as two very fallible humans, both humbly sitting at the foot of the cross. Just as a warning, be careful to not let these incidents turn into gossip. If you find yourself saying, "oh so-and-so nurse has insulted and wronged me…" this is self-righteous talk. May our words be full of humility, honesty, thankfulness and joy.

I pray that we will be able to acknowledge God in each day and each step we take. That in our weakness, we can cry out to God and be reminded of our dependence on Him as our great Heavenly Father. I pray we may be able to boast in our security and hope in God, to have the humility to ask, admit and apologise in the workplace. I pray that in everything we do, for the glory of God, by always tapping into God's strength. ●

SNIPPET

The powerful mutual attraction that existed between Jesus and the sick and troubled was paralleled in his relationship with others who, for a variety of reasons deemed by society as right or inevitable, were marginalised and ostracised. Not only did he not reject them; he frequently sought them out and embraced them. The gospel records are replete with example after example of Jesus confounding or enraging his critics by such "deviant" behaviour, and encouraging his disciples to similarly misbehave. Those who became companions and friends of Jesus found that this relationship led them also into the company of the poor, the dispossessed, the disapproved of, and those pushed out of sight and mind. Why? Because, quite simply, to be a companion of Jesus was to walk where he walked and be led into holy deviancy.

Vol 7 No 2 May 2002 – "Holy Deviancy" by Steve Bradbury

SNIPPET

People are put in prison because the judges had determined that society needed to be protected from people such as these. And so the prison management rightly go about doing all they can to effect this charge. Rules and regulations are a necessary part of this. In a place where people who steal, rob, kill, shoot up, fornicate, beat up other people and regularly tell lies without batting an eyelid are all put together, it is not surprising that the worst of humanity are brought to the fore. They do all the things that Christians consider sinful. But if we recall Scripture, and especially the standard that our Lord Jesus set in the Sermon on the Mount, and take time to reflect, one quickly realises that we ourselves are truly not much better. As Paul reminds us, "All have sinned and fallen short of the glory of God". If we are now different, it is because we have experienced the love of God. Amazing grace!

I am glad that I work in a place where have had the opportunity of being regularly reminded of God's grace and mercy. "But for the grace of God go I". Lady Megan Bull is quoted as saying, "The years I spent as a prison doctor were the most rewarding of my professional life."' This too has been my personal experience. It has been my training ground in discipleship. Each day find myself challenged to "act justly, love mercy and to walk humbly with God" (Micah 6:8).

Vol 1 No 4 September 1996
Care of the Incarcerated
"Care of the Incarcerated – Reflections of a Prison Doctor" by Chris Liew

What is 'Christian Wholeness Counselling'? Psychiatry prides itself in an eclectic and holistic approach. This includes the well-known 'bio-psycho-social model'. However, as research has shown over the last number of years, the spiritual side of the equation is often left out. Generally, providers of mental health services are significantly more areligious and atheistic than the community. This difference has resulted in the so-called 'Religiosity Gap'. Christian Wholeness counselling attempts to close that gap. It can be integrated with medication and the psychotherapies, and acknowledges that the patient has an extra dimension of change, that a third person is present in therapy, and there is an additional family outside the doctor's rooms.

Vol 7 No 3 Aug 2002
Who Cures Souls? Christians and Mental Illness
"Touching Heaven, Changing Earth" by John Warlow

There have been some interesting studies on the beneficial role of prayer and of a religious affiliation on outcomes in coronary care, burns and even paediatric oncology. (*The Faith Factor* by Matthews). And there was some recent debate in Christian Medical and Dental Association email lines about whether or not RCTs were appropriate to explore this dimension. I can say from a "Study-of-1" that when I blew up*, my wife emailed friends and relatives around the world and we both felt uplifted on a bed of prayer from four continents, including those of my Muslim cousins in Malaysia. Robin says at no stage did she feel doubtful of the outcome nor was she ever laid low in her spirit during those first couple of weeks. It is salutary to contemplate to whom were my Muslim cousins praying – to the one True God, I believe.

Vol 11 No 1 Feb 2006 – In Health and In Sickness
"One Heartbeat Away from Heaven"
by Anthony J Radford
*This is a quote after Anthony Radford suffered a ruptured aortic aneurysm and was seriously ill.

So who am I? I am a surgeon in the Royal Navy, with over 20 years service under my belt, and I headed up the surgical capability afloat for the UK Forces deployed into Iraq earlier this year.

By virtue of my age, I am of the 'old school' of surgeons, having trained in the generality of surgery, rather than superspecialising at an early stage. Consequently, I am equally at home dealing with vascular injury and bowel injury, breast cancer and paediatric surgery. I received my trauma training in Johannesburg, South Africa, which has the highest rate of gunshot wounds and stabbings in the world. I also happen to be an ordained Anglican priest – and the Professor of Military Surgery for the Defence Medical Services, UK. An odd combination, I will admit.

God was neither bolted on, nor an augmentee – He was there already. Indeed, His representative – a naval chaplain – was integral to the ship's complement, though he, too, was only drafted in as an augmentee because we were going to war.

It is strange to note that it was through the effects of the first Gulf War on the ship's chaplain then, that I began to explore my own path to ministry and the priesthood.

Vol 8 No 3 Nov 2003 – Casualties of War
"Gulf War 2: A Time to Kill and a Time to Heal"
by Philip Barker

I have argued for religious voices to be recovered from the modernist wilderness.

Religious voices, along with other marginalised voices, need to be allowed access to the ethics conversation table.

The challenge to medical ethics, in particular, is to become more inclusive of different voices – including religious ones. In order for this to happen, the field of ethics must subject itself appropriately to a critique of its modernist assumptions concerning the rationality of religious belief.

It is at the table of public conversation that all voices offer themselves for critique. Only then can legitimate discourse within medical ethics, a discourse amongst equals, even begin to take place. Only then can we move towards finding answers for some of the more serious moral questions of our time.

Vol 9 No 2 Jun 2004 – Religion and Ethics
"Religion and Ethics: A Conversation We Ought to Have"
by Edwina Vance

Scientific and religious prophets have sounded the 'clarion call' for the distress being experienced by ecological and social systems. They are calling us to repent of current lifestyles and start living more in communion with the environment. Decisions regarding our food, clothing, housing, and transport provide daily opportunities to consciously 'live' our faith. Our religious faith, and deep love of fellow humanity and creation, will underpin the hope necessary to empower and maintain effective and sustained action.

Vol 14 No 4 Dec 2009 – Climate Change
"A Changing Climate: Some Christian Responses"
by David King

The chief concern of this article is to consider [Peter] Singer's defence of infanticide in the light of recent events in Queensland, over which the philosopher's shadow looms, which show the attempt to move beyond theory to practice, introducing social infanticide on a continuum with social abortion.

I write as a specimen of the old tradition, for whom the sanctity of life ethic, properly understood, has not collapsed, and for whom the "something better" heralded by Singer gives no joy.

Singer has been laying the theoretical basis for infanticide-on-demand since at least 1979, writing in *Practical Ethics*: If the fetus does not have the same claim to life as a person, it appears that the newborn baby does not either, and the life of a newborn baby is of less value than the life of a pig, a dog, or a chimpanzee... In thinking about this matter we should put aside feelings based on the small, helpless and – sometimes – cute appearance of human infants... If we can put aside these emotionally moving but strictly irrelevant aspects of the killing of a baby we can see that the grounds for not killing persons do not apply to newborn infants.

The call to "put aside feelings" recurs in Singer's work. Gaita saw in this "an impoverished understanding of reason and its relation to feeling, of the distinction between knowledge of the head and knowledge of the heart." CS Lewis, who may have crossed paths with the philosophy student at Oxford, made the point in *Men without Chests*: "It is not excess of thought but defect of fertile and generous emotion that marks them out. Their heads are no bigger than the ordinary: it is the atrophy of the chest beneath that makes them seem so."

Vol 2 No 1 Mar 1997 – AIDS and Abortion
"On the Sactity of Human Life" by David van Gend

The goal of healing?

So what is the goal of healing? One refugee who had been receiving help for a while said, "I feel good coming here, I appreciate the practical help I get, I'm sleeping a little better, and the massage relaxes me, but I'm not healed yet. I will know when I am, for then I shall be free."

Is not freedom a core element of God's promises? That we shall be free. Not just from persecution, poverty, and pain, but from sin, and the final enemy, death.

It is ironic that Australia, which prides itself as a freedom loving country believes that locking people up is a long term solution for indigenous and refugee "problems". Australia locks up more people than any other country except China and the USA. For those asylum-seekers in the limbo of detention centres, death can be seen as the path to final liberation, the act of suicide the only act in their power.

Vol 7 No 4 Nov 2002
"I was in Prison" – Refugees and Asylum Seekers
"Reflections on the Refugee Experience"
by Martin Chittleborough

There remains much for the church to do in caring for the sick and dying and bereaved.

We are exhorted to call the elders to pray and anoint the sick. We are not promised miracles at our whim. Thankfully the outcome of our prayers remains firmly in the hands of our heavenly Father.

One dear and faithful member of our church with lymphoma had severe ieucopenia following chemotherapy. The church offered much prayer both corporately and at her bedside.

My mobile phone rang in church one Sunday morning just after the pastor had finished leading in prayer for her healing and the phone message was that she had just died.

Does God have a sense of humour? Or is his kindness just so much deeper than we will ever fathom?

Vol 5 No 2 May 2000 – Death and Dying
"To Weep With Those Who Weep"
by Richard Chittleborough

The Gospel of Luke as a celebration of difference

From the very beginning Luke's Gospel presents Jesus as the faithful preserver of Israel's tradition of hope for the nations. His mother is honoured as a prophet in the tradition of Hannah (1 Samuel 2:1-10). The baptismal acclamation of Jesus as Son of God is a literary link to the Adam, son of God in Jesus' genealogy. The proclamation of Jesus in the synagogue at Nazareth reminds the reader of Elijah, whose beguiling narrative weaves its way through the tedious listings of Kings illustrating the heart of a compassionate God who blesses and heals Jews and Gentiles, males and females, children and adults, and who cannot be confined to one geographical space. Ultimately, the Lukan Jesus is a martyr *par excellence*. He is not prepared to compromise on the faith he is handing down, but instead of revenge he takes pity on his executioners, forgiving them as will all the martyrs that follow Jesus' example. For Luke's community, Jerusalem is not to be remembered as a place of condemnation, however, but as a place of new life and hope. There is no leaving for Galilee to find the risen Christ. he is in the region of Jerusalem, will ascend to heaven from Jerusalem and his church will be inaugurated in Jerusalem. In Luke's Gospel, the truth of God's presence is found in the midst of extravagant hospitality offered to friends and enemies alike.

Vol 9 No 3 Oct 2004 – Tolerating Differences
"A Biblical Basis for Tolerating and Celebrating Difference"
by Merrill Kitchen

Fruit blooming in the desert

by Jacki Dunning

Student worker for CMDFA

At my first IMPACT conference, I met a doctor who lived and worked in the Northern Territory – in Alice Springs. It had always been my dream to work in Alice and I had already been there on placement. In fact, every year I went back to Alice as a student.

Finally as an intern, I was offered two jobs – a big Melbourne hospital (the Alfred Hospital), and Alice Springs Hospital. I took the plunge, shifted mine and my husband's lives to the Northern Territory, and haven't looked back since. Who was the first doctor I saw when I picked up my pager at the hospital? It was the same doctor who first planted the seeds at my first IMPACT as a student! She was there on my first day as a doctor to see the fruits of her conversation with me, all those years ago.

Today, I work with Indigenous Australians every day and can't imagine doing medicine any other way. God constantly uses people to challenge my faith, to keep me questioning, to shake my complacency, to inspire me, to make my heart burn, to flame my passion, to sharpen my skills and harden my armour. My current burden is my role as the oncology resident in Alice Springs Hospital. Alice doesn't have a specialist; there is just myself with a telephone, and a hassled oncologist on the other end of the line. I feel so inadequate. Never before have I had to deliver bad news, so frequently, to patients. "Your treatment has failed." "We have tried everything, you have fought so bravely, but it is time to stop chemotherapy."

Yet every day I am reminded that this is not the end. There is always more that can be done – and that more is to pray. I can pray for my patients. I can speak light. Yes, I am hampered by the professionalism of the job, by political correctness, by time, by space, by emotion, and often by language. But that doesn't mean I say nothing. I can at least say something with a touch of the hand, a hug, genuine and from the heart, I can tell my patients I pray for them. And God can water the seed. God will water the seed, in my patients as He did with me. ●

There is enormous support provided when people can hear each other's stories. Those of us who have ongoing contact with people with life-threatening illnesses should encourage them to tell, or write, or paint their stories, even if the only hearers, readers or viewers will be their families or friends.

It is somewhat ironic that the accounts proclaiming the fullness of life discovered through facing death are nowadays to be found not in Christian devotional manuals but in first-person accounts published in palliative care journals and magazine articles. There are stories about how the imminence of death has led to liberation that people have avoided in the rest of their lives, stories about near death experiences that have transformed the way people now live. Stories about encounters with angels that have re-directed people's paths (and spawned the odd telemovie along the way). Stories you'll find in the New Age section of your local bookshop, alongside a dwindling remnant of Christian materials that also make their way there.

Where then are the stories which emerge out of mature Christian reflection? We have some catching up to do, even though it's Christian tradition that gives shape to this new literature in the first place.

Vol 5 No 2 May 2000 – Death and Dying
"Death, Health and Medical Practice" by Bruce Rumbold

Once you've managed all the basics of stepping into another culture, probably the next step is to earn acceptance. When others realise that you're also human and vice versa – despite the different language, different skin colour, different life experiences – then acceptance should come naturally. They key is that living and working within another culture is necessarily a two-way exchange if it's going to be successful: **don't expect others to share their lives with you unless you're willing to reciprocate.** So be willing to share what makes you happy, what makes you sad, who is in your family – these things are universal.

Sometimes even I am pleasantly surprised at how this works out in my own life. I have some very good Aboriginal friends with whom I have very little in common: they may have never seen the ocean, let alone travelled abroad, who may have never known someone Chinese, who have not completed secondary education, who speak limited English, who do not have much money in their bank accounts, and who have never owned a camera. Not long after I visited my friends and relatives in the United States, several of these Aboriginal friends took great delight in looking at hundreds of photos of my American family and friends in big cities, by the sea, and eating in restaurants! I didn't expect them to be that fascinated! In turn, one friend told me stories about travelling across the desert on a donkey with her family when she was a child, another told me a story that her grandmothers and grandfathers told her – every week, I have more stories to tell of how my friends (with whom, on the surface, I have very little in common) share their joys and sorrows with me, I share mine with them.

Vol 14 No 2 Dec 2009 – Cultureh and Professional Care
"A Global Nomad's Thoughts... On Living and Working Across Cultures" by Teem Wing Yip

There is great value in getting out of the surgery and taking a clean break from work, on a weekly basis, for my own sanity and mental health. There is usually a degree of isolation – it is unusual for me to see anybody else at all, apart from my walking companions, on most of my walks. I find after a day out in the bush I feel refreshed and ready to face the rest of the week.

In spite of all this, I am often reminded that God's primary concern is for people and their eternal salvation. Although one can sense the presence of God when in the wilderness, He is especially to be found in people: Heaven is often described in terms of a city, with buildings and streets, full of people. The ultimate picture in Revelation is one of people: it is the praise and honour of people that God ultimately desires, above and beyond that of the bush.

Vol 14 No 4 Dec 2009 – Climate Change
"He Restores My Soul: Why I Go Bushwalking in Tasmania"
by Philip Andrew

We are all familiar with the mentor concept so well described in the Paul-Timothy relationship in the New Testament. I believe that today, more than ever, young Christian dental and medical students need mentors from the profession who can provide a mature, balanced view of the world from a Christian point of view. At our own dental school, we have been blessed in having the involvement of Christian dental fellowship members with the student group on a regular basis over recent years. It has had an enormous impact on the Christian dental students both individually and as a group. Thus my challenge to readers of Luke's Journal is to look for opportunities to become involved with the Christian student population in your local university dental or medical school. Our students need and value your input and witness!

Vol 12 No 1 Mar 2007
Medical Teaching and Christian Faith
"Dental Education – Parameters for Personal Growth" by Laurence Walsh

Before I ever met him, one of Melbourne's leading oral surgeons was described to me as "a good oral surgeon and a good Christian". Another dentist used the same words shortly afterwards. When the phrase was repeated a third time I realised that the life and actions of the oral surgeon followed the teaching of Jesus Christ: *"Let your light shine this way that people may see your good works and glorify your Father who is in Heaven"*. (Matthew 5:16) Some time later we became acquainted. He told me that he often "shot up a silent prayer" during a treatment session. His choice of words caused me to reflect. If God works through His Spirit and prayer (Philippians 1:19) and Jesus commends secret prayer (Matthew 6:6) should we consider the silent prayer to be as effective as the audible when we are being "workers together with God" (2 Corinthians 6:1) in the 'treatment room?

Vol 12 No 2 Jun 2007 – Leadership
"Witnessing Happens" by John Messer

The first is to show grace to all people. Grace is the one quality that distinguishes Christianity from virtually all other faiths, and certainly the self-centred, secular world around us. Grace has been described as receiving that which cannot be gained for yourself. God's gift of Christ crucified to restore relationship between himself and us was the ultimate expression of grace. Showing grace in the medical school demands showing as much respect and honor to the first year students and the cleaners as to the Dean of the Faculty. It means acting as a servant, making yourself available, making sure every question asked is answered with respect. it is particularly guarding against the temptation to exasperation or a cutting riposte. It is making time to be a listening ear when there are pressures inside and outside the course. It is the antithesis of much of the university culture, where success is lauded loud and long, and everyone is exhorted to strive for the next grant or publication. The two are not mutually exclusive, but Christians in that environment must be continuously wary of being seduced by noisy adulation and demands to be productive.

Vol 12 No 1 Mar 2007
Medical Teaching and Christian Faith
"Medical Teaching and Christian Faith – A Personal Perspective" by Geoff Mitchell

Keep going! Talking about ethical issues in the workplace can be challenging, but also extremely rewarding. It takes practice, and some people will find it easier than others. Don't give up! Ethical discussion offers a window into understanding our coworkers better than would be possible otherwise, and into letting ourselves be better known. For Christians, ethics is ultimately about living out our faith, and we should pray that conversations about ethics will also lead to opportunities to share what we believe and why.

Vol 16 No 3 Dec 2011 – Ethical Grand Rounds
"Talking About Ethics at Work" by Justin Denholm

Doctors Who Inspire Us

The Life and Work of Three Famous Australians

by Don and Michael Todman

Don is a Neurologist in Brisbane, and Michael, School of Medicine, The University of Queensland.

All of us in the medical field have mentors who have guided our paths in clinical training. The process of mentorship involves a personal relationship between teacher and student. As such we can aspire to follow in the way of those who have taught us.

Mentorship is part of our formal academic study and medical practice, but good teachers can instruct us in much more, for example: humility, service and dedication to work. We are fortunate indeed if we have teachers who overtly express their Christian faith in their daily medical practice.

There is a further level of inspiration that can come from leaders in our profession who have demonstrated high achievement and have publicly honoured Christ in their lives. One could think of many famous Australian Christian doctors whom we could esteem and in some way seek to emulate. This paper will highlight the inspirational lives of three renowned colleagues - Catherine Hamlin, John Carew (Jack) Eccles and Graeme Clark. Their life and work demonstrate in different ways outstanding professional achievements, but also personal Christian attributes that we could identify as 'fruit of the Spirit'.

Catherine Hamlin

Catherine Hamlin is an Australian obstetrician who with her husband, Reg Hamlin, established the first hospital in the world specialising in the repair

Catherine Hamlin

"[The Hamlins] have successfully operated on over 30,000 women and the centre has been a major base for teaching surgeons from all over Africa and the developing world."

of the obstetric fistulas. The Hamlins first left Australia in 1959 for what was to be just a short-term contract in the midwifery school in Ethiopia. Now aged 92, Catherine still oversees the Addis Ababa Fistula Hospital, one of the few medical centres in the world dedicated to relieving the agony of vaginal fistulas after childbirth injury. Catherine Hamlin has received many honours in her life and is recognised as a great Australian and a 'living national treasure'.

Catherine was born in Sydney in 192. After medical training in Sydney and obstetric training at Crown Street Women's Hospital, she married her husband Reg Hamlin who was a medical superintendent at Crown Street.

In 1959 they responded to a job advertisement in *The Lancet* for a short-term appointment in Ethiopia. Not long after arriving, the magnitude of obstetric complications and suffering became apparent to them. They became aware of the problem of obstetric fistulae, occurring as a complication of obstructed labour, which in western hospitals would have been treated with forceps delivery or Caesarian section. In remote parts of Ethiopia, women with obstructed labour could strain for days without the infant being expelled. The consequences were catastrophic with loss of the child and, in a high proportion of cases, women developed a fistula between bladder and vagina.

The Hamlins decided to specialise in fistula repair and established a clinic especially for this purpose. Since then, they have successfully operated on over 30,000 women and the centre has been a major base for teaching surgeons from all over Africa and the developing world.

The motivation for Catherine Hamlin's work has been her Christian faith. She writes in her autobiography 'I'm sometimes asked how I have come to spend the greater part of my life in Ethiopia. The answer is simple. I believe that Reg and I were guided here by God'. Catherine's early life was centred on home and church and from an early age she began her day by reading *Daily Light*, a practice that she still continues over 60 years later.

The publication of Catherine's book, *The Hospital by the River*, led to a greater international profile. As well as her many national and international honours, Catherine was interview by Oprah Winfrey in 2004 and after a donation; the hospital opened an Oprah Winfrey wing. *The New York Times* has described Catherine as 'the new Mother Teresa of our age'.

John Carew (Jack) Eccles

John Carew (Jack) Eccles

Sir John (Jack) Eccles (1903-1997) was one of Australia's most eminent medical scientists and a leading neuroscientist of the twentieth century. He is best known for his work on the synapse, which led to the Award of the Nobel Prize in 1963, though his research spanned 50 years in Australia, Oxford and the United States. During his career he was fascinated by the uniqueness of the human condition and much of his work especially in his latter years was devoted to the 'mind/brain' problem. Throughout his life Eccles was outspoken in defending

"[Eccles] endeavours were characterised by an extraordinary energy and thirst for new knowledge of the brain, but also a deep love for humanity and Christian spirituality. "

Christian faith. He was a practising Catholic and his Christian faith was central to his life and scientific endeavours. He challenged scientific materialism, which he regarded as impoverished and empty, and sought to develop a unifying theory which would account for 'the wonder and mystery of the human self with its spiritual values, with its creativity and with its uniqueness for each of us."

Eccles was born in Melbourne in 1903 and much of his early education was from his parents. After graduating in medicine from University of Melbourne in 1925 he travelled to Oxford as a Victorian Rhodes scholar. As a student he was fascinated by the mind/brain problem and recounted that when 18 years old he was struck by 'an awesome feeling of uniqueness'. His sense of wonder at his own brain was the motivating force for his life-long study of neuroscience. At Oxford, Eccles joined the team of Sir Charles Sherrington, Professor of Physiology. Sherrington is regarded as the father of modern neurophysiology and his school was renowned, attracting many young scientists from throughout the world. Eccles was Professor of Physiology at the University of Otago, Dunedin from 1944–1951 where he continued his studies on the synapse. His work was instrumental in proving chemical neurotransmission in the brain and overturned the previous view that electrical transmission was the primary means of neuronal processing.

It was at Dunedin, where Eccles first met the philosopher Karl Popper with whom he shared a life-long collaboration on the mind/brain interaction. The dialogues were recorded and broadcast and led to the publication of his book, *The Self and Its Brain – An Argument for Interactionism*. Over several decades, Eccles and Popper developed an alternative theory of mind known as dualist-interactionism. His approach, rooted in Christian understanding, challenged the monists who advocated a purely physico-chemical explanation for human consciousness. 'I maintain that the human mystery is incredibly demeaned by scientific reductionism, with its claim in promissory materialism to account eventually for all of the spiritual world in terms of patterns of neuronal activity. This belief must be classified as a superstition.... We have to recognise that we are spiritual beings with souls existing in a spiritual world as well as material beings with bodies and brains existing in a material world'.

Throughout his life his endeavours were characterised by an extraordinary energy and thirst for new knowledge of the brain, but also a deep love for humanity and Christian spirituality. As well as his remarkable scientific discoveries, he followed his mentor, Sir Charles Sherrington in affirming the Biblical worldview which is consistent with brain science.

Graeme Clark

Graeme Clark is one of Australia's best-known clinician scientists. He has achieved international renown for his life's work; the development of the bionic ear (cochlear implant). This device has brought hearing and changed the lives of countless recipients. Although his stellar achievements have brought him international recognition and success, it is his unwavering Christian faith that inspires us.

Graeme Clark

Graeme Clark was born in Camden in country New South Wales in 1935. His father, a pharmacist, was severely deaf and often struggled to communicate with customers. After medical studies at Sydney University,

continued over page

he qualified in ENT surgery and also completed a PhD on *Middle Ear and Neural Mechanisms in Hearing and the Management of Deafness* in 1969. In 1970 at the young age of 35 he was appointed to the first Chair of ENT at the University of Melbourne. Although he faced opposition from academics and colleagues, he persevered in his research and efforts, which eventually led to the development of the bionic ear. Together with bio-engineer, David Dewhurst, Clark performed the first cochlear implant in 1978. Since then, the device has been widely used throughout the world, often with dramatic results in bringing hearing to profoundly deaf children and adults. Graeme Clark's achievements have been recognised with many awards including Companion of the Order of Australia, Fellow of the Royal Society, Florey Medal and the Lasker De Bakey Prize.

The popular biography of Graeme Clark by Mark Worthing gives a clear picture of his committed Christian life. It speaks of his humility in seeking God for strength, whether just prior to surgery or relying on Him in his academic and public life.

From early in his professional career Graeme Clark sought to reconcile Christian faith and scientific medicine: "the more he saw of the wonder of human hearing and the human brain, the wonder of nature and all its grandeur, the more he sensed the presence of a loving God." (p141)

In 1979 as a young academic Graeme Clark published *Science and God: Reconciling Science and the Christian Faith.* His personal and public advocacy for the Gospel has been a hallmark of his life and a wonderful example to all of us in the Christian medical community.

Conclusion

As Christians, our desire is to know and follow Christ in our whole lives including our working lives and profession. Following or imitating others who have gone before is a thoroughly Biblical approach to discipleship. The Apostle Paul develops this theme a number of times in his Letters. Best known is 1Corinthians 11:1: 'Follow my example, as I follow the example of Christ'(NIV). Also 2Timothy 3:10-11: 'You, however, know all about my teaching, my way of life, my purpose, faith, patience, love, endurance, persecutions, sufferings… .'(NIV). In Paul's example to others, he points them to Christ. Likewise, our inspiration from our medical colleagues can point us to our Lord Jesus through their faith, witness and perseverance.

"The more [Clarke] saw of the wonder of human hearing and the human brain, … the more he sensed the presence of a loving God."

From the life and work of these three famous Australians there is much that we could emulate. For Catherine Hamlin, a life of sacrifice in answering the call of God on her life is evident from her long tenure in Africa. John Eccles, the pre-eminent neurophysiologist of his generation, demonstrated boldness in his unwavering advocacy for a Christian worldview of the human condition distinct from the prevailing views of scientific materialism. Finally, Graeme Clark, whose life and career have brought hearing and hope to so many: a quiet humility epitomises his character and can inspire all of us. ●

Further reading:
1. Hamlin, Catherine, *The Hospital by the River. A Story of Hope.* Pan Macmillan, Sydney (2001)
2. Popper, KR, Eccles JC, *The Self and Its Brain. An Argument for Interactionism.* New York, Springer-Verlag, (1981)
3. Worthing, M, Graeme Clark, *The Man Who Invented the Bionic Ear,* Allen and Unwin (2015)
4. Excerpts of biographies of Catherine Hamlin and John Carew Eccles have previously appeared in *Luke's Journal* in the section *Doctors Who Have Made a Difference.*

SNIPPET

It takes a disaster to turn the minds of contemporary Westerners to God. Sure, we dabble with spirituality, but a serious and genuine engagement with God, or the idea of God, seems to need an enormous jolt. The jolt may be personal, as when we or someone close to us is seriously ill, or when there is an unexpected death. Or it may be almost global, as when on St Stephen's Day 2004, hundreds of thousands died and many more were left homeless by the "Asian Tsunami." The response may be a desperate cry for help, or it may be an angry accusation: "Why did God let this happen?", or "Where was God when this happened?" or "Why didn't God do something to stop this?" Believers and non believers alike may respond in this way. But the Western secular press expressed it in the form of an ancient Greek dilemma: if God is both perfectly good (or loving) and all powerful, why does evil/suffering exist? The tsunami was thus an occasion to question the existence of God, or at least His goodness or power, both of which are fundamental to a Judeo-Christian belief.

We will look in vain to the Bible or theology for a neat solution to the dilemma posed above. The Bible never tries to explain suffering: Job receives not an explanation, but an overwhelming revelation of God's power and sovereign freedom. It seems what is important is not *why* (as if we could understand the purposes of God anyway) but *how* we will respond to suffering. Will we continue to trust God, and allow Him to comfort us? But even this can seem trite when offered as advice by someone who has no personal experience of suffering themselves. So we have the personal testimony of David, of Jeremiah, of Paul and of Jesus himself, all of whom knew intense suffering.

The greatest miracle is that faith survives in spite of suffering, and despite the lack of a neat explanation.

Vol 10 No 1 Mar 2015 – Tsunami
"Can Faith Survive the Tsunami?"
by Denise Cooper-Clarke

Living out our faith in the workplace

by Jo Ng

Jo is a child of God and a final year medical student at the University of Queensland.

Thank you for the opportunity to share about my time in Australia as a medical student.

Before I came from sunny Singapore to even sunnier Brisbane, I had some (and by some, I mean a substantial amount of) trepidation. I was leaving the church in which I had spent most of my life, my loved ones and my close-knit cell group. I was venturing into a completely new career. Much time was spent in prayer – praying for a family away from home, and praying for God's continued presence in my life.

During these last few years in Brisbane, God has reminded me of how tremendously generous He is. The one who brings the jacaranda trees to flower (a reminder of exam season) is the one who provides for my needs. He is the one who loves to hear, and continues to listen to, my prayers. At university I have fond memories of praying, giggling, and belting out songs of praise with brothers and sisters in my campus fellowship group. They bear witness to God's provision of a family away from home.

I clearly remember the excitement of watching my first colonoscopy – seeing how the pink lining of the large intestine gave way to the villi-covered small intestine. I smiled as I pondered on how imaginative God is in His creation, and how wonderfully made we are. As I look back on time spent learning about pathophysiology, anatomy, the Krebs cycle and more, I found that the greater treasure still was the time spent growing to know Jesus in the company of others.

In His generosity, God has helped me to think deeply about how the gospel shapes the way I live. I saw Jesus afresh through reading the Bible with others in the workplace. We worked out together that knowing Jesus meant that we could begin to relinquish the stubborn control we had over our lives and our time, and instead trust that He is in control and He is Lord. Journeying with others required careful planning around schedules and intentional conversations (heaped with a whole lot of prayer), but the result of that effort gave rise to wonderful times of encouragement. Finding time to read the Bible in the workplace, and integrating faith with work were challenging. However, I learnt that God provides opportunities aplenty and have also found myself gaining accountability partners at the workplace!

My student life has not been without its downs – from self-doubt, to seeing critically ill patients pass on, and fellow pilgrims turning away. God has seen fit to teach and discipline me to be more like Christ, allowing me to share with others in their suffering and death. Through these moments of difficulty, and deep sorrow, beautiful hope remains! Hope, in our deliverance from the dominion of darkness into the kingdom of God's beloved Son, in whom you and I have redemption and the forgiveness of sins (Colossians 1:14).

If you are a working professional now, I hope that you will continue to see others through Jesus' loving eyes. I hope that you will not be caught up in work, but that your work will be a means to share the gospel and to live out your hope through Christ. I pray that you desire for Christ to be king during each working day. May you desire this more than desiring to do your work well, furthering your training, or for the workday to end quickly.

If you are a struggling student, I pray you will find hope. Continual, Spirit-refreshing, strength-giving hope, not in your privileged role as a student but in your privileged position as sons and daughters of our living God, in Christ. It may not seem or feel that way, especially when the world and the institution of medicine tells you otherwise, but as Paul reminds us, *"Once you were alienated from God and were enemies in your minds because of your evil behaviour. But now he has reconciled you by Christ's physical body through death to present you holy in his sight, without blemish and free from accusation – if you continue in your faith, established and firm, and do not move from the hope held out in the gospel…* – Colossians 1:21-23"

My experience with God in Brisbane and in medicine has not been exclusive. As I have been blessed and encouraged, I hope this encourages you to know that just as God has worked and continues to work in my life, He does and will work in yours too. May He show you Christ! ●

Psalm 8 (NIV)
Lord, our Lord, how majestic is your name in all the earth!
You have set your glory in the heavens.

Through the praise of children and infants you have established a stronghold against your enemies, to silence the foe and the avenger.

When I consider your heavens, the work of your fingers, the moon and the stars, which you have set in place, what is mankind that you are mindful of them, human beings that you care for them?

You have made them a little lower than the angels and crowned them with glory and honor.

You made them rulers over the works of your hands; you put everything under their feet: all flocks and herds, and the animals of the wild, the birds in the sky, and the fish in the sea, all that swim the paths of the seas.

Lord, our Lord, how majestic is your name in all the earth!

Can we call our Health System, our politicians, our administrators, our teachers, our clinicians and even our patients to account at this time? Why should we?

6 reasons:

1. Patients are demanding more and more, but the health dollar is shrinking.
2. Few are willing to say out loud that perhaps we need some limits to what we can afford in Australia.
3. We face ridiculous additional costs to our economy through things such as class actions against Blood Banks for Hep C which could not be reasonably protected against.
4. The drive to cut costs is leading to worse staff handling than I have ever experienced.
5. The belief that we can make life safe is leading to more and more costly precautions being taken at a time when we can't afford the basics in some situations.
   We spend millions in our teaching hospitals but only cents in our rural outback.
6. People across the system are unhappy.

What does being salt and light really mean in the hard world of medical practice?

- We need to stress the absolute importance of people and of God.
- We can strive to show the relevance of Christianity to all of the problems that surround us.
- Someone needs to help the money counters see that we in the medical profession really do care about the budget.
- We also should have no scruples about declaring that we care that the community is not being told the whole truth about Medicare, about the real cost of delivering health care in Australia and for that matter about the real financial state of the nation.

I believe that this is what being *salt* – to preserve, but also to tickle up the system – and what being *light* – to show the way more clearly – really means for us here and now.

Vol 4 No 1 Feb 1999
Current Thinking in the CMDFA
"Christian Health Professionals and Societal Values"
by Robert Batey

INSTRUCTIONS FOR CONTRIBUTORS

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. Photos supplied should be high resolution JPEGs.

Advertisements and short news items should be submitted directly to the **sub-editor**. See page 2 for contact details.

So then, what is it to be human? We are animated stardust, sharing our physicality with the earth and with the animals, sharing similar genetic material, but being given the ability to reflect on our emotions and drives. We are social beings learning how to interact through our relationships in family and community. We are driven people. Some of these drives are in conflict with others and in conflict with our best intentions. But most deeply we broken, sinful conflictual beings are recipients of the free grace of God in Christ by which we are empowered to develop a new way of living in community and in the hope that one day we will be like God, when we see him face to face.

Vol 16 No 2 Aug 2011 – What it is to be Human
"Who Am I? Animated Stardust"
by Asoc Prof Alan Gjisbers

Trite but true, effective workplaces have vision and passion. Clarity of role and business objectives give staff focus and direction. They are committed to the greater good. Personal agendas give way to public service. God's wisdom endorses the importance of a clearly articulated strategy focused on achieving outcomes for others. After all, some of the last words Jesus spoke on earth set out a clear strategy for mankind in administering the resources God entrusted to us: "Go and make disciples of all nations, baptising them in the name of the Father and of the Son and of the Holy Spirit and teaching them everything I have commanded you."

Vol 17 No 3 Dec 2012 – Administrative Affairs
"Godly Wisdom on Governance and Administration"
by Norelle Deeth

Matthew 25:34-40
The king will say *"I tell you the truth, when you did it to one of the least of these my brothers, you were doing it for me."*

"I was hungry and you gave me something to eat and drink" (Indigenous nutrition issues, food supply, access to fresh fruit/vegies are among the worst in Australia).

"I was a stranger and you invited me in." (Indigenous housing, overcrowding, vagrancy, and home ownership is the worst in Australia).

"I needed clothes and you clothed me."(Indigenous disposable income among lowest in Australia for usual necessities, National Aboriginal and Torres Strait Islander Survey).

"I was sick and you cared for me." (Indigenous health is the worst of any group in the country, with shorter life expectancy – median age at death in Queensland for males is 53 years vs 71 for the rest of Queensland).

"I was in prison and you visited me." (Indigenous is highly over-represented in prison – 2.6% of the population and 21% of the prison population).

I could add a few more that I am sure would be consistent with scripture…

I was hot and smelly after walking five kilometres in the hot sun to get to the clinic and you didn't look down your nose at me but offered me the same service as anyone else.

I had cardiovascular disease and you offered me a CABG. (See AIHW (MJA-Cunningham) review on the odds of getting a principal procedure at an Australian hospital if you are Indigenous versus non Indigenous).

The list could go on, but I am sure you get the drift.

Vol 16 No 2 Aug 2011 – What it is to be Human
"Aboriginal and Torres Strait Islander Issues"
by Mark Wenitong

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.

Vol 16 No 1 Apr 2011
Transplantation, Adoption and Wellbeing
"The Theology of Adoption" by Wendy Bourke

Regardless of how complicated or complex are the needs of the person who comes to seek our clinical service, we can do little wrong and much good if we approach the person with sensitivity and respect and seek their permission as appropriate. The patient may or may not have a spiritual understanding. We as clinicians of faith, yet are called to be Christ-like, to be competent, compassionate, good communicators and to be encouragers.

Vol 16 No 3 Dec 2011 – Ethical Grand Rounds
"Wednesday Morning at The Clinic" by Michael Burke

What does the Lord require of us but to 'Do Justly, Love Mercy and Walk Humbly with our God'

by Anthony Radford

Anthony is one in a long line of doctors – his grandfather (a surgeon), two uncles (both of whom became Presidents of the RACGP, and one of WONCA), an aunt who worked as a rural practitioner until she was in her eighties, a cousin…with a son and two in-laws to follow. A graduate of the University of Adelaide, he did postgraduate training at the universities of Liverpool, Edinburgh and Harvard. After finishing his course in Adelaide, he spent a decade in PNG as a sole practitioner for up to fifty thousand people and has returned on numerous occasions, doing consultative medical work with the PNG and Australian governments and sundry NGOs. While there he established extensive undergraduate and intern programs in rural health and conducted considerable research on numerous clinical and public health topics.

As an undergraduate he was concerned that he had learned little about himself, nothing about healthcare outside a tertiary institution, and nothing about the environment and its relationship to illness – especially the social environment. He also claims he learned very little about the relationship between doctors and their patients, and almost nothing about the other professional participants in healthcare delivery and what they had to offer.

In 1974, he was appointed the foundation Professor of Primary Care and Community Medicine at Flinders University. He has spent fifty years as a consultant in primary health care and international health to international organisations such as WHO, UNICEF, The World Bank, governments and numerous NGOs such as World Vision and YWAM. After his retirement in1994 he has spent fifteen years as a rural locum GP. He has written two books. One is about his life and work in PNG – *Singsings, Sutures and Sorcery* – and the other (in preparation) is about his experiences over 15 years as a locum GP in remote and isolated South Australia – *Have Stethoscope, Will Travel.*

He is a former national chairman of CMDFA and International vice-President of ICMDA.

Like Timothy, I grew up on my mother's (and father's!) knee with a known relationship to, and later with, Christ. This didn't make me better than anyone else, far from it. But it gave me an objective in life – namely, to 'Love the Lord my God with all my heart and soul and mind and strength, and my neighbour as myself.' A life call into medicine was confirmed one day as Paul White – 'the Jungle Doctor' - spoke at a school assembly.

Such a basis led me to work in areas where the need was great and resources few, and particularly with more isolated communities. I become involved in medical education not only at undergraduate and postgraduate levels, but also with primary care workers and communities. Much of this training was conducted

"I have always believed it important to be intimately linked to the community."

outside hospitals, in the community – in 'wards without walls.' While most of this work could be labelled broadly as 'public health' – it wasn't the public health I learnt in medical school which had consisted of a few ad hoc excursions and a pub crawl through the Adelaide Hills, looking at primitive waste disposal systems and the like. Further, as an academic, I have always believed it important to be intimately linked to the community and so have maintained a clinical role as a physician and general practitioner throughout my career.

When I graduated, most of us entered general practice, when there was a distinct reflection downward by most of the profession on 'general practice' and more especially on 'public health', as if its practitioners were some lesser form of medical being. I became convinced that general practice was the most difficult trade in the profession and public health was the most important. One of my first tasks on becoming foundation head of a department of public health and general practice was to be an expert [sic] witness for a government commission addressing whether or not public health physicians should be paid commensurately with 'left and right' eye doctors. The person responsible for the maternal and child health services in my state of more than a million people was paid less than a neonatal intensivist.

On graduation I wanted to be involved in medical education and to get into the medical curriculum those aspects I felt most lacking – especially behavioural sciences, public health and general practice. These included doctor-patient relationships, ethics, aged care, palliative care and care of the disadvantaged. As Osler observed at the beginning of the twentieth century when it was proposed that all medical education should be conducted in, and only in, teaching hospitals – "Cabined, cribbed, confined in the four walls of the teaching hospital practising the cloistered virtues of clinical monks [and presumably nuns] how can they forsooth train men [and again presumably women] for a race of dust and heat, of which they know nothing and, this is a possibility, care less [looking down their myopic corridors at the total world of illness, which may contain the weightier particles but it is open to question as to whether they are the more important.]"

My faith has been and is still regularly challenged in several areas. To me, the acceptance of the creation of the cosmos and the sequences of DNA structures as chance happenings has always been a greater leap of faith than belief in a Creator, though I cannot always put together why He might have done that. That He should send His son to earth to show us how His human creation could and should live in relation to the totality of it was very rational.

In teaching, I saw the need for a more comprehensive definition of health than the WHO standard of 1947. And so, in the 1970s I came up with "The health of individuals and groups is the level to which we can adapt to and live in harmony with the inter-related social, spiritual, mental (personal), chemical, physical and biological environments in which we live, work and recreate, without disease and without dis-ease'. At the end of the twentieth century, WHO added the 'spiritual' environment to their definition in belated recognition that most individuals and communities have some spiritual dimension to their lives which influences their level of health and happiness.

There were parts of human behaviour in medicine which were totally out of alignment with what I believed was a Christian perspective. I could not be a part of abortion and euthanasia – working and writing, even preaching against them. I argued that when a woman came to me seeking an abortion I would gently point out that I was not only her doctor but I was also the doctor of the child developing inside her. To abort it or, as was often requested, to simply refer them to someone else who would do it was the same as doing it myself.

"Challenges were not infrequent when your colleagues knew that you were a Christian."

The case was similar with euthanasia for those close to death or just wanting to die. I was trained to heal and to help and to comfort the sick, the distressed, the dying and bereaved and those in pain together with their relatives and carers. To deliberately intervene to cease life was contrary to that – as with abortion, to 'just do something' as asked, was murder. There were certainly times when it seemed that the contrary position was acceptable – such as when the mother's life was being compromised by the continuation of the pregnancy or pain control was difficult. A greater challenge were the times when the growing fetus was forming abnormally. Was continuation of the pregnancy the lesser or greater of two almost intolerable options? I didn't wear one of those wrist bands so common some years back on which was printed 'WWJD' (what would Jesus do?), though I often sought counsel in prayer – but not always with a clear answer. I received precious little instruction or discussion time in my medical course concerning these matters, but it became one of the objectives of my department that we did so, and established perhaps the first course in topics such as 'Death, Dying, Loss and Bereavement', Care of the Elderly and 'Counselling in Medical Practice'.

Another area where I was often at war with myself, my colleagues and certainly the government, was the distribution of resources, especially the over-allocation to hospitals and the very low level of allocation for public health-related research compared with molecular biology and its ilk. I also firmly believe that society has a role to play in such allocations, and not merely the medical profession. This became more acute in my work among less-resourced countries – where the centralised hospitals (providing care for a lot less than ten per cent of the population) received sixty-to-seventy percent of the health budget. These hospitals demanded, and as often as not, got, for example, the installation of CT imaging facilities whilst the rural district hospitals went without even a basic X-ray machine. Similarly, when headquarters acceded to demands of centrally-situated hospital staff for third generation cephalosporins, peripheral health centres were not supplied with basic first-line antibiotics such as penicillin or amoxicillin, and often basic vaccines.

Challenges were not infrequent when your colleagues knew that you were a Christian. Once, when I described to a senior member of the bench that I was having significant reaction against me at work, her immediate response was, "Of course. That's because you are a Christian." At such times my wife would pray over me the 'whole armour of God' (from Ephesians 6) before going to work.

Would I do anything differently if I had my time again? Not a lot I suspect, except to offer prayer more often as part of my therapeutic armamentarium. On one occasion when I was addressing a Christian medical group and I asked, "How many of you have ever prayed with your patients". Only a third answered in the affirmative and none had done so recently. I have never had a negative response to that question and often the affirmative response has been quite firmly requested, even by those who acknowledge a different faith, such as Hindus and Muslims. ●

No Fire in the Belly?

Sliding into Spiritual Apathy

> " I have not made this article anonymous. This is not an account from some obscure random person you have never heard of. This could be you one day. ."

by Lisa Koo

Dr Lisa Koo has been a rural general practitioner in the Clare Valley for 11 years, working a 0.7 load. She is married to Paul, and they have two children aged 2 and 4.

An alarming number of medical and dental students 'fall away' from their faith sometime after they graduate.

I believe the reason of 'falling away' is multi-factorial.

I think that we slide into spiritual apathy. When we doubt, we are agitated like the waves in a sea (James 1:6) – we know that we are struggling. But when the waves die down to nothing, so slowly we don't realise, or even care – this is far worse. We are inexorably taken out by the cultural tide – and only notice if we are actively trying to keep land in sight.

I remember someone asking me if the reason why there weren't more Christians coming out of universities was because evolution, not creation was being taught. I was surprised in his naïve reasoning.

However, there may be a hint of truth in his statement.

In the Australian Bureau of Statistics Social Trends, November 2013 *Losing My Religion?*[1] article, rates of reporting 'no religion' was increased in people with higher educational qualifications. It's not so obvious in people in their 20's (comparing high-school-only to tertiary educated) – probably because younger people across the board are increasingly reporting no religion. It's more obvious in the over 65's (high-school 3%, tertiary educated 31%).

In the 2011 Australian Census[1], people who studied Bachelor Degrees in the creative arts (37%) and sciences (36%) were the most likely to report no religion, while those who had studied education (21%) or health (22%) were the least likely to do so. Physics and astronomy had the highest rates of reporting no religion (45%).

Reporting a religious affiliation is not the same as actively participating in religious activities. In the 2010 General Social Survey[1], 15% of men and 22% of women aged 18 years and over said they had actively participated in a religious or spiritual group. Even fewer (7.2% of men, and 9% of women) reported doing voluntary work for their church or organisation:

There is a rise of people reporting no religion, and it has become the largest "belief category" in 5 out of 8 states and territories.2 61% of Australians in the 2011 Census identified themselves as Christians. Only 1 in 7 of these 61% regularly attend a church.

This is a personal account of my 'falling away'. I think it gets talked about in hushed tones, but no one ever seems to go through it in great detail. Maybe it's too shameful (I think doubt and its cousins are still taboo subjects in the Christian community). I hope you understand why I and others might drop off the circuit. I have not made this article anonymous. This is not an account from some obscure random person you have never heard of. This could be you one day. Some of my explanations may sound very 'unChristian'. Yes, you are probably right. I don't feel very Spirit-inspired at this moment. This is not an article written to dissuade you from being a Christian. No – actually, I wish I was someone who was strongly convicted one way or the other! I doubt my article will change your religious persuasion, as much as talking about suicide does not make someone suicidal. I hope that my article will be a discussion point for how we might approach people in a similar thought-frame. Maybe by reading this you might understand how a non-Christian might think, and that when you talk to them about Jesus, they probably think you come from a different planet.

I never thought the day would come when I would doubt the existence of God.

I was brought up as a second-generation Catholic and went to Mass until I was an intern. I had Evangelical exposure through high school, university and work life, including some Pentecostal experiences. CMDFA has been a big part of my spiritual life, and I have at one time been a CMDFA State secretary, a National Secretary, a National Board member, and part of the organising committee for two IMPACTs.

I did not understand how people could be non-believers. To me, God's Word was real, and His presence in my life was unquestionable. I was single for a long time (I married Paul when I was 36), so a huge proportion of my major life-changing decisions were made solo. But I never felt unaided, as I knew God was my constant companion and best friend. I had grown comfortable being single, and enjoyed the life that He had given me. I would perceive God in nature, God-moments through His Word, and God-moments in the everyday interactions with family, friends and patients. I blossomed through 'hardships' and always knew that by the end of a hardship there would be a lesson from God in it. In my weakness I drew on His strength.

So how did I get to the point where I started to doubt His existence?

God was very present and confirming whilst Paul and I were dating, but not so apparent after we were married. Was it because I had married a new Christian who wasn't really into Bible studies? (Isn't it a Christian girl's dream to find a godly man who is a sensitive 'strong Christian', who is good at quoting and explaining Scripture, who had attended Bible College whilst solving the world's problems? These sort of guys seem to date and marry by their twenties.... they have so many Christian women to choose from!) My husband Paul is not into sharing his feelings over cups of tea during Bible studies, or singing lovey-dovey praise and worship songs. He would rather be in his shed creating an artwork devised out of his brain, going camping in the untouched beauty of remote Northern

> **"Remembering to talk to a physically invisible God is challenging. The visible people in front of me take priority."**

Flinders Ranges in the camaraderie of other men, or loading up in a chicane on a motorbike. Paul is also not too keen about playing his guitars to formulaic Praise and Worship. He would rather punch out harmonically daring funk, jazz or rock'n'roll numbers with musos who are in it for the sheer love of music. Where is the creative challenge in our churches? And besides, what's the point of attending church when you can't hear what's going on at the front when you're out the back in the crèche getting cabin fever with two little daughters?

Our churches can be so feminised. How did this happen when Christianity started with Jesus and a dozen men? David Murrow explains this phenomenon in his book *Why Men Hate Going to Church*.[3] Murrow says churches often use ' Jesus-is-my-boyfriend' imagery. It's fairly common for pastors to describe a devout Christian male as being "totally in love with Jesus", or to describe "falling deeply in love with your Saviour", phrasing that men would probably find rather creepy. It's easier to talk about the docile Lamb than to call on the Lion of Judah with a controversial temper that overturns tables and incites unrest among the powerful religious. Sermons can focus on relationships and feelings, rather than exegeting Scripture and calling us to spring into action... but I digress!

I think the main reason for falling away has to do with conversational availability. When I was single, my life was my own, I could talk to God any time of the day. In 1 Corinthians 7:32-35, Paul talks about being single-minded for Christ. I didn't used to think I spent a lot of time with God – but now,married with children – wow, comparatively, back then I was a saint!

Home life went from having conversations with God (or monologues with myself), to living with one, then three other humans 24/7. Two and four year old girls never seem to cease talking!! There is no off-switch. Even after our girls go to bed, they are still in our thoughts and conversations. Before I had children, I naively thought, why can't mums stop what they are doing to answer their child's question? Why do parents only seem to talk about their children? Answer – because their pre-school child may ask fifty questions per day and constantly demand their attention! It is so hard to hear my own thoughts, let alone God's voice!

I am time-poor. I look back at my bachelorette life and marvel at how much time I wasted. Nowadays after coming home from work, I make choices between spending time with my daughters, spending time with my husband, having me-time, or doing household chores. The couple of hours between my children's bedtime and my bedtime is short and precious. Do I have an adult conversation with housedad/husband Paul (who is too tired to talk, and craving silence after a day spent with two little wanting children), or go for solitude? If I opt for me-time, do I upskill my medical knowledge, read through multiple emails (many with long attachments) from various institutions, trawl the internet, sew, or read the Bible?! (Answer: my priority is to do something that least resembles work!)

Remembering to talk to a physically invisible God is challenging. The visible people in front of me take priority.

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I was used to praying to God for significant life-changing events: what specialty to train in, where to work, what country town to live in, what church to attend, who – if any – would be my life-partner. As a trainee, clinical work was new and challenging and I was often praying for wisdom and guidance. Nowadays, I have gone from being consciously incompetent to unconsciously competent, so am confident at handling most situations. This is another reason for praying less.

King Solomon asked for wisdom and discernment, and made some pretty difficult decisions. My daily decisions are 'Which daughter gets the pink dinner set?'(and 'Which one will end up in tears?'). Do I decide to tell them that poo-poo talk, or drawing on each other, is inappropriate? Is God really interested in what brand of nappies work the best?!

I want to live authentically. I used to pray with my patients and talk about God with them. But if I harbor doubts, I can't be a sincere witness, and I don't feel qualified to talk about the Good News. Hence I am less likely to see God at work. (I do sometimes admit to select patients and work colleagues that my spiritual life is lacking, as some way of showing them that we can't be super-Christians 100% of the time.)

Am I doubting, because I rely more on God experientially, than reading His Word? (When I don't see God at work in my life – I doubt he exists.) Am I still spiritually living on baby milk and haven't yet graduated to solids?

In the olden days, people were illiterate, so the priests read the Bible to them. Nowadays we have no excuse, right? Reading the Bible is hard work. I used to love reading as a child, but I think reading medical textbooks dampened any desire to read for enjoyment. We are reading a translation from Hebrew, and Greek, written in a time and place so remote from our own. There have been many times where I've read and reread a passage and it doesn't compute. I can fall asleep reading a picture book to my girls, so keeping awake is problematic. I have resorted to reading *Our Daily Bread* on my phone whilst on the toilet – but even there I can get interrupted by a little person! I also have a memory like a sieve which does not retain information that I have read or heard (I am a visual learner).

I don't like the idea of God being treated like Father Christmas, so I have swung the other way and not asked Him for help. I also have not asked, because I think I need to find the solution myself. For example, when Paul was in agony with a prolapsed lumbar 4/5 lumbar disc, we did not think to pray because we knew one day he would improve, and were told it would take about six months (and so it was). If we are wondering how to parent, we read a book on raising children. If I am not sure what to do with a patient, I will use a medical resource or ask a colleague.

"If I harbor doubts, I can't be a sincere witness, and I don't feel qualified to talk about the Good News. Hence I am less likely to see God at work."

I get bogged down in the trivial and the banal, or get tangentially distracted by Pinterest and what people are doing on Facebook.

We are interested in micromanaging the world. Wiki or Google anything, and you have an answer. If there is a fifteen-step process on successfully buying the right digital television for your lounge, there is not a lot of time to think about the big questions in life. And if you do question Christians on how can there be a God when there is so much suffering in the world, and they reply in one paragraph, the answer seems a bit too simple, bizarre, illogical, or incomprehensible.

Sundays are no longer sacred. Shops are open on Sundays. There are sporting events and entertainment to attend and participate in. We use Sundays to catch up on work, go to work, or catch up on our sleep before the (working) week starts again on Monday.

If we have had sheltered lives, as doctors and dentists we are thrust into the fallen world at an early age. I came from a sheltered middle-class life. In my case, doctoring was my loss of innocence. As a GP, I have prematurely discovered through my patients that life can get challenging, ugly and very unfair, early on in life. Sure, I learnt not to take home my patients' burdens, but constantly seeing people who are unhappy from their illnesses does take its toll. When we listen to our patients' complaints, we can't help but be affected.

If we were missionaries overseas, we would be set apart by language, culture and colour. Often missionaries will socialise with other missionaries within a Christian community and hence be 'set apart'. But when we are missionaries in our own backyard, these distinctions between secular and Christian are more subtle, and therefore more easily blurred. The more we 'blend in' and empathise with our surroundings, the more we can become like our surroundings. How do we be in the world, but not of the world?

Patients have their unique view and opinion of their world, and are from different faiths and spiritual journeys. Sharing these journeys with my patients opens my mind to other worldviews. So if we get talking to the other 39% of the population who might be Buddhist, or Hindu, atheists, or calathumpians, we can start to question our own faith. Which is the correct world view? Which God is the right God? Is there a God?

Recently I went to a Flinders (University) Evangelical Students 50th anniversary dinner. Someone representing my decade group spoke, and described the 1990's as the last decade where life was "black and white" and you could tell someone about Jesus using the Four Spiritual Laws. Nowadays the world is more "grey" and proselytising is considered more offensive. It was telling that we were now meeting in an inter-religious building which has its own Buddhist, Hindu, Muslim and Pagan chaplains, and runs meditation and yoga courses.

In the same weekend, I attended an anaesthetic refresher course where they had a session on leadership. The military acronym VUCA – volatility, uncertainty, complexity, ambiguity – has been used to describe our current world, with its dizzying change of pace. How do we respond to a constantly changing world?

News used to be just local – limited by horse and cart, a telephone exchange, or television. The world's woes were contained mainly to a state or national level. Nowadays we have news from all parts of the world, at any time. We are more aware of other people's suffering, and can feel like an insignificant human being – emotionally shouldering burdens of people in worlds we hardly recognise, and barely making a difference. What is our role in the face of global suffering? Are we supposed to pray for all of them? Where is God in all of this? Compassion fatigue sets in.

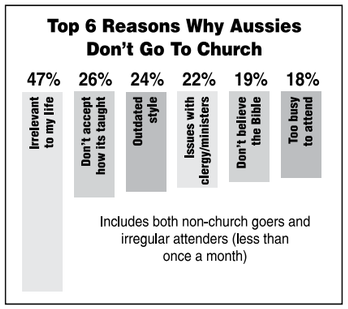
Suffering can draw us closer to God, but it can also make us question God. I think doubt creeps in when we become deeply disappointed; when we feel that we aren't in control of our lives; when we are beyond breaking point and God hasn't answered our prayers.

I am of an age:

- where significant medical and mental illnesses statistically occur.
- where one can be debilitated by one or more chronic illnesses.
- where one can still be single and have waited faithfully for a Christian life partner, but have been disappointed so far.
- where one has married a non-Christian.
- where one suffers the sorrow of not being able to have children.
- where one has experienced separation and divorce.
- of feeling vulnerable when one knows a close friend, relative or colleague who has committed suicide.
- when one has failed an important exam. Again.
- when one is exhausted by working long hours, or is being bullied at work by bosses, colleagues or patients.
- when one feels undermined or demoralised in their workplace, or feels like an insignificant cog in the wheel of a larger (often government hospital) organisation that does not seem to hear their voice.
- when we feel like we are treating the paperwork, not the patient.
- where one has experienced enough of life to become world-weary, or cynical.
- where one sees others being mistreated.
- when one thinks they've done something really awful or humiliating, or they're not 'as super-spiritual' as others, and we withdraw from other Christians.

And for those who are not suffering – how will they ever find God? Christianity seems to be marketed to the needy, the poor and oppressed. So what about those who are already socially, physically, emotionally and financially content with their lives? Why would they want to become Christian?

15 to 40 year olds are under-represented in church.



http://www.mccrindle.com.au/the-mccrindle-blog/church_attendance_in_australia_infographic[4]

How do we nurture our faith?

Do we only attend Christian events, read Christian literature, and only hang out with our Christian friends? But then we would not be missionaries.

Do we avoid being hurt, and choose career paths and billing practices that shield us from unpleasantries?

How does hope return when youthful enthusiasm gives way to realities of life?

Does God calls us to be mediocre? (Being super at everything is very time consuming!)

How do we minister to men? (Read David Murrow's book *Why Men Hate Going to Church*[3] for some suggestions of what Jesus did!) As Murrow, interviewing Mars Hill Church's Mark Driscoll states: "Start making little changes. One song at a time. One sermon at a time. One lace doily at a time". *(See table over page.)*

If I am redefining my life, what are my goals?

I enjoyed the South Australian power outage last September. No mobile or internet for twenty hours and my workplace was closed. We enjoyed the candles, cooking food camp-style, being drenched in our raincoats, splashing in puddles, and watching the power of the rising water carry a 150kg tree trunk down the usually dry creek through our town… what an adventure!

I'd love:

- to get out-of-doors, and to be refreshed and reminded of God in His beautiful Creation.
- to learn how to meditate on Scripture like an old century Catholic monk.
- to not always be the serious responsible parent/doctor/cranky prophet, and have fun.
- to meet with kindred spirits face to face, rather than on Facebook.
- to feel joyful and hopeful again.

Suggestions of how to get out of spiritual apathy

- Be honest and authentic – you have permission to be grumpy… but try not to wallow in it!
- Thank God for what He's done for you in the past.

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- Acknowledge Him in the little things of the now, and be open to what He may be showing you in the everyday.
- If you're time poor, at least be generous with your money.
- Understand the need to make time for God. You're not going to be able to get to that regular Bible study, or church every Sunday. You can't wait for things to come to you; you probably have to go looking for them.
- Listen to podcasts of sermons from around the world.
- Music has the ability to touch your soul, when no words sink in.
- We tend to copy the attitudes and behaviours those around us, so it's prudent to think who is influencing our lives; the 61% 'Christian' or the 39% 'other'.
- CMDFA is attractive to the 'fringe' doctors and dentists – the non-conventional, or those who have had 'dropped out' of the mainstream. We need to embrace these people – the 'fringe' could become the norm! (One day the majority may no longer be third-generation white Anglo-Saxon Protestant!) We are treating patients who don't fit in a neat little box, and neither do we.
- "Don't stop meeting with one another" (Hebrews 10:25) even when you don't feel 'holy' enough. Even when keeping up with the "Big Four" spiritual disciplines (Read your Bible. Pray. Give. Go to church) is an epic fail, at least try to hang onto fellowship. For me, this means keeping in contact with CMDFA friends, or people I have 'had history' with for twenty years. If I'm attending CMDFA events and I don't have the headspace to absorb the seminar, at least I can pour out my heart to a kindred spirit. My eyes see the faithful guys in their 60's and 70's, who have walked the Christian walk, have had their times of doubt, and are still in it. If they are still hanging around, so can I.
- I thank CMDFA, my spiritual family that nurtures and supports me with gentle encouragement, collective wisdom, and shared experiences. I have found CMDFA people to be open and non-judgemental.

The 2015 National Graduate conference was a precious time for me. Thank you, CMDFA people, for sharing your own honest stories with me – your raw times of despair, the times of transitions, the highs and the lows, the times when you've clung to your faith. Your journeys, and the stories of your interactions with your patients are the modern-day parables of life. ●

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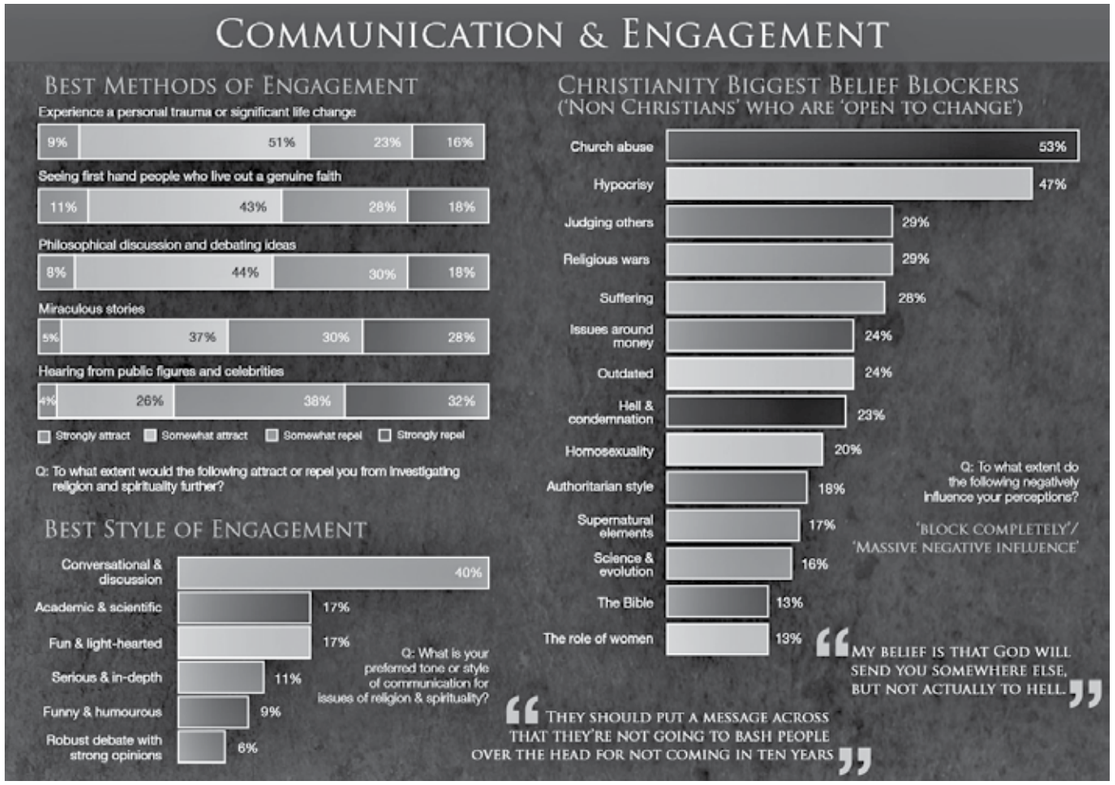
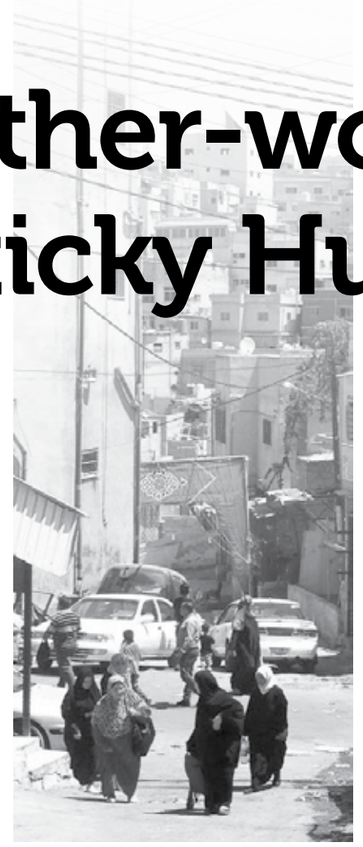


Excerpt from http://mccrindle.com.au/resources/Australian-Communities-Report_McCrindle-Research.pdf 5

An Other-worldly Sticky Hug

by Jill

Surname not published. Jill lives in a big city in the Middle East. She is in the painful school of humility, studying Arabic full-time. Her dream is to work with refugees who have flooded this region. She came here after a long journey of preparation in Australia and often thought, 'Am I ever going to get there?!' In God's kindness, her preparation in Australia included university student ministry, GP training in Perth and studying the wisdom literature at Bible college in Sydney.



I peered into the waiting bus. It was nearly empty.

Sigh.

I was looking for a way back to the city. It was a Middle Eastern summer. Knowing I'd have to wait in the sweaty heat on my vinyl seat until the bus was full before I saw any action … I went to investigate share taxi options. There were a few shabab (young men) loitering around a taxi, and I was promised the front passenger seat. Not ideal culturally, but the best option in a car of mixed company. But then 5m behind us, the bus suddenly revved its engines and looked ready to go, so I dashed back on. We rolled 10m down the road. Then stopped. And waited. And people got on, then off, lured by the taxis. And then back on. And maybe one and half hours later, the bus was finally heaving with people. *Yay!* But then… a big man poked his head in the door. A BIG man. The ticket seller man pointed at me, then pointed at a tiny weeny bit of double seat on view, where a young mum and her two children had settled themselves. '*You move*'. I felt indignant. 'But how will I fit?'. He nonchalantly replied, *'mish mishkala' (no worries).*

So grumpily I moved.

Typical. Women always have to fit around the men here.

I wedged half my bottom into the seat. My legs stretched out to prop me in. Hands gripping the rail in front ready for the 3+ hour journey. I realised there would be trouble at the 30 minute mark. Eyelids drooping… and then I jerked awake, finding my bottom sliding its way to the aisle. *Blast.* I blinked sleepily, weighing my options… and picked up the sleeping 4 year old next to me. Plopped her on my lap. Put my chin on her head. Encircled her with my arms, and we drifted off to sleep together… I woke an hour later and we'd slid right down the seat, awkwardly into her mum next to us. The little girl was sleeping peacefully, despite flies dancing around her lips. She was sweaty, with dark curly hair sticking to her forehead. I was sticky, warm, very thirsty (and not allowed to drink water in public during Ramadan). But we were both safe and content.

And I realised I was so glad to snuggle with this sweet, sweaty, sticky 4 year old, dressed in her best Ramadan plastic sparkly necklace. Probably on her way to visit extended family during this fasting and feasting month. In a small way, I could care for her, while her mum was busy snoozing and gripping her 2 year old brother, all of us crammed on this seat. And I asked G to bless her.

The bus stopped. I followed the mum with her sleepy toddler stumbling behind her, to the door and handed over the still-deeply-asleep little girl. The veiled mum mumbled *'shukran'* (thank you) and the door closed. I sat back down to a glorious double seat. All to myself. But to be honest, I felt a little sad at losing my buddy. I felt joyful that I'd been 'stuck' with her. And then I concluded that actually, I had been blest. Then I glanced over at the BIG man with his head rolled back, snoring on his seat, on *my seat*, and I felt like the winner.

It was a little taste of that other-worldly promise. That, in the life to come, Jesus will reverse everything. The most important will become the least. And those who… by abuse, neglect, poverty, war, discrimination or injustice… have been treated as rubbish here, will be given *great honour* there, *in His kingdom.*

Just chew over that for a while.
What a *glorious* day that will be.
What a *glorious* truth, that our broken world needs to hear.

P.S. Last week I visited a refugee friend from Iraq. We read Psalm 139. She was equally delighted/captivated with the 'bloodthirsty' bit we try to avoid at the end, "O God, if only you would destroy the wicked!", as with the bit that ends up embroidered on our walls, "I am fearfully and wonderfully made". ●

Why Psychiatry?

by Kuruvilla George

When I opted to specialise as a psychiatrist the most frequently asked question from Christians was, "Why psychiatry? How can a Christian survive in the field of mental health?"

I did my post-graduation in Edinburgh, Scotland. Even in a developed country like the UK there were few Christian psychiatrists in the 1970s. Christians shied away from mental health because of perceived conflicts with their faith. So why did I decide to specialise as a psychiatrist?

As a medical student I was attracted to the specialty of Obstetrics and wanted to become an Obstetrician. I loved watching babies being delivered as I found it a great miracle to see the birth of a new life. However, my medical career took a major and drastic turn due to some experiences I had as a young intern in 1973/74. Three major events made me disillusioned with medicine as I saw it being practiced. The way the poor and those suffering were often treated was worse than animals. I began to question whether medicine was a career for me or whether I should go into full-time Christian ministry.

As I was considering my future in medicine, the third incident occurred which finally changed my medical career. I was working as a intern in the department of Pediatrics at a Medical College Hospital in India. Early one morning, as the nurses opened the doors of the department, they found an abandoned basket. When they looked into the basket they saw a small bundle. As they looked closer they noticed a newborn baby with big brown eyes looking at them. When the nurses began to unravel the layers of clothing and got to the baby, they realised that the newborn baby had no hands, arms, feet or legs. The baby had only stumps where there should have been limbs. No one knew who the parents were and why the baby was abandoned at the door of the department. We could only presume that the baby was born to some poor village folk who were unable to look after the baby and who thought that by abandoning the baby at the hospital the baby would at least be looked after.

"In psychiatry one was not focused on an organ, or part of a being, but the whole human being."

The hospital did not know what to do with the baby. One day a major case conference was held to discuss the future management of the baby. After much discussion, the Professor of Pediatrics made the final decision that the baby would be kept in the hospital, be given half feeds, gradually weaken, catch a hospital infection and die in a comfortable environment. As a Christian I could not accept the decision and immediately stood up and protested. Interns in India do not have much say or voice and so it was a surprise to everyone when I stood up and protested. However the Professor did listen and then put the challenge back to me to do something if I wanted to save the baby. As a single 24-year old unmarried man, I had no experience in looking after babies and my parents, who might have been able to help me, were in Singapore. What could I do?

There were a group of us Christians that belonged to the Evangelical Union. We prayed about the matter and then I wrote to the Ramabai Mukti Mission in Kedgaon, Maharshtra. Mukti Mission was a Christian ministry set up by a saintly woman called Pandita Ramabai. I knew a couple of the doctors who worked in the Mission. After discussion with the management, they agreed to accept the baby into the hospital section of the orphanage. The next challenge was to get the baby to Kedgaon in Maharashtra from Manipal in Karnataka. A good friend of mine, another young intern, agreed to accompany me. The two of us set out on a 36-hour journey by 2 buses and 2 trains to Kedgaon. It was an experience!! Two inexperienced young men caring for a newborn baby. Some of the nurses in the hospital were very helpful in cutting up bandages into nappies for the baby and preparing some bottle feeds. We had all kinds of questions asked during our journey about the baby and where the mother was. By God's grace we managed to get the baby to the Mission where she was accepted, loved and cared for. The little baby had to endure a lot of challenges without any limbs. She was named Manyata, which in Marathi means 'Acceptance'.

Manyata as a baby in India.

Lisa Manyata Olsen with her adopted American mother.

Photos: http://dailyrunneronline.com/beating-the-odds-without-limbs/

This was the final and most significant incident which contributed to my disillusionment. As I was considering giving up medicine, I spend some time travelling and visiting medical colleges in India with Dr Frank Garlick, a missionary doctor from Queensland, Australia. Dr Garlick left his prestigious position as the Professor of Surgery at the Christian Medical College in Vellore to work as a staff worker among medical and dental students and graduates with the Evangelical Union in India. This ministry gradually grew over the years to become the Evangelical Medical Fellowship of India. Dr Garlick, with much wisdom, advised me against giving up medicine as a vocation at such an early stage of my career. He warned that I might regret it later on in life. He suggested that I could continue my training and that I could still do Christian ministry at any time in my life. I took his advice and am still grateful for his spiritual wisdom. I began to consider psychiatry as I felt that in psychiatry one was not focused on an organ, or part of a being, but the whole human being and as a Christian I could also consider the spiritual aspect of a human being.

Coming back to the story of Manyata, in God's sovereignty a lady from a mission in the USA decided to adopt her. Manyata was given a new name by her mother in the USA and she was called Lisa Manyata Olsen. Her American mother accepted her, loved her and brought her up to cope with all the challenges which she faced. Manyata accepted the Lord Jesus as her Saviour at the age of 5 years. She went to school, learned to read, write and feed herself. She learned to swim and drive and competed in games for the disabled. Lisa obtained an undergraduate degree in communication and a post-graduate degree in journalism. She then obtained a job at Regent University, Virginia as a Career Guidance Counselor where she is still working today. Sadly, her mother who brought her up developed dementia and after 10 years of suffering passed away a few years ago. This was a big blow for Lisa Manyata as she lost the closest person in her life. Lisa continues to have a lot of challenges in her life and depends on other people for many of her daily tasks. However, through all this she is a big-hearted, cheerful 41 year old lady whose desire is to help others and to share God's love. She says that there are multitudes of people in the world who do not have hope. God's love is the answer. To this end she has started a ministry called 'Manyata Ministries'. She is a motivational speaker and accepts invitations from churches and other groups to speak and encourage people.

Lisa Manyata Olsen with Kuruvilla George.

"We should be willing to stand up for what is right and to be the Voice for the voiceless.."

I met Lisa Manyata again after 41 years in September,2015 during a visit to the US. It was such an encouragement and a challenge to me personally to see and hear how God has looked after and blessed this lady who in 1974 was a vulnerable little baby with no limbs and at the mercy of a hospital where she was almost euthanised. God works in wonderful ways and always has our best interest in mind. Lisa's favorite verse is Jeremiah 29: 11, "For I know the plans I have for you," declares the Lord, "plans to prosper and not to harm you, plans to give you a hope and a future."

I hope this story about Lisa will encourage you that there is hope in all circumstances. The other lesson is that we should be willing to stand up for what is right and to be the Voice for the voiceless. We do not realise how God can use even a little act of ours. What God wants from us is our availability and not our capabilities. He will use us to bless others if we are willing and available. ●

You can view or hear Lisa's story and read about her ministry if you were to Google – 'Lisa Olsen – Woman born without arms and legs'.

What on earth did Jesus say?!

by Geoff Francis

Geoff Francis retired last year from general practice. He was active on the Victorian branch committee in the 1990s. In 1975, Geoff, and his wife Jenny, worked with Jim Smith assisting at the Salvation Army Hospital in Turen, East Java, Indonesia. They then lived in the Latrobe Valley, Victoria for fifteen years, where Geoff was a GP-Obstetrician. He stood as an independent candidate for the Victorian State Seat of Morwell in 1985, gaining a vote of thirteen percent. Returning to Melbourne in 1993, he worked at Knox Medical Centre for nineteen years, following in the footsteps of John Cranswick. Geoff and Jenny live in Melbourne and have three daughters and two grandchildren. He enjoys running, woodwork, and assisting Jenny in the English Conversation Class associated with their church. The Bible Study associated with this class is called, "Let's talk about Jesus!" (gandjfrancis@ozemail.com.au)

We live in an increasingly connected 'global village' and Australia is becoming an increasingly secular society.

Tim Costello discusses this secularism in his new book, *Faith*.[1] He notes that the secular society includes "the emptying out of religion and faith from public spaces." In the first Century, when Jesus was preaching around the county towns and villages of Galilee and Palestine, the Roman Empire was connecting previously-isolated communities and cultures, and enforcing the worship of the Emperor; the Jewish religious leaders were losing the respect of the people, and "the common people" were longing to find moral leaders whom they could look up to. Jesus was gaining a reputation as a teacher who spoke with moral authority, in contrast to the priests and religious teachers.

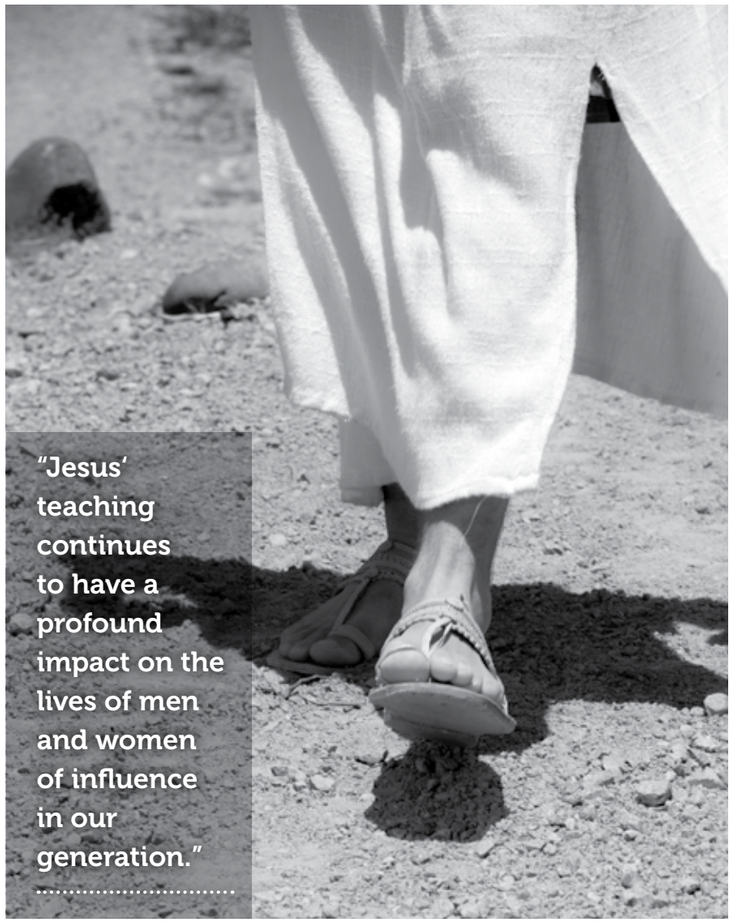
Can you imagine Jesus doing a preaching tour of Australian towns and cities today? Who would go to hear him? What reception would he get from cynical, secular Australians who have no time for "waffle, nonsense and lies" (otherwise labelled "bulldust")? If a reporter went to his meetings, how would the newspaper report Jesus' message, and what headlines would be written to grab our attention?

These ideas were on my mind in 2002, the year after the September 11 hijacking in the USA. I imagined driving down the road, and reading a headline outside the Newsagent's, drawing attention to something Jesus said, for example; **"Love your enemies. – Jesus".** I set myself a challenge: to read through the four Gospels, and write some headlines taken from his public preaching. Day by day, I worked my way through Matthew's Gospel, trying to summarise the different things Jesus taught in a few words. After six months, I had only reached the end of Matthew. Interestingly, I had written 52 headlines!

What to do with **52 headlines from Jesus?!**

In 2003, internet access was reaching 50% of Australians, but this was via painfully slow dial-up service. ADSL was just starting to take off. I was not a high-tech guru. I was interested in starting a website, but knew very little about it. Evan Englezos was a young Christian man in our church who had just completed a degree in computing and website design! I was able to employ him to design and set up the website. I purchased the domain name www.whatdidjesussay.com and the fifty two headlines, with the Gospel records and some background pages, went live. (In the last ten years, the rapid spread of smartphones has made the internet and its amazing resources instantly available in the palm of my hand!)

For each saying of Jesus I started writing brief comments. Then I started asking other Christians to write comments, so that the website would not be just one person's response to Jesus' message. At first I asked people from my church and circle. Someone suggested I could invite retired Governor-General Sir William Deane to contribute. This seemed a bold move, but I contacted him, and he promptly replied with a brief comment on headline 51; **"Hungry, homeless, locked up… How you treated them, you treated me!"** His comments, and the words of Jesus, remain strikingly relevant to the ongoing debate about our treatment of refugees. His willingness to contribute to the project in this way was a great encouragement to me. Since then Prof Graeme Clarke has commented on headline 39; **"With just a seed of faith you can move mountains,"** linking this saying with his work developing the bionic Ear. Former world leader of the Salvation Army, General Eva Burrows wrote a comment on headline 50; **"Use your talents for God."** Tim Costello has written on **"Don't neglect justice, mercy, integrity!"** Former Liberal State and Federal politician Bruce Baird comments on double citizenship under the headline, **"Pay the taxes you owe, and give God his due."** Neil Bell was the Labor Member for McDonnell in the NT Parliament from 1981 to 1997. He represented a largely Indigenous electorate, and was involved in proposing alternatives to the Euthanasia law that was enacted in the Territory. He commented on Reconciliation; **"Be reconciled to your brother before you worship God!"**



Are Jesus' words relevant for secular Australians today?

The wide range of Australian Christians, including CMDFA members, who have contributed comments on Jesus' words suggests that Jesus' teaching continues to have a profound impact on the lives of men and women of influence in our generation. As Christians, we are at risk of living in a separate culture with different language, and jargon that is foreign to people who have not been initiated into our tribe. Eugen Peterson's modern translation, *The Message* began with his attempt to translate one of Paul's Epistles into "Contemporary American" for the members of his Lutheran parish. The positive response he received led him to translate the whole Bible. My project is an attempt to translate Jesus' message into "contemporary Australian!"

Jesus did not confine his ministry to preaching in synagogues and in the Temple. He also preached to crowds in the open air, beside the lake and on the mountains. He ate and drank with publicans and sinners. He touched lepers, talked to prostitutes, and challenged his disciples' prejudices by engaging in conversation with an outcast, unaccompanied Samaritan woman at Jacob's well – in broad daylight! As health professionals, we have the great privilege of meeting people from many backgrounds and different faith journeys, often in times of need. We must strive to express our faith in the language of our culture. When Jesus spoke of **"Take my yoke upon you,"** he used the image of bullocks in domestic service; ploughing or carting loads. Today we might use the image of a sports coach, and say; **"Keep in step with me!"** (Headline 33.) Jesus said, **"If your hand causes you to sin, cut it off!"** This shocking saying resonates with the story of Aron Ralston, the hiker whose hand was pinned by a boulder in Ohio in 2003. After being trapped for five days, he saved his life by cutting off his own arm! (Headline 42.)

There is widespread revulsion at the failure of the Christian Church to protect children from abuse by clergy. How good it would be if this discussion was followed by the obvious question, "But what did Jesus, the founder of the Christian Church, have to say about this?" If we were to translate his headlines into **three word slogans**, (and I have done this exercise and posted it on the website!) his words would ring loud and clear **"DON'T HARM CHILDREN!"** (Headline 41.)

Are Jesus words more important to me than Paul's?

For ourselves, we must ask whether in practice, we place more importance on the words of Paul than of Jesus. Growing up in a conservative church, I sometimes felt that the words of Paul were given priority over Jesus' message. Indeed, many Christians followed the dispensational overview of Scripture laid out in the Schofield Bible, and relegated the Message of Jesus to the "Kingdom teaching" that Jesus presented to the Jews. In this way of reading the Bible, the teaching of the Kingdom was then put on hold when they rejected their King. This scheme sees Christians as living in "the Age of Grace" (The Church Age) and looking forward to the Rapture, when they would be spared the Great Tribulation. There was, and remains, a serious risk of being selective in our response to Jesus' clear teaching. If Jesus' call to be the light and salt of the earth is not central to our calling, it is easy to think the problems of our age, - poverty, inequality, climate change, a just and lasting Middle East peace process, and the refugee crisis - are not our responsibility. The popularity of Tim LeHaye's "Left Behind" book series and movie, and the close links in the USA between many evangelical leaders, the moral majority and the right wing

continued over page

agenda of the republican Party might be seen as a symptom of this selective application of Jesus' message. But it was Jesus, not Paul, who said "Therefore everyone who hears these words of mine, and puts them into practice, is like a wise man who built his house on the rock." Matthew 7:24. For myself, I want to test my life and theology – and politics – by the teaching of Jesus, and not try to limit his teaching to fit into my theological system.

The Stats! In 2010, the website underwent a major upgrade. Statistics are now available. The website receives over 100 hits daily, and has been accessed from most countries in the world (211 to be precise!) One in five visitors look at more than one page. 62% of visits are from USA, but it is also accessed from many "restricted access" countries. (I am encouraged by the parable Jesus told about the farmer who sowed the seed. Whether he was awake or sleeping, the seed was growing!) The website is not interactive, but the occasional feedback I receive is encouraging. Some people ask for the free bumper sticker. One man wrote that he was challenged by headline 11; **"Don't cheat on your wife – not even with your eyes!"** He said the headline helped him make the connection between his addiction to pornography and damaging his relationship with his wife.

On Easter Sunday, 2014, the website was featured by Rachel Kohn on her ABC National Radio program, "The Spirit of Things.' Four of the contributors including myself were interviewed. Several of my patients told me they heard the interviews!

As an amateur woodworker, I carved a model of "Open Hands." Around this theme, I wrote a meditation, including the powerful idea of "letting go." The meditation and image have been a blessing to me as a devotional aid. I printed some copies in the form of bookmarks, and found that I could easily share them with many of my patients. They were well received, and I have now added the "Open Hands Meditation" to the resource page on prayer – "Teach us to pray!"

Open Hands – a meditation; Honour Him, who holds in His hands your life and all your ways. **Letting go** – of the past, of things lost, taken away, or never received, of bitterness over past hurts, of fear and anxiety, **receiving** – the gift of life today our daily bread, every good gift from the Giver, every ray of love, **offering** – ourselves to the Father, our resources to bless others.

This project has taught me that we can pursue our passions and hobbies, and in God's hands they may become instruments for His Kingdom.

As a student, and throughout my career, I have been greatly encouraged in my Christian faith, and in integrating my faith with the science and art of Medicine, by contact with many members of CMDFA. **John Cranswick** worked in India with his wife Joy, encouraging students at Vellore Medical College to work among the rural poor. He then worked in General Practice, where he became a mentor and example to me, and was active on the Victorian State CMDFA committee when Rod Stephenson was writing his newsletter – the forerunner to *Luke's Journal*. John Cranswick described the approach of an Indian chaplain at Vellore Hospital, working among the Hindu patients, and respectfully asking them, **"Please, consider Jesus."** This attitude impressed me as the right mind for us to be in to encourage people to investigate Jesus' message for themselves. My ambition is thus to be **a signpost to Jesus**; whether I am called to stand by a major thoroughfare, or at a rural intersection with only an occasional passer-by! ●

Reference:
1. Costello, T. *Faith*. (Hardie Grant books, 2016.)

SNIPPET

If ever there is a period of contradictions and contrasts, this is it. Retirement – a period of anticipation and regret, of confusion and clarity. Most of all it is personal, yet universal. It seems at times to blend in to the mystical. Much is written and talked about retirement. That's good, or is it? It is often easier to talk, or write, than to do. And if there is one thing I find difficult, it's having to do something about it, that is to retire, gracefully!

Retirement – The period of learning, changing. In what areas? Here are just a few that are important for me:

- Learning to listen better, differently, with the art of asking the right question – there's a mutuality required in listening.
- The more I can encourage another, the better – encouragement helps others to make their own discoveries.
- Trying to replace memory lapses with graciousness, forgetfulness with kindness rather than querulousness, to myself as well as others.
- Giving more time to prayer and meditation, lifting up the many others to our Father.
- Surprisingly there is the challenge of deepening trust in God and His word – the inner journey needs more nurture as the outer journey wanes.
  "Lord what a change within is one short hour Spent in thy presence will avail to make...."

And the last lines of Archbishop Trent's memorable sonnet conclude:
"Why should we ever anxious or troubled be when with us is prayer And joy and strength and courage are with thee."

Vol 15 No 2 Nov 2010 – Professional Life and The Lifecycle "Faith and Work in the... Lifecycle (Retirement Stage)" by Frank Garlick

Tribute to John Foley

by Paul Mercer

Paul is Co-editor *Luke's Journal*.

John Foley and I have shared the editorship of *Luke's Journal* for some eleven years. It has been a productive partnership. Ageing, health issues and time elapsed since clinical practice, have indicated to John it is time to let go of this role. His contribution has been very significant and reliable. The quality of his legacy can be identified in the editorial on page 3.

As I reflected on John's legacy, I stumbled across an article entitled "Past Mastery".[1] It is an excellent description of John's contribution, coming through the journal. It acknowledges his rich clinical and academic career and the disciplined way he has helped produce each journal over the past decade.

In this final edition of our partnership, the theme around faith and history in John Wolfe's article[1] provides a framework to wish John Foley well.Wolfe observes that for Christians, history is a vital link between the past and the future. The scriptures, which inform the integration of our work and practice, are a revelation with historical character. A weak sense of the history of revelation is likely to correspond with a weak sense of Christian hope for the future. He argues a number of consequences of a robust engagement with history:

- **Clouds and Rainbows.** Exploring the historical lessons of failure and success will always inform our current practice. The dictum, "Failure to learn the lessons of the past contributes to our ability to repeat them," holds enduring credibility. John's editorship has accepted this perspective.
- **Unlocking the present.** History not only contextualises the original revelation but provides us with a robust sense of where modern medicine/dentistry has arrived and how we got here. The historical nature of revelation challenges any clean slate view of human existence. John's commitment to the encouragement of the integration of work and faith in his work is evident in the *Luke's Journal* "product".
- **History as escape.** In the consciousness of mature human beings is the tendency toward nostalgia. History in this sense is an escape from the real challenges of justice, compassion and ethical behaviour in practice today. "Original sin" does imprint the past and certainly impacts the present. History should assist a sober reflectiveness, which John has advocated in our journal.
- History helps us **recognise the place of the church in the world**, even the worlds of medicine and dentistry. There is space for robust debate. Our journal has grasped the hope God has graciously chosen for the church and the role of Christians in our professions. The Russian communist leader Khrushchev once observed: "Historians are dangerous people. They are capable of upsetting everything". The role of editors of a journal is not to always confirm our prejudices, but to engage through the Holy Spirit in the business of "upsetting everything" for the sake of true freedom.

As a fellowship, it is right to honour one such as John Foley who has served us so well. For now, his wish is to continue in the long journey of faithfulness through other pursuits... Praise God! The baton is now free and the emerging *Luke's Journal* team are grasping. ●

Reference
1. Wolfe, John. Past Mastery. *Third way Magazine*. 22 Feb 1989

Disciple Making in the Hospital - A Pilot

by Anonymous

Anonymous is a final year medical student at Monash University, Victoria. He is part of Praxeis, a simple church planting organisation that aims to see multiplying communities of Christ established in every city and town in Australia. His wife works full time with Praxeis. Together, they lead a team of young adults who make disciples that multiply.

"What will it take to reach my hospital for Jesus?" **We asked each other this question week after week as we explored the Great Commission and its implications for our work in the hospital.**

In early 2016, the small group of us that comprise CMDFA Victoria's "Movement Equipping team" sensed God's heart to see movement spread through the hospital system in Australia – Christian medical professionals discipling colleagues and others we encounter in the hospitals, multiplying disciples to reach many! We set out to pilot a training module that would not only teach the critical elements of a disciple-making movement, but would walk with trainees in accountability and practice in order to empower them to live out this radical lifestyle.

In August we launched the pilot with a group of ten young medical professionals. Over eight weeks we explored five key aspects of the fruitful disciple's lifestyle: vision, prayer, transparent spirituality, disciple-making and perseverance. Each week we allowed the Holy Spirit to prompt new steps of obedience – habits to build into our daily rhythm in order to transform the way we live.

"If we are to seriously hope for a movement throughout Australia's health system, we must begin, continue and end in prayer."

Vision

God's vision is to see Australia reached for Jesus, to see the kingdom of God come on earth in every sphere. As disciples of Jesus, we must set our eyes on no other goal. When we read the Great Commission in Matthew 28 to "make disciples of all nations", or Jesus proclaiming "Good news to the poor… freedom for the prisoners and recovery of sight for the blind…" (Luke 4), we learn about God's vision, and our hearts are moved to be aligned with this vision. During our first training session, we talked about the challenge of keeping this vision burning strong in our hearts in the busy hospital environment. Each week, we centred our minds and hearts on this. Some of the trainees found crafting a prayer a powerful way to be centred on this vision each day. Others of us found the act of "casting" this vision weekly gave us a renewed focus during the week.

Prayer

We learn in John 15 that "If you remain in me and I in you, you will bear much fruit; apart from me you can do nothing". From the early disciples gathering prayerfully on the day of Pentecost, to the century long 24/7 prayer chain of the Moravian church, or John Wesley's bold assertion that "God does nothing except in response to believing prayer," we see that gospel expansion is always preceded by passionate, persevering prayer. If we are to seriously hope for a movement throughout Australia's health system, we must begin, continue and end in prayer. Again, the busy life of a medical professional presents unique challenges in living out a lifestyle of prayer. We spent much time exploring these unique challenges and asking God for his ways for us to obey his call to prayer. Two doctors working at the same hospital began to meet before work to pray. A couple of other trainees found that arriving at the hospital early was a natural and effective way to pray for the day ahead.

Transparent Spirituality

In order to find those that are open and hungry to the gospel, we need to live fruitful and transparently spiritual lives. It was amazing to watch as one medical student start to meet with other Christians to pray for their classmates. When he was talking about this prayer time in the student common room, other students began to ask questions, joining in with spiritual curiosity. From there, an unchurched girl asked if she could join their prayer meeting! A nurse began to ask each new patient she cared for about their spirituality- and was surprised at how many patients kept the conversation going! A colleague of one of the trainees heard that she was walking and praying around the hospital before work and asked her about it. This started an ongoing conversation about faith.

Disciple-Making

In order to see a multiplying movement of the gospel, we need to make disciples, not just converts. A disciple obeys Jesus' commands right from the start – repenting from sins, loving others and sharing what they learn with friends and family. We learned to disciple a person of peace using a simple, Bible-centred process called the Discovery Bible Study (http://praxeis.org.au/wp-content/uploads/2013/07/DBS-explained.pdf), and practiced facilitating this process together. Several of us have discipled unchurched friends into obedient relationship with God using this process, and we dreamed of this being repeated in the lives of every trainee.

Perseverance

During our final week, we encouraged each other to persevere in the new behaviours we learned and started to practice. We held on to this promise: *"Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up"* (Galatians 6:9). Through the laying on of hands and praying for each other, we commissioned each other into our mission field at the hospital, and committed together to seeing the hospital world reached for Jesus.

The question *"What will it take?"* continues to echo in my mind as I look back on this pilot, and look forward to the task ahead. But over these eight weeks, it felt like we tasted a glimpse of the answer, and it's enough to spur us on to try to become disciples that can fulfil the Great Commission in Australia. ●

SNIPPET

When you are an administrator or department head you spend a lot of time chairing meetings. They can often be productive and can also be enjoyable but some of them aren't that easy. In contrast, to the Christian board or committee meeting, they don't open and close with prayer. At times Christian meetings can also be quite challenging, particularly when big issues are being discussed. I was privileged to serve as Board Chair of AFES, the Australian Fellowship of Evangelical Students. When we came to a difficult problem and were grappling to find a solution we would often pause for a time of prayer about the issue. I often had the feeling that these wonderful meetings were bathed in prayer. But when you're running a hospital, you can't really call a halt when a difficult or contentious issue is being discussed so that the assembled group can pray about it. However, I would often quietly breathe a silent prayer for guidance in these difficult situations.

Vol 17 No 3 Dec 2012 – Administrative Affairs
"Leadership for Clinicians and Administrators: A Personal View" by Kim Oates

SNIPPET

Suffering is a universal experience whose boundaries extend beyond the horizon of our understanding and its depth may be unfathomable to our enquiry. According to Cassell, suffering "arises from perceptions of impending destruction of an individual's personhood and continues until the threat of disintegration has passed or the integrity of the person is restored". Life threatening illness represents an assault on the whole person, the physical, psychological and spiritual. Furthermore, suffering is experienced by whole persons, not bodies. Coulehah suggests that suffering "is the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish". The experience of suffering is idiosyncratic, mysterious and may vary in terms of intensity and duration. Reed characterises the intensity of suffering as a continuum extending from distress, through misery, anguish to agony. Perhaps the major themes of suffering are expressed most succinctly by Manon in Puccini's eponymous opera, when she tearfully declares herself to be "sola, perduta, abandonata", – alone, lost, adandoned. The four great themes of suffering, variably expressed in their intensity, are isolation, hopelessness, helplessness and loss. Concomitant with all suffering is some element of fear because according to Reed, "the patient's world view and sometimes his or her very existence are threatened by the disease or circumstances".

In conclusion, three recommendations appear appropriate. Firstly, understand and appreciate suffering. As a result, you will learn more about yourself. Secondly, understand and appreciate the stories that your patients need to tell you. As a result, you may become healers. Finally, never underestimate the therapeutic potential of who you are, whether student, intern or senior consultant. In the words of Remen, "who you are may affect your patients as deeply as what you know. You will often heal with your understanding and your presence things you cannot cure with your scientific knowledge."

Vol 17 No 1 Apr 2012 – Suffering
"Therapeutic Use of Self and the Relief of Suffering" by John H Kearsley

Dying Healed
A source of hope

by Doug Bridge

After training as a general physician and in tropical medicine, Doug lived for two years in a Bangladeshi village. Upon returning to Perth in 1979, he helped pioneer the development of Palliative Care in Australia and Asia. He was the Head of the Palliative Care Service at Royal Perth Hospital 1993-2013. He is a Clinical Professor of the School of Medicine and Pharmacology, University of Western Australia. He was the President of the Australasian Chapter of Palliative Medicine 2014 to 2016. His special interest is the psychospiritual challenges of dying.

"For most of human history, death was a common, ever-present possibility. But now, as medical advances push the boundaries of survival further each year, we have become increasingly detached from the reality of being mortal." This statement is from the back cover of *Being Mortal*, the recent bestseller by American surgeon Atul Gawande.[1]

Contemporary Australian society shares this illusion that we can somehow overcome all diseases, and even defeat death itself. Australia has been a world leader in medical research and innovation. The Australian spirit of exploration, freedom, curiosity, and independent initiative has produced spectacular success. Sadly, this has been accompanied by a steady departure from our Christian cultural roots. For many Australians, confronting the reality of death – of a close family member or the possibility of their own death – may be the event that finally forces them to reflect on the meaning of life, and the possibility of life after death.

The pig in the green box: a turning point in my life

In 2002 I received a request from the Cancer Foundation of Western Australia. Perth was hosting a ten day visit – a group of doctors and other health professionals from Taiwan wanted to learn more about palliative care services in Australia.

I was happy enough to take two doctors on a ward round at Royal Perth Hospital. They were very interested and eager to learn, but their limited English language skills were a handicap.

Later, I was asked to give the final address to the whole group. I had no idea what topic would be of interest to them. On impulse, I gave a presentation entitled *Dying – a spiritual journey.* The presentation was cumbersome, because it had to be translated. When I finished, the group broke out into vigorous conversation, in Mandarin. I sensed something was wrong. How had I offended them?

Then a cheerful, plump man in orange robes stood to address me – "I am a professor of philosophy, a Buddhist monk, chosen to speak to you because I can speak English. We have decided that your presentation was the best lecture we have heard all week. We would like to give you a gift. I need to explain the 12 animals of the Chinese Zodiac; we think that the best animal is the pig, because it symbolises health and wealth. We present you with this box." He handed me a large green cardboard box. I opened it with some curiosity and trepidation. It contained a brown hollow clay pig. Trying to be culturally appropriate, I bowed graciously, and expressed my profound thanks for the gift of the pig.

"For many Australians, confronting the reality of death... may be the event that finally forces them to reflect on the meaning of life, and the possibility of life after death."

Two months later I received an unexpected email. I was requested to come to Taiwan to deliver my lecture "for 18 hours". That request required some clarification. Eventually I understood the message. Taiwan was a sophisticated, well-developed country, with a high standard of health service. Even their palliative care services were well-established. Yet there was one glaring deficiency: they could not face death. From my presentation in Perth, they had decided that I had the capacity to work with them to develop a "spiritual care training program".

So, with much trepidation, I read the Lonely Planet guide to Taiwan, in preparation for my venture to Taiwan. The guide was not encouraging. Beards were not appreciated – did I have to shave mine? Giving gifts was extremely important. Saving face was even more critical. One should never show anger.

At the end of my ten day visit, after numerous workshops and lectures, I was brought before the Chairman for his final assessment. The program was a success, he said. They wanted me to commit to a long-term relationship, to return every year for five years. And next year, to please bring my wife! Thus began a decade of annual teaching visits, during which I believe I learned the most. Trenna never did accompany me, observing (correctly) that it was no fun travelling with a conference speaker who was totally preoccupied with conference business.

Taiwanese pioneers

Prof Chantal Chau, a professor of palliative care nursing in Taiwan, interviewed Taiwanese hospice patients for her PhD research. She published her findings in a paper entitled "The essence of spirituality of terminally ill patients." She reported that patients sought wholeness and integration in four dimensions: communion with self, communion with others, communion with nature, and communion with a higher being.[2]

English hospice developments

In England, the Rev Dr Michael Wright, chaplain, researcher, and educator, conducted similar research. He reported: "hospices arose in a Christian context, but non-religious patients demonstrate similar needs to their religious counterparts: for **love**, for **meaning**, for forgiveness and for **transcendence**."[3]

SNIPPET

The local cerebral molecular background to various aspects of human mental function, including some phenomena that may fall within the rubric of spirituality, is beginning to be explored. An ongoing watch should be kept on the advance of knowledge in this area, to see where the findings may lead. The data that accumulate will always need to be evaluated with scientific rigour and considerable caution. There will be danger that the unwary and the over-enthusiastic may allow themselves to be misled, and perhaps may mislead others, by thinking that more than underlying molecular physiological mechanisms have been explained.

Vol 11 No 2 Jun 2006 – Our Spiritual Brain
"A Molecular Basis for Spiritual Existence?" by M J Eadie

The Australian and New Zealand Society for Palliative Medicine Spirituality Workshop, Totara Hospice, Auckland, July 3, 2016.

Inspiration from Canada

In Montréal, Québec, Professor Balfour Mount has been the undisputed leader of palliative care for decades. He promoted the concept of "healing", as opposed to the standard medical goal of "curing". An editorial he wrote 14 years ago presents a profound analysis of medical practice, and the need for a spiritual approach. His scholarly wisdom invites reflection and discussion:

"Healing is a relational process involving movement towards an experience of integrity and wholeness, which may be facilitated by a caregiver's interventions but is dependent on an innate potential within the patient. It is not dependent on the presence of, or the capacity for, physical well-being. Indeed, it is possible to die healed."[4]

Restoring the spiritual dimension to health care in Australia

Professor David Tacey, of La Trobe University, observed: "Australia has lurched in two directions: it is thirsting for spirituality more than ever, and is more resistant to religion than ever." Patients confronting death are particularly in search of spiritual answers. Our medical students need and deserve training in this difficult area.

After my third visit to Taiwan, I realised that they were developing some very good concepts and teaching material. I wrote to the medical school in Western Australia, suggesting that spirituality should be part of the curriculum. The Dean, CMDFA member Professor Ian Puddey, gave me twenty minutes to address the curriculum committee. They approved the proposal, and so began my career developing a training module in spirituality for healthcare professionals. I found Chantal Chao's "four dimensions" and Michael Wright's "four needs" very useful as starting points for lectures and workshops.

Australian medical students today may be "resistant to religion" but I have found many of them nevertheless "thirsting for spirituality". Over the past seven years more than fifty students have taken my two week fifth year elective in *Spirituality, Suffering and Healing*. Among my most recent group of five students, one was a Muslim, two were Christians, and two declared they were "SBNR". 'What was that?' I asked? "Spiritual But Not Religious"!

In 2000 the Royal Australasian College of Physicians established the Chapter

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of Palliative Medicine. In Australasia there are currently 140 postgraduate students undertaking the three year advanced training program. This is similar in many ways to the training of cardiologists and neurologists. One striking difference is the strong emphasis on spiritual issues. Although addressing the patient's and family's spiritual needs was listed as an essential skill for advanced trainees, until recently there was no structured teaching in this area. Our palliative medicine specialist society, the Australian and New Zealand Society for Palliative Medicine, has taken the initiative in sponsoring a full day interactive Spirituality Workshop. I was responsible for designing and facilitating the workshop. Drawing on my experience in Taiwan, and with the medical students, I constructed a full day program based on small group sharing. Participants were asked to form groups of three, who would become an intimate unit for sharing, discussion and reflection. I used stories, images and quotations, and sometimes included carefully chosen episodes of personal self-disclosure. In groups of three, the participants

"My ultimate dream is to have Spirituality Workshops available to advanced trainees and consultants in every medical specialty."

then discussed a set question for a period ranging from 5 to 20 minutes. Throughout the day, the questions became more sensitive. For example, after a case presentation about a woman tormented by long-standing guilt, workshop participants were invited to discuss this question: "In your own family, do you have any broken relationships that need healing before you die?"

Thirty-two participants attended the inaugural workshop in Melbourne last year. This year there was a second workshop in Auckland with more than 40 participants – mostly palliative medicine specialists or advanced trainees, plus two oncologists, two nurses, and two chaplains. There is now a strong demand for more workshops, and a recommendation that they be expanded to two days. An oncologist who completed the Auckland workshop was so impressed that he recommended all oncologists to participate.

Poised for expansion

After two years of negotiation, the RACP Chapter of Palliative Medicine has just approved the formation of a Spirituality Working Party, charged with refining and expanding the workshops, and "training trainers" so that more workshops can be held each year. My ultimate dream is to have Spirituality Workshops available to advanced trainees and consultants in every medical specialty.

Psychotherapy and Religion

Facing death is an overwhelming, terrifying prospect. For centuries religion has provided a framework to confront death. Existential psychotherapy has emerged as a secular substitute. But is it really non-religious? Christian psychotherapist David Benner urges us to integrate modern insights from psychotherapy with the ancient wisdom of biblical truth. He writes, "The great paradox of therapeutic psychology is that instead of replacing religion, in many ways it has come to serve as the functional religion of secularised Western society. Despite its packaging as a social science, psychotherapy is much more similar to religion than science – more a matter of spiritual guidance for problems in living than an empirically-derived technical treatment of mental disorders."[5] Writing in the 70s when the cult of self-worship was at its peak in North America, American psychologist Paul Vitz argued that psychotherapists had become the priests in the new religion of selfism – a religion with Christian roots but dangerously anti-Christian in its basic direction.

The concerns patients bring to psychotherapists routinely push service beyond what consensually-validated scientific research has established. This fact was noticed by Jung, who stated that "patients force the psychotherapist into the role of the priest and expect and demand that he shall free them from distress. That is why we psychotherapists must occupy ourselves with problems which strictly speaking belong to the theologian."[5(pp42-43)]

Carl Jung illustrates a much less reductionistic and psychopathological approach [than Freud] to the understanding of the place of spirituality in personality. Jung's clinical experience convinced him of the deep interconnection of the spiritual and psychological aspects of persons and of the crucial role spiritual considerations played in psychological healing. It was he, for example, who asserted that among his patients over 35 years of age, there had not been a single one whose problem was not fundamentally that of finding a religious outlook on life. He went on: "it is safe to say that every one of them fell ill because he had lost that which the living religions of all ages have given to their followers, and none of them have been really healed who did not regain this religious outlook."[5(p 56)]

If we limit our medical practice to a secular scientific framework, birth and death are merely physiological

"Anyone who has been present at the moment of birth or death can testify to the profound mystery associated with both."

events. Birth is when a foetus begins life independent of its mother. Death is when all vital organs fail, consciousness ends and the body begins to decompose. However, if we include a spiritual framework, birth is the awesome beginning of a new human being, created in the image of God. Death is the transition from this mortal world to the immortal world. For a brief period a door appears in the wall that normally separates the two worlds. Anyone who has been present at the moment of birth or death can testify to the profound mystery associated with both.

Is there life after death?

Australian palliative care physician Michael Barbato has researched the mystery of death for decades. We are indebted to him for his sensitive description of the mystical events which often occur just before death. He describes these as Death Bed Visions. These include vivid visitations by dead relatives or religious figures, clearly visible and audible to the dying person, but not to others present in the same room. In pondering such mysteries we may glimpse hints of other worlds beyond time and space. Our mortal senses lack the capacity to understand.

I am reminded of a hymn from my childhood: "Immortal, invisible, God only wise, in light inaccessible hid from our eyes." Astrophysics may give us some clues, but these mysteries are taught more by revelation than calculation. We do not need to understand Einstein's theory of relativity to grasp what Jesus taught us about the afterlife, as recorded by the apostle John:

> *"There are many dwelling places in my Father's house. Otherwise, I would have told you, because I am going away to make ready a place for you. And if I go and make ready a place for you, I will come again and take you to be with me, so that where I am you may be too". (John 14:2, 3)*

This same apostle John, as a very old man on the island of Patmos, gives us a glorious insight into the next world:

> *"Then I saw a new heaven and a new earth… And I heard a loud voice from the throne saying: 'Look! The residence of God is among human beings. He will live among them, and they will be his people, and God himself will be with them. He will wipe away every tear from their eyes, and death will not exist any more – or mourning, or crying, or pain, for the former things have ceased to exist.' " (Revelation 21:1, 3, 4)*

That, surely, is our ultimate hope! ●

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SNIPPET

From a personal viewpoint, the only one I have, it seems that being by nature a bossy person who wanted things done his way was a good start. That may not be all bad. Leadership is undoubtedly a spiritual gift, though not specifically quoted by Paul. I guess I had that gift and I have tried to use it for good.

In 1972 when my childhood Christianity bloomed into deep faith I questioned whether Christians should be leaders outside the Church. I consulted older and wiser folk and was able to understand that Christian leaders carry special responsibilities of example and moral character. This may not be a winning combination in the big world of capital and politics! To accept a leadership role of any kind exposes one and one's family to criticism and negative responses. As a Christian leader one's children may be targeted at school and deterioration of relations with friends and colleagues can be included in the price for standing up publicly for Christian values. A Christian leader should be unafraid of opposition. Christ himself predicted that his followers would be subjected to hard times. The quote "Blessed are you when men persecute you for thus they also persecuted the prophets" does not comfort greatly when one considers the high mortality of Prophets!! The statement "what doesn't kill you makes you strong" may be more practical.

Vol 12 No 2 Jun 2007 – Leadership
"Leadership" by Digby Hoyle

SNIPPET

I believe the wholesale rejection of God really began in earnest in our society with the advent of Darwinism that made people think the Bible was no longer reliable. This belief system also popularised the notion that Aboriginal people were less evolved and indeed Darwin described them as the missing link.

This affected government policy until even fairly recently and it is reflected in some of the statements around the removal of aboriginal children now referred to as the "stolen generation."

The ongoing emphasis on an ancient stone-age culture may only serve to reinforce the subliminal message of aboriginal people being lesser evolved beings less worthy of our concern.

Ashamedly this thinking has also influenced the church over the years and strongly influenced the way that missionaries and the church dealt with indigenous people in the early days and probably even now. I also think that many Christians are reluctant to get involved in indigenous affairs because of how much missionaries have been demonised in Australia, emphasising the negative experiences and ignoring the role that many missionaries played in protecting many Aboriginal people from further slaughter and destruction.

Vol 11 No 3 Dec 2006 – Love, Health and Hope
"Issues of Aboriginal Health" by Lara Weiland

The Visible and the Invisible - Part II

The Visible Revealing the Invisible

by Joseph Thomas

Dr Joseph Thomas is a Senior Specialist in Maternal Fetal Medicine and Obstetrics at the Mater Mothers Hospital in Brisbane. After training at the Christian Medical College Vellore, he worked at the Bangalore Baptist Hospital and Asha Kiran Hospital, Orissa, India till 2003. He subspecialised in Maternal Fetal Medicine in Adelaide after which he moved to Brisbane. He is passionate about human formation and currently he and his family worship at the Creek Road Presbyterian Church. *See Part I in Luke's Journal, Sept 2016.*

The unusual circumstances surrounding the conception and birth of Jesus Christ, as well as his life, death, and resurrection are recorded in the gospels. These events give us an unique opportunity to see how "The Visible" (heard, seen, looked at and touched [I Jn 1:1][1]) reveals aspects of "The Invisible" (the radiance of God's glory and the exact representation of His being [Heb1:3][2]). In this article we will look at some aspects of the Immaculate Conception, pregnancy, labour, and delivery that resulted in the birth of Jesus, from a 21st century obstetrician's perspective.

The Conception

The conception and the birth of Jesus Christ have been recorded for us in detail by Dr Luke, a first century Physician. In the gospel report named after him, he states that he arrived at his report after careful investigation [Luke 1:3].[3] As an astute clinician researcher, Dr Luke reports the first case of a virgin birth, prophesied several centuries ago [Isa 7:14][4] and records it in an open access letter to a man called 'Theophilus'. The other pregnancy that he reports is of an older woman who was likely post-menopausal [Luke 1:7].[5] Dr Luke could have well titled it "Two cases of unusual conceptions." The pregnancies in both cases were announced by angels. To highlight the virgin birth, Dr Luke compares the events surrounding the conception, pregnancy, and delivery of Elizabeth with that of Mary. John was conceived naturally by Zacharias (biological father) and Elizabeth (biological mother), both of whom were well past their normal reproductive ages [Luke 1:13].[6] Jesus, on the other hand, was conceived by a virgin [Luke 1:27][7] through the "Power of the Holy Spirit" [Luke 1:35],[8] with Mary giving birth to Jesus. Joseph is assumed not to have had a role in the pregnancy – he is a "non-biological father," as is stated overtly by Matthew [Matt 1:25].[9]

The pregnancy

The recording by Dr Luke of the angel's visit to Mary gives us the gestation for Elizabeth around 24 weeks. Though Dr Luke records 'At that time Mary hurried to a town' we do not know when exactly Mary visited Elizabeth; we presume that Mary would have been in her early pregnancy and Elizabeth over 24 weeks along in hers. [Luke 1:36].[10] Again attempting to highlight the difference in the foetuses within their wombs, Dr Luke records the meeting of Elizabeth and Mary with the fetus within Elizabeth 'jumping for joy' when Elizabeth hears Mary's voice [Luke 1:41].[11] Obviously Dr Luke does not imply any feto-fetal communication in this passage and the sequences of events imply a fetal response to maternal happiness communicated through neuro-endocrine pathways. Even as Mary knew of the special circumstances leading to Elizabeth's pregnancy, I suggest that Elizabeth already knew of the special circumstances surrounding Mary's pregnancy, most likely through family circles. Mary stays with Elezabeth, I assume, through her first trimester of pregnancy and till Elizabeth is almost 36 weeks pregnant and ready to have her baby (add 3 months to 24 weeks) [Luke 1:56].[12]

Labour and Delivery

Elizabeth had spontaneous labour at term and delivered a healthy boy baby, most likely under the care of a Hebrew midwife [Exo 1:15-16][13] in her own village [Luke 1:57][14] surrounded by her own family and friends. Contrasting the two births, Dr Luke records the arduous journey (100 kms by walk or on a saddle) that Mary undertook from Nazareth to Bethlehem in late pregnancy [Luke 2:4].[15] We have no reason to believe that this journey caused Mary to go into labour or any reason to suspect that the birth was preterm. To highlight the difference further, Mary had no place to give birth, and Jesus was placed in a manger. It could be debated whether Jesus was surrounded by farm animals at birth rather than by friends and family [Luke 2:6-7].[16]

21st Century conceptions and families

Dr Luke as a 1st century physician put in all his knowledge and understanding of those days on record to explain the immaculate conception of Jesus and it challenges me as a 21st century fetal medicine specialist to see it in the light of the knowledge that we now have. We have made several advances in understanding reproduction over the last few decades. From Edward and Steptoe[P1] to Dolly the cloned sheep[P2] and the elucidation of the human genome[P3] we have come a long way. Genome sequencing and free fetal DNA in maternal circulation for prenatal diagnosis is becoming routine practice.[P4] Definitions of marriage and family are changing – in the modern family the reference to children as yours, mine and ours has now given way to numerous combinations with single mothers, biological mothers and fathers, and surrogate mothers. Recently, the UK legalised three parent conceptions (donor maternal cytoplasm; maternal nucleus, and sperm).[17] How then do I view the Immaculate Conception in the 21st century?

Mosaic: The Virgin Mary and Angel, Basilica of the Annunciation in Nazareth, Israel.

Immaculate Conception – a 21st Century revisit

We are happy to accept that Joseph was not the biological father of Jesus and that Joseph did not have any contribution to the genetic make-up of Jesus. However, when it comes to Mary the mother of Jesus, several theories are mooted. Even if the egg alone started a parthenogenetic process by some stretch of the imagination, then the resulting being would have to be female.[P5] We know for sure that it was not from Mary's egg since Jesus was a male. Mary, I theorise, had no genetic contribution to make to the formation of Jesus. Mary would therefore have been a 'surrogate' 'a vessel' in whom the power of God created a whole new perfect human genome, an entirely new set of toti-potential cells, ready for cell replication and organogenesis (de novo, in vivo embryogenesis).[P6] Indeed, Mary *is* the mother of Jesus – the birth mother of Jesus, not the biological mother; with Joseph as the adoptive father.

"Dr Luke as a 1st century physician put in all his knowledge and understanding of those days on record to explain the immaculate conception of Jesus..."

Where then did Jesus's genes come from?

I want to suggest that Jesus as well as the first Adam/Eve were created with a perfect set of human genomes, without any mutations or copy number variants. If Jesus were to have Jewish genes or perhaps Mary's contribution, they would have been flawed.[P7] Paul in the letter to Romans refers to Jesus as the second Adam. Paul states that Adam was in the pattern of the one to come – who through obedience would bring life rather than the death that had come through disobedience [Rom 5:14-15].[18] Therefore Jesus, as the one in the pattern of Adam, was fully human with a full copy of the human genome that the first Adam had before the Fall. We believe that Adam was the father of the human race, not just the father of the Jews. The fatherhood of God then becomes a reality for me as well as the brotherhood and sisterhood of all mankind. This means that no particular nation, culture, or tribe can lay exclusive claim to Jesus as a person. Yes, Jesus was by genealogy (family tree of births) a Hebrew but not by way of genetics. Dr Luke in his gospel account traces the ancestry of Jesus all the way to Adam, the son of God, as if to emphasise the universality of Jesus Christ [Luke 3:38].[19]

In Genesis and in Hebrew we have the description of a man called Melchizedek who was a 'type' of Jesus Christ without a genealogy or a father or a mother. It states that Melchizedek was the "High Priest of God Most High."[20] The writer of Hebrews reiterates this by emphasising "Without father or mother, without genealogy, without beginning of days or end of life, like the Son of God he remains a priest forever."[21] On the one hand the historic, geographic, and cultural context of the birth of Christ cannot be denied and needed to occur in Bethlehem within the nation of Jews at a specific time, place, and context. On the other hand, we need

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to recognise that the birth, life, death, and resurrection of Jesus Christ our Lord is beyond genealogies or genetics, beyond a time/place/context. It is part of a cosmic event.

Genotype, Phenotype and Pneumatype of Jesus

What about the 'phenotype' of Jesus, since a perfect genome may not necessarily translate into a perfect phenome? There are numerous mechanisms of in-utero programming and developmental origins of health and disease (DOHaD) that are proposed in human growth and development.[P8,9] One presumes that Mary when she carried Jesus as a surrogate was 'protected' from any abnormalities of in-utero programming. Could this mean that Jesus had a near perfect 'phenome'? This is debatable since there are passages in the Bible [Isa 52:13-14][22] that allude to Jesus both as attractive and as unattractive. This could also mean that the phenotype of a person was less important and the emphasis in scripture was more about the pneumatype (the spirit) of a person in contrast with the pre-occupation of modern humans with the phenotype. Jesus is known to have been conscious of his spirit 'pneumone' and the constant fellowship he needed with the 'Holy Spirit' so that he could continue to do the works of His Father in heaven [John 5 19-20].[23] There is therefore

"...through the enabling of the Holy Spirit, there is hope of restoration of the genotype, the phenotype, and the pneumatype for each of us."

no question about the full perfect expression of the 'pneumatype' in Christ or His perfect genome from the original creation, but the actual expression of the phenotype is not clear.

The implications

I believe this has more implications than I can fathom; it is not just the futile musings of a 21st century physician. Jesus is not a God of the Jews or of the western world; I don't follow a foreign God but a God of all nations. For instance, it would make clearer the role of Mary, the mother of God, who is most blessed of all women as the bearer of our Lord, but was possibly a surrogate birth mother of Jesus. This is more fitting with the truth of the gospel than what has been taught in some churches for the last two millennia. It also makes clear to many of our friends who accuse us of having a God who has a wife and a son. Indeed no! We are monotheistic with our God being a Trinitarian God. In addition, the pre-occupation of the 21st century with the material, visible world and the phenome, to the great neglect of the invisible spiritual world and the pneumone[24], needs to change. It will be the invisible world that moves the visible world.

If any of us claim to be able to explain all the mysteries of the Godhead, we deceive ourselves. However, I must admit I am glad that even as Dr Luke used his knowledge and understanding to write the gospel, I with my modern knowledge and understanding am able to understand why Jesus is a God of all nations, why Mary is the "birth" mother of Jesus, why Jesus as the "Son of God" is the exact representation of my Father God, and that through the enabling of the Holy Spirit, there is hope of restoration of the genotype, the phenotype, and the pneumatype for each of us. ●

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I. Jn 1:1 – That which was from the beginning, which we have heard, which we have seen with our eyes, which we have looked at and our hands have touched – this we proclaim concerning the Word of life
2. Heb 1:3 – The Son is the radiance of God's glory and the exact representation of his being, sustaining all things by his powerful word.
3. Lk 1:3 – With this in mind, since I myself have **carefully investigated** everything from the beginning, I too decided to write an orderly account for you, most excellent Theophilus
4. Isa 7:14 – Therefore the Lord himself will give you a sign: The **virgin will conceive and give birth to a son**, and will call him Immanuel
5. Lk 1:7 – But they were childless because Elizabeth was not able to conceive, and **they were both very old.**
6. Lk 1:13 – But the angel said to him: "Do not be afraid, Zechariah; your prayer has been heard. Your wife Elizabeth **will bear you a son**, and you are to call him John
7. Lk 1:27 – '**a virgin**' pledged to be married to a man named Joseph, a descendant of David. The virgin's name was Mary
8. Lk 1:35 – The angel answered, "The Holy Spirit will come on you, and the **power of the Most High will overshadow you**. So the holy one to be born will be called the Son of God.
9. Matt 1:25 – But he did not consummate their marriage until she gave birth to a son.
10. Lk 1:36 – Even Elizabeth your relative is going to have a child in her old age, and she who was said to be unable to conceive is in her sixth month.
11. Lk 1:41 – When **Elizabeth heard Mary's greeting**, the baby leaped in her womb, and Elizabeth was filled with the Holy Spirit.
12. Lk 1:56 – Mary stayed with Elizabeth for about three months and then returned home.
13. Exo 1:16 When you are helping the Hebrew women during childbirth on the delivery stool, if you see that the baby is a boy, kill him; but if it is a girl, let her live
14. Lk 1:57 Her neighbours and relatives heard that the Lord had shown her great mercy, and they shared her joy
15. Lk 2:4 So Joseph also went up from the town of Nazareth in Galilee to Judea, to Bethlehem the town of David, because he belonged to the house and line of David
16. Lk 2:6 & 7 While they were there, the time came for the baby to be born, and she gave birth to her firstborn, a son
17. The UK approved the use of donor maternal mitochondria as reported by BBC news 24th Feb 2015
18. Rom 5:14 & 15 Nevertheless, death reigned from the time of Adam to the time of Moses, even over those who did not sin by breaking a command, as did Adam, who is a pattern of the one to come. But the gift is not like the trespass. For if the many died by the trespass of the one man, how much more did God's grace and the gift that came by the grace of the one man, Jesus Christ, overflow to the many!
19. Luke 3:38 … the son of Enosh, the son of Seth, the son of Adam, the son of God.
20. Gen 14:8 Then Melchizedek king of Salem brought out bread and wine. He was priest of God Most High
21. Heb 5:6 And he says in another place, "You are a priest forever, in the order of Melchizedek."
22. Isa 52:13 & 14 See, my servant will act wisely; he will be raised and lifted up and highly exalted. Just as there were many who were appalled at him—his appearance was so disfigured beyond that of any human being and his form marred beyond human likeness
23. Jn 5:19 & 20 Jesus gave them this answer: "Very truly I tell you, the Son can do nothing by himself; he can do only what he sees his Father doing, because whatever the Father does the Son also does. 20 For the Father loves the Son and shows him all he does. Yes, and he will show him even greater works than these, so that you will be amazed
24. The world has embraced the virtual reality of the Google glasses and the augmented reality of the 'pokemon go' however we have a long way to go before the reality of the invisible world is embraced.

SNIPPET

All in all, the responsibilities of a professional who is also a Christian can be complex. At the heart of the matter is the need to defend the integrity of both of the persons involved in a consultation, while recognising the specific responsibilities which lie with the professional. It means respecting rights and acting responsibly while, at the same time, maintaining the integrity of being a Christian and therefore viewing people holistically – and therefore spiritually – whether this is explicit or not. It is important to pay attention to the social consensus and the expectations concerning specific situations which are derived from it while also understanding that the expression of the general principles can change from time to time.

Vol 12 No 3 Nov 2007 – Faith in Practice
"Faith Sharing as a Professional" by Brian Edgar

SNIPPET

Traditional morality, including Christian morality, is characteristically "thick". Its conception of the good life is complex, based on a particular notion of the goal of human life. Another way of thinking about this is in terms of what it means to flourish as a human being in terms of right relationships between people, between people and God, and between people and the earth (sometimes called *shalom*). What makes for right relationships is revealed in the Scriptures, not only through rules and principles, but through narrative, poetry, proverbs and parables. These show that some kinds of attitudes, behaviours and relationships are not conducive to, or even compatible with, human flourishing, with *shalom*.

Men and women are not entirely free to define for themselves as individuals what is the good life, or what human flourishing is for them. Of course, there is some freedom, but it is freedom within the parameters set by the Creator God who genuinely knows what is best for us and what attitudes, behaviours and qualities of character will lead to us living life to the full, both individually and communally.

When we discuss ethical issues within the Christian community, it is in the context of this shared rich and contentful understanding of what is good and what is right, ultimately derived from the character of God. We won't always agree, but we are speaking a common language, with a mutually comprehensible vocabulary. We are singing from the same hymn book, so to speak, if not always the same page.

Vol 15 No 1 Jul 2010 – Plagues and Population Health
"Chicken Broth or Minestrone?" by Denise Cooper-Clarke

SNIPPET

The Parable of the Good Samaritan found in Luke Chapter 10 raises the question of "Who is my neighbour?" **Who is my neighbour in a hospital?** I believe we need to be on the lookout for how God is working in our neighbour's lives within hospitals. I would suggest that it includes our colleagues (both more senior and junior), other health professionals such as nursing staff, as well as other hospital staff, such as orderlies. Finally, we need to show unconditional love and mercy to our patients.

Vol 12 No 2 Jun 2007 – Leadership
"Sharing Faith in Hospital Practice" by Anthony Herbert

SNIPPET

Jesus taught that God sees our intentions and our actions as overlapping. They are both to be judged according to God's law. Secular law will differentiate between intention and act – for example the killing of an innocent human will be judged as murder when the intention was to bring about death, but as the lesser charge of manslaughter when it was not. In the case of late-term abortion, where we are considering deliberate killing of an unborn child who is close to if not at the point of viability, God demands both good intentions and good actions for our choices. It is not enough to have good intentions with wrong actions; Paul refutes the notion that we would do evil with the intention of a good outcome in Rom 3:8. Similarly it is not enough to have good intentions and do nothing; James rejects this notion in Jas 2:16. Both intentions and actions have individual significance. The Bible teaches us in Exodus 20:13 that killing an innocent human is wrong (one of the ten commandments – *'Do not murder'*). Biblical commands represent absolute values – there are some things we should never do, whatever the consequences. By this argument late-term abortion, by definition, will always be wrong.

Vol 14 No 3 Nov 2009 – Abortion
"The Ethics of Late-Term Abortion" by Megan Best

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Brendan So

One of the main reasons why I chose to study medicine was for the opportunities it would allow for sharing the gospel in a medical missionary context. I was able to take a year off medicine to study at SMBC full-time. It was an immensely enriching and rewarding experience, and one that I will carry with me for the rest of my life. I feel equipped to handle the Bible more effectively, but more than that, I really feel that I have a far greater appreciation and understanding of what cross-cultural missionary work involves. How should a doctor balance life between clinical work and ministry? Is it even legitimate to separate the two? What does it actually mean to contextualize the gospel to another culture? If these are questions you've thought about yourself, I could not recommend SMBC more highly to you.

Hayley Thomas

I wanted to spend dedicated time studying God's word, growing to know him more, and building a foundation for whatever he has for me in the future. During my year at SMBC, I enjoyed consistently hearing God's word taught faithfully, and having dedicated time to delve into it in study. This was complemented by the blessing of building relationships with staff and students –seeing the Christian life modelled and walking alongside others. I also benefited from the chance to reflect on the relevance of theology to a specific area of medicine, as I completed a research project in medical ethics. My time at SMBC has equipped me with knowledge to think more systematically about the Bible and theology, has broadened my exposure to mission, and has challenged me to grow in my own Christian walk.

Steven Naoum

My year studying at SMBC was certainly the most significant year of my life. On reflection it equipped me greatly for every endeavour I have undertaken since as I have sought to live as a child of God in his world in all I do. Spending a year completely focused on God, his goodness and sovereignty, and dwelling day after day on his word - what he has said and done throughout history - was the best decision I have made!

Study was rigorous and of a very high standard, and I still say this having completed a PhD and being half way through specialist clinical training. But it wasn't just a thing of the head – my heart and will were continually challenged – both in the classroom and by living in the college community.