Luke's Journal

of Christian Medicine & Dentistry
Vol. 31 No. 1 – March 2026
ISSN 2209-9441

Christian Medical and Dental Fellowship of Australia

GOD at the Bedside

+ Spiritual Assessment in Aged Care
+ Nurse Mentoring in Sierra Leone
+ Midwives as Hands of God
+ Pastoral Care for the Dying
+ MUCH MORE

lukesjournalcmdfa.com

March 2026 – God at the Bedside

Editorial

Contents

PACIFIC EAST ASIA REGIONAL *Conference*

27 - 31 OCTOBER 2026

CULTIVATING CHRISTLIKE EXCELLENCE IN NURSING: TO CARE AND TO LEAD

KATOOMBA CONVENTION CENTRE
BLUE MOUNTAINS, SYDNEY, AUSTRALIA

NCF Australia

www.ncf-australia.org

St Luke's Hospital General Training School badge

EDITORIAL: Journeying with St Luke – Georgie Hoddle, retired RN

Fascinating insights, with a special focus on the work of Registered Nurses and carers

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

"The Lord nurses them when they are sick and restores them to health." Psalm 41:3 (NLT)

It is an honour to present this issue of Luke's Journal (LJ) to our readers.

The evangelist Luke has been a part of my life since I was born in St Luke's Hospital (Sydney). As I was operated on there several times as a child and teenager, it seemed natural to train for my General Nursing Certificate there (attained in 1971). Now, in the role of guest editor of LJ, I feel I have come full circle as I embrace the challenges of ageing.

The list of contents reveals that the subjects range from medical missions to ministry at the bedside, particularly by nurses, midwives and carers. God and his Holy Spirit are ever present, with Jesus, the Great Physician, providing healing as witnessed in the Gospels of John and Luke, who recount Jesus' miracles with people who presented with diseases and disabilities.

Watercolour of Georgie in hospital by Miss Maloney, Art Teacher at Kambala, (1967)

Christian nurses, midwives and other healthcare professionals, as well as pastoral care workers, present some intriguing contributions in different genres – from a poetic description of a golden bacteria to the Saline ProcessTM. We know that saline at 0.9% is therapeutic, but here the reader will discover that saline is not just a medicinal solution but also a healing process of the spirit that leads to knowing and being loved by Jesus Christ. Physical, social, emotional and spiritual care and support are described from Mercy ships, doctors' offices, hospital beds or being cared for at home. These articles are interspersed with poetry, which the anonymous author pens as the presence of God in various situations.

Most of the authors are known to me, and each other, as both colleagues and friends; we are ageing together! "Friendships enrich and enliven lives that are, at times, increasingly limited by diminished sight, hearing and mobility." God provides us, especially in our weakest and most vulnerable states, with the resources to overcome our weaknesses and indeed our disabilities in order to serve Him (1 Corinthians 12: 12-22). Disability is a recurring theme throughout this issue. People with disability are the largest minority group in the world (according to the WHO); one in five Australians lives with a disability, seen or unseen.

The final journey through this issue of Luke's Journal is written by the Directors of Nurses Christian Fellowship Australia Ltd (NCFA). A few of them have finished serving the profession of nursing, but God has redirected them to other ministries in the community, in particular, pastoral care – Christian nurses, it seems, never retire. Charity Foo (the newest and youngest Director of NCFA) provides the reader with insight into hospital ward work in different scenarios, and she has also provided us with her original Prayer Menu.

This issue of Luke's Journal ends with a book review (Brock, Brian: Disability: Living into the Diversity of Christ's Body), which is the fruit of studies with Louise Gosbell, the renowned advocate for disability, and I am grateful to her and Mary Andrews College for permission to publish this assignment.

It's been quite a journey, and it's not over yet; embracing even more study at age 75 is a gift from God. Often, I write from my bed, like Florence Nightingale after she took ill. My final message and thanks go to the LJ Editorial Team who helped me pull this issue together, as reviewers and artists - be encouraged, remain prayerful and thank the Lord, always (Romans 12:12).

Georgie Hoddle
Member of the Board of Directors, NCFA Ltd
NCFA Saline Process Co-Ordinator
Guest Editor of Luke's Journal

Georgina Hoddle, retired RN
Georgie, as she likes to be called, is a retired Registered Nurse who now volunteers on the pastoral care team of an aged care facility. Georgie is the Saline Process™ Co-Ordinator and a board member of the Nurses Christian Fellowship Australia (NCFA). She also works closely with CMDFA on Saline Process™ courses in accordance with a Memorandum of Understanding. Georgie has spoken at numerous national and international conferences. Her current interest is directed to compiling research on pastoral care for mental health.

References:

1. McNamara, Laurence. Ethics, ageing and disability. In: Ageing, Disability and Spirituality. MacKinlay, E. (Ed.) Jessica Kingsley Publisher, London and Philadelphia, p.38, 2008
2. World Health Organization. Disability. http://www.who.int accessed 15 October 2025

Illustration by Jean Burke

Cover Artist's Statement – Jean Burke

Proclaiming Christ through compassionate care

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

This wood-block print depicts an evangelist praying by the bedside of a patient at the Berega Mission Hospital in Tanzania.

The hospital works in partnership with the Anglican Diocese of Morogoro, combining physical and spiritual care to make Christ known among the villagers.

My husband Michael and I, together with our sons, were sent by CMS Australia to serve in this village for four years, from 1992. Michael worked as a hospital doctor alongside two other doctors and a team of one hundred other staff members.

Staff, like the evangelist depicted in this print, prayed for patients and cared for them practically in their times of need – by the bedside, on the operating table, and in the labour ward, and in times of transition into life and death.

I carved this image from local wood, rolled black ink onto the raised parts, and printed it onto paper. This creative process reminds us that we are made in God's image to love and serve God and our neighbours.

Jean Burke – CMS

Jean Burke
Jean Burke has served with Church Missionary Society (CMS). From 1992 to 2003, she and her husband Michael, were sent to Central Tanzania, where Jean worked in Beregа Hospital, Mvumi Mission Hospital, and later with a local HIV program in Dodoma. In 2022, they enquired with CMS about short-term medical education ministry opportunities in East Africa. Soon after, they were invited back to Tanzania to help establish a new model of Christian medical education in family medicine at Kilimanjaro Christian Medical Centre in Moshi. Drawing on her qualifications, teaching experience, fluency in Swahili, and deep familiarity with Tanzanian life, Jean will explore further opportunities to serve on location.

Ayla Lopez with patient

Nurse Mentoring in Sierra Leone – Ayla Lopez, RN

It's no exaggeration to say that this has changed my life.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

Finding my place

For the past three years, I have been volunteering as a nurse with Mercy Ships. It is no exaggeration to say that this experience has changed my life.

Mercy Ships is an international Christian NGO that operates hospital ships in Africa, delivering free surgical care to people in low-income countries who would otherwise have no access to safe surgery. Beyond surgery, Mercy Ships is deeply committed to working alongside local professionals to strengthen healthcare systems so that transformation continues long after the ship leaves port.

When I first joined Mercy Ships, I thought I was signing up to volunteer my nursing skills. What I didn't realise was that God was about to take me on a journey that would reshape my faith, my understanding of global health, and my sense of calling.

For most of my time with Mercy Ships, I served on board the ship, working in the hospital as a nurse. I truly loved it. There is something profoundly special about providing direct patient care, about walking with patients through fear, pain, hope, and healing. To witness lives transformed through surgery, sometimes after years of suffering, is humbling beyond words. Add to that the unique, faith-filled community onboard, and it becomes a place that gets under your skin and into your heart.

At the same time, God was doing something within me. Looking back, I can see that Mercy Ships wasn't just a volunteer opportunity, it was part of how God has shaped my faith. Serving among suffering has a way of stripping away what is shallow and revealing what is real. It confronts you with questions you can't tidy up with quick answers. It forces you to decide what you believe about God's presence in pain, about justice, about human worth, about hope. For me, Mercy Ships became a place where faith moved from being something I thought about to something I had to live.

And yet, from the very first time I stepped on the ship back in April 2023, something else stirred within me. I remember hearing about our Education, Training, and Advocacy team (ETA) and feeling an immediate pull. Even before I fully understood what they did, I knew that was where my heart was being drawn. I have always been passionate about development work, about creating change that lasts long after we leave. The idea of equipping and empowering local healthcare professionals to lead in their own hospitals and communities resonated deeply with me.

Looking back now, I can see that this wasn't just a professional interest or a personal preference. It was a calling. God was planting a seed long before I realised what He was preparing me for.

In January 2024, that seed became reality. I stepped into a new role with ETA, one that would take me off the ship and into the heart of Sierra Leone's healthcare system, where I help run a Nurse Mentorship Program. I want to give you a glimpse into what it means to work alongside some of the most resourceful, resilient nurses I've ever met.

> "I want to give you a glimpse into what it means to work alongside some of the most resourceful, resilient nurses I've ever met."

You'll hear about the realities of healthcare in Sierra Leone – not sugar-coated, but also not hopeless, because what I've seen here is not defined by limitations, but by possibility. I want to share the vision and structure of our Nurse Mentorship Program, the changes we're seeing, and the stories of nurses whose confidence, leadership, and clinical skills are growing every day. I'll also share my own journey – how this work has challenged me, changed me, and deepened my belief that when you invest in people, transformation follows.

Context is everything

When I talk about nurse mentoring, I can't simply dive straight into what I do. To understand this work, you first have to understand the place in which it happens, because context changes everything.

Sierra Leone is a country of approximately 8.4 million people, and its healthcare system is best described as a patchwork. There are government-run hospitals, private clinics, and facilities supported by NGOs or faith-based organisations. At the centre of this system sits Connaught Hospital, the country's main teaching and referral hospital, located in the heart of Freetown. Connaught is where the most complex and urgent cases from across the country are sent. It is the place of last resort, the place where hope is often fragile but fiercely held.

The history of Sierra Leone has profoundly shaped its healthcare system. The civil war of the 1990s devastated infrastructure and displaced countless healthcare workers[1] for decades. Just as the country began to rebuild, the 2014-2016 Ebola outbreak struck, claiming thousands of lives and taking an enormous toll on the very people meant to protect public health – nurses, doctors, and community health workers[1]. Even today, the system continues to feel the ripple effects of these crises: chronic shortages of trained staff, fragile supply chains, and limited access to essential medicines and equipment.

To put staffing shortages into perspective, there are approximately 0.2 surgeons per 100,000 people in Sierra Leone[1]. In contrast, Australia has around (estimated) 22 surgeons per 100,000 people, a ratio 110 times higher[2]. Numbers like these don't just represent statistics; they represent delayed care, preventable deaths, and immense pressure placed on already-stretched healthcare workers.

The Nurses

But I want to talk about the nurses, because they are who I work alongside every single day. Nurses are the

Connaught Nurse Mentees

backbone of healthcare in Sierra Leone. They are the ones who keep the wards running day and night, often with little more than their own skill, creativity, and determination.

There are three main cadres of nurses in Sierra Leone.

- First are the State Enrolled Community Health Nurses (SECHNs). This was a certificate-level qualification and SECHNs make up the majority of the nursing workforce at Connaught Hospital. This course is no longer offered – part of a national move toward higher levels of nursing education and standardisation. Many SECHNs working today bring decades of experience, and it is encouraging to see many now returning to school to upgrade their qualifications.

- Then there are State Registered Nurses (SRNs), who complete approximately three years of training, similar to a diploma in many other countries.

- Finally, there are Nursing Officers (NOs), whose training is equivalent to a bachelor's degree, although in Sierra Leone this takes five years. NOs often step into leadership or specialist roles.

Despite these differences in training, all cadres work side by side on the wards, often covering for one another in the same high-pressure environments. On most wards at Connaught, there are usually only one or two NOs, with the rest of the nursing staff made up of SRNs and SECHNs.
One reality that is difficult to grasp until you witness it firsthand is that not every nurse is actually being paid. Sierra Leone operates on what is known as a "pin code" system. To receive a government salary, a nurse must be formally registered and allocated a pin code. The process is slow, bureaucratic, and positions are limited. This means many nurses working full shifts in the hospital are technically volunteers.
They show up every day, care for patients, and receive no salary.
They do it because they feel a calling, because the need is overwhelming, and because, without working consistently, they may never be considered for a pin code at all. Some wait months. Others wait years. The uncertainty is immense, but still, they keep coming.
At Connaught, we are fortunate that most nurses do have pin codes. Even so, staffing remains stretched beyond belief. There are days and nights when one or two nurses are responsible for dozens of post-operative patients, each requiring careful monitoring. And even when nurses have the knowledge and the will, the tools they need are often missing.

Working without what you need

In Sierra Leone, patients are required to purchase almost everything needed for their care – medications, IV fluids, gloves, tubing, syringes, dressings. If a patient cannot afford these items, the nurse simply does not have the resources to provide safe or timely care.
I have witnessed countless emergencies where nurses have had to beg nearby patients' families for permission to use their supplies for someone in crisis. Imagine pleading with one patient's family to borrow IV tubing or gloves to stabilise the patient in the next bed. Imagine deciding who receives oxygen when there is not enough for everyone.

Mercy Ships Nurse Mentors

Nurse Teaching

On many wards, there is only one set of vital signs equipment. Sometimes it is broken. Sometimes it is missing. Sometimes it has no batteries. When that happens, nurses are forced to delay or skip monitoring, relying solely on observation and instinct.

Oxygen supply is another constant challenge. Cylinders run out mid-shift. Concentrators break without warning.

I will never forget one shift when a patient deteriorated rapidly. We needed to ventilate them urgently, but the only ambu bag on the ward was broken, literally full of holes. We searched cupboards, trolleys, and other wards. Every bag we found was missing parts or unusable. To make matters worse, the oxygen tank had run out, and we had no adrenaline.

We did everything we could. But sometimes, despite knowing exactly what to do, patients die because the tools simply aren't there.

In moments like that, faith becomes something you cling to. Not because it makes everything easier, but because it keeps you human. It reminds you that despair is not the only option. It reminds you that God is close to the broken-hearted, even when you feel broken-hearted yourself.

I share this not for sympathy, but because this is the daily reality for nurses at Connaught. And yet, despite all of this, they keep going.

Jose's story

One story that has stayed with me, and that reflects the compassion and dedication of the nurses I work alongside, is that of a young man named Jose. Jose had a chronic leg ulcer that required daily dressings and eventually complex plastic surgery. His family, unable to afford the cost of care, abandoned him at the hospital. With no financial support, Jose was discharged and left to fend for himself.

Not long after, one of the nurses found him outside the hospital, his wound badly infected. The nurses refused to

Nurse Mentoring by the Bedside

turn their backs on him. They brought Jose back to the ward. They pooled their own money to buy his food, cover dressing costs, and advocate tirelessly for his surgery. Eventually, Jose underwent an amputation, a decision that, while not the original plan, ultimately saved his life.

Jose stayed on the ward for around four months. During that time, he became part of the ward family. Each day, he sat outside reading his Bible, greeting me with the brightest smile. His faith and resilience marked me deeply, but even more so, the nurses' selflessness spoke volumes about the heart of nursing here. They showed me what faith in action can look like, God at the Bedside.

Resourcefulness and resilience

There is extraordinary strength in the nurses here. They are resourceful in ways that constantly amaze me. I have seen cervical spine collars made from cardboard; water-seal chest drains fashioned by hand; tourniquets made from old IV tubing; and homemade traction devices constructed from whatever materials were available.

One day, during a critical moment, an oxygen tank malfunctioned. In most hospitals back home, you would simply switch to another tank or rely on piped oxygen from the wall. At Connaught, most wards have only two tanks, and they are often empty. That day, without hesitation, the nurses assessed the problem and improvised a solution using tape, tubing, and sheer determination. And it worked.

I remember standing there afterwards, overwhelmed, not by the fix itself, but by the spirit behind it. When the tools fail, the people don't. It reminded me of how God often works, through ordinary people doing extraordinary things, not because they have everything they need, but because they refuse to give up.

What is it we actually do?

So, you're probably wondering what exactly I do at Connaught Hospital?

I help lead our Nurse Mentorship Program, part of Mercy Ships' Safer Surgery Program. Our focus is on five surgical wards, two male, two female, and one paediatric. The heart of the program is simple: every surgical patient deserves safe, high-quality care, not just in theatre, but before and after surgery as well.

Mentorship here is about walking alongside nurses, not standing above them.

A key part of this program is the way we show up. We do not come in as outsiders to "tell nurses what to do." We come as colleagues, mentors, and partners, working shoulder to shoulder. This matters because mentorship is relational. Skill development is relational. Confidence grows inside relationship. And in this environment, where nurses are often under-supported, under-resourced, and sometimes overlooked, relationship isn't a 'nice extra'. It's the foundation.

In many ways, this reflects in faith, too. Jesus didn't lead by distance. He led through presence. He walked with people. He ate with them. He noticed them. He restored dignity. Mentorship, at its best, is a form of presence. It's saying: I see you. I'm with you. Let's grow together.

Year One of the program focused on trust. Before the program even formally began, we spent months building

relationships, listening, learning, and showing up consistently. Trust grew slowly, but once it did, mentorship flourished. Over that first year, we trained 45 nurses, developed eight clinical modules, and delivered mentorship through classroom teaching, simulation, bedside mentoring, and structured assessments.

Simulation became a favourite. Nurses practiced critical skills in a safe environment, laughed through mistakes, and learned together. Confidence grew visibly. Some days, formal teaching wasn't possible. On those days, we worked as nurses. True mentorship happens in the middle of chaos.

Time to pause...

After one full year of mentoring on the wards, we intentionally chose to pause. This was not a pause because the work was finished, but because reflection is essential if growth is to be meaningful and sustainable. We needed to step back, look honestly at what had worked, what hadn't, and what the nurses themselves were experiencing through the program.

The challenges of that first year were very real. We were working with nurses who had vastly different levels of training and experience, some with strong clinical foundations, others still developing basic surgical nursing skills. Staffing shortages meant nurses were frequently pulled away from mentoring sessions to respond to urgent patient needs. Attendance was sometimes inconsistent, not due to lack of interest, but because nurses were juggling overwhelming workloads, unpaid shifts, and in many cases, ongoing university studies.

> "We were creating something new while actively living inside the pressures of the system."

On top of all of this, there was no pre-existing mentorship framework to build from. We were creating something new while actively living inside the pressures of the system. And yet, despite these challenges, the outcomes were remarkable. When we assessed nurses' skills at the beginning of the program using an A–E assessment OSCE, only 16% were able to pass at baseline. By the end of the year, after consistent bedside mentoring, simulation, and skills practice, that number had risen to 76%. This wasn't just an improvement in technical skill; it reflected growth in clinical reasoning, confidence, and the ability to recognise and respond to patient deterioration.

We saw a similarly significant change in post-operative vital signs monitoring. At baseline, 0% of patients were receiving post-operative vital signs at the recommended intervals. By the end of the year, 26% of patients were receiving full, correct post-operative monitoring. In a resource-constrained setting, that figure represents far more than a statistic. It means deterioration was being identified earlier. It means nurses had the information they needed to escalate concerns. And ultimately, it means lives were being protected, and in some cases, saved. These improvements affirmed something we had believed from the beginning: when nurses are supported, mentored, and equipped, they rise to the challenge.

So, what's next?

Year Two of the Nurse Mentorship Program is about sustainability. While external mentors like me continue to play an important support role, we learned that long-term impact depends on mentorship being driven from within the hospital itself. This year, we transitioned to a ward-based mentorship model focused on developing local nurse mentors.

We are now training 20 State Registered Nurses (SRNs) and Nursing Officers (NOs) from the surgical wards to become clinical mentors. Using a "mentoring the mentors" approach, these nurses are being equipped not only with advanced clinical knowledge but also with skills in adult learning, bedside teaching, coaching, and giving constructive feedback. The goal is not simply to increase knowledge, but to develop nurses who can confidently guide, support, and inspire their colleagues in day-to-day practice.

Each month, a new clinical topic is introduced, topics that were identified and selected by Connaught nurses themselves, ensuring relevance and ownership. Learning happens where care happens; at the bedside, during real patient interactions, embedded into the rhythm of daily ward life rather than separated from it.

One nurse said to me, "I want to be the nurse who teaches the next nurses."

That statement captures the heart of what we are working toward. This is the ripple effect, mentorship

multiplying beyond us, knowledge being passed from nurse to nurse, and a culture of learning and leadership beginning to take root.

What a journey

This work has taken me on an emotional journey I didn't expect.

There have been moments of deep frustration, standing at a bedside knowing exactly what to do but not having the tools. Moments of tears, carrying the weight of patients lost, not because people didn't care, but because oxygen ran out or equipment failed.

Those moments have tested my faith. They have forced me to sit with God, not in neat answers but in lament. And I've learned that lament is not a lack of faith. It is faith that refuses to disconnect from pain. It is prayer with tears.

And yet, woven into that frustration has been joy. Joy in watching a nurse who once doubted herself teach her colleagues with confidence. Joy in seeing patient smiles after suffering. Joy in laughter on a chaotic ward when something finally clicks.

This journey has changed me. I came thinking I would teach, but I have learned just as much from the nurses I walk alongside. They have taught me resilience, faith that holds steady when resources run dry, and servant leadership that is about presence, sacrifice, and community.

They've also reshaped the way I view nursing itself. Back home, nursing often looks like skill wrapped in professionalism. Here, nursing is courage: showing up without pay, improvising without tools, fighting for patients who have no one else.

There are still days when doubt creeps in. But then I remember the faces, nurses stepping up as mentors, patients whose stories remind me why we do this, and I find hope again.

Final thoughts

If you take nothing else away, let it be this: investing in people changes everything.

Buildings, equipment, ships, these matter. But when you equip a person with knowledge, confidence, and vision, the impact ripples outward for patients, families, communities, and entire systems. Jesus said in John 15:16, "You did not choose me, but I chose you and appointed you so that you might go and bear fruit, fruit that will last." That's what this work is about: fruit that lasts. Seeds planted in nurses who will teach other nurses. Confidence growing into leadership. Care becoming safer. Hope becoming more real.

And in the middle of all of it, I am reminded again and again: God is not only working through grand outcomes. He is working through ordinary faithfulness, through nurses who keep showing up, and through the quiet, stubborn decision to hope.

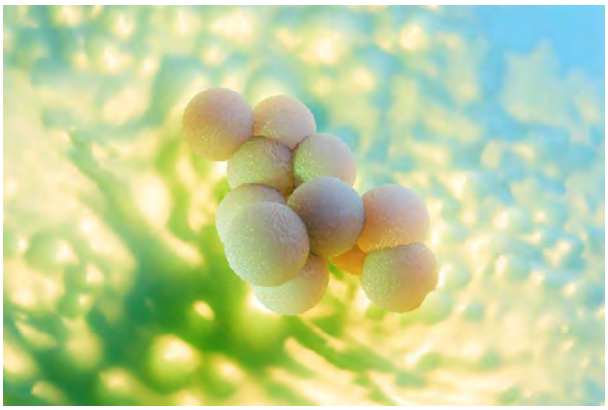
Ayla Lopez, RN

Ayla Lopez is a Registered Nurse, working in Sierra Leone with Mercy Ships, who is passionate about Global Health. She leads a Nurse Mentorship Program supporting surgical nursing teams through education, training, leadership development, and sustainable, locally driven healthcare initiatives.

References

1. Willott C, Boyd N, Wurie H, Smalle I, Kamara TB, Davies JI, et al. Staff recognition and its importance for surgical service delivery: a qualitative study in Freetown, Sierra Leone. Health Policy and Planning. 2020 Nov 27;36(1):93–100.

2. Edwards T, Garne D, Parker-Newlyn L, Ivers RG, Mullan J, Mansfield KJ, et al. Surgeons Outside of Cities: Longitudinal Trends in the Surgical Workforce of Rural Australia From 2013 to 2022. Australian Journal of Rural Health. 2025 Sep 26;33(5).



Staph Aureus

An Ode to Staph Aureus – Dr Harvey Ward

St. Aphyllo Kokisorius was a renegade Greek monk, after whom this nasty pathogen is named

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

This pyogenic fellow grows in colonies of yellow
That are round and smooth when raised on Petri dishes,
But pathogenically invasive,
Metabolically persuasive,
Should he populate your person if he wishes.
Though normally he's quiet, of course, unless your diet
Contains milk from bovines stricken with mastitis.
For the cramping he induces
from the toxin he produces
Bends you double, toilet tethered, weak and lifeless.
This coccal strain microbic, of necessity aerobic
Should remain quite passive, calm and not excite us
But if he squats on dodgy meats,
(or reheated cheesy treats)
You'll have gastro–procto–colo–ileitis.
So, if your razor slashes turn to full-blown septic rashes
Or your osteomyelitis hasn't healed
If your menacing furuncles
gallop on to huge carbuncles
Lance the phlegmon – swab and culture –
he's revealed!!
So, in abscess, inflammation, any focal suppuration On
the tonsil, toenail, pilonidal sinus
You will find the fiend, Staph Aureus,
quite Gram Positively glorious
knock 'em awful crook from tramp to Royal Highness!!

Dr Harvey Ward
Dr Harvey Ward is a retired OBGYN after 40 yrs of practice – 28 years as a specialist in South Africa, Canada and Australia. He is married to Kathy, a physiotherapist, and has 3 children and 6 grandchildren. He has been in public and private practice in Coffs Harbour for 20 yrs with special interests in teaching, infertility, urogynaecology and high-risk obstetrics. He has been a CMDFA member for 40 yrs from student days. This poem was included on the menu for the Medics Ball in 1982! Harvey is a Saline Process™ Trainer and is currently studying the Shroud of Turin post-grad.

Medina at her graduation with her children

Midwives as Hands of God – Medina Lamunu, RN/midwife

Midwifery under God's stewardship is ingrained in biblical stories

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

As I entered the room for handover at the start of my shift at the bedside, I could sense a low energy in the room – no sound, no light, no support person – just a lady in bed.

Introductions were made, and the handover done. My mind was scanning words; I didn't know what to say, knowing that whatever I said may not be the right words.

This was not a normal situation where the expectant mother is in labour, looking forward to hearing the first cry of her baby or giving the first feed. It was none of those. I said beneath my breath, "God lead me… please."

I uttered to the lady, "Would you like a shower?" To my relief, she said yes and explained she badly wanted one because it had been a while since she had showered and was worried about the odour in the room. As it turned out, she was actually too afraid to ask and assumed it was not for her in that situation.

While she showered, I made her bed with clean linen and dimmed the lights. She changed into a fresh gown, relaxed in bed, and I gave her a scented tissue with a pleasant perfume to smell.

She felt her first contraction not long afterwards. She had been hoping for "everything to end" that day so that she could go home.

One contraction came after another, and soon she delivered; the obstetrician entered the room and examined the foetus confirming – no heartbeat – as expected.

Just before moving her to a different room, the lady thanked me for providing such humane care and for the scent that helped her focus during contractions. It was her late mother's favourite perfume, and it brought her a deep sense of peace.

> "I gave glory to God for all His guidance that day, from providing the right words, to taking my perfume to work, which is rare."

The Orison Medical Centre will bring hope to South Sudan, where diseases like malaria, measles, and meningitis are widespread, and the lack of timely care continues to cost lives.

I gave glory to God for all His guidance that day, from providing the right words, to taking my perfume to work, which is rare.

To the mothers of babies without a heartbeat, I see you, and I feel your pain; God is close to you."The Lord is close to the broken-hearted and saves those who are crushed in spirit." (Psalm 34:18).

The principle of midwifery under God's stewardship is deeply ingrained in biblical stories and metaphors, illustrating God as a midwife figure who guides and assists His people in their physical and spiritual journeys.[2]

All women have the right to quality maternity and medical care regardless of their geographical, religious, social, political or economic status. In biblical times, the role of midwives extended beyond childbirth as they were often viewed as protectors of life. Prominent midwives like Shiphrah and Puah demonstrated remarkable moral courage by defying Pharaoh's orders to kill Hebrew male infants (Exodus 1:15–21). [3]

In 2018, as a student midwife, I completed work placements in rural settings, caring for expectant mothers from both rural and remote communities. I soon realised that there was much to be done to improve safe and satisfactory care for mothers, their babies and families. Health services must be accessible to every woman who needs them.

Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical and economic barriers, or if the community is not aware that they are available. Healthcare workers can effectively promote accessibility by addressing physical and economic barriers, and exploring cultural competence, acceptability and appropriateness.[3]

Women who are refugees and asylum seekers living in the community should have continued access to culturally appropriate, patient-centred health care, including specialist care, to meet their ongoing physical and mental health needs, including rehabilitation.

To determine the women's specific health needs, all asylum seekers and refugees should undergo comprehensive and timely health assessments in a culturally appropriate manner by suitably trained medical practitioners as part of a primary health care team. This assessment will be used to establish ongoing care, with appropriate and descriptive records being taken regularly to enable multidisciplinary teams and healthcare providers to give effective care.

> "The Bible also presents God in the role of a midwife, emphasising His nurturing and protective qualities."

The Bible also presents God in the role of a midwife, emphasising His nurturing and protective qualities.

Verses such as Psalm 22:9-10 reflect this imagery, portraying God as one who brings forth life and sustains it from birth. This metaphorical use of midwifery illustrates the divine involvement in the process of new beginnings and spiritual rebirth.[1]

Yet you brought me out of the womb;

you made me trust in you, even at my mother's breast.

From birth I was cast on you;

from my mother's womb you have been my God. (Ps 22:9-10)

Every woman, especially expectant mothers, should be treated with compassion, respect, and dignity. This is where Orison Medical Health Centre is set to play a big role in South Sudan.

Once the facility is completed with the help of African Action International Australia and HealthServe Global, it will showcase God's love in action. By working together, we can strengthen healthcare in disadvantaged regions. Health is paramount.

Read more about Medina and the Orison Medical Health Centre in Chris Dickons' article "Transforming Communities Through Sustainable Healthcare"

To hear more about Medina's powerful journey in her own words, watch her full Vlog interview on YouTube or Spotify.

Ms Medina Lamunu, RN/midwife

Ms Medina Lamunu is a former refugee who became a registered nurse/midwife and is the mother of six children aged 7-18 years in Australia. Medina felt the calling to be an instrument of God's love by advocating for mothers during their antenatal, intrapartum and postnatal periods.

References

1. Christianity.com (2025). https://www.christianity.com/bible/niv/psalm/22-9-10
2. A spiritual midwife: God's helpers in birthing new life (2013).
3. The Gospel Coalition Australia Ltd (2025).
4. Australian Institute of Health and Welfare. (2013).

Orison Medical Centre, Obbo, South Sudan

Transforming Communities Through Sustainable Healthcare – Chris Dickons

A glance at Orison Medical Centre, Obbo, South Sudan

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

HealthServe Global is a dynamic international health and development Christian movement committed to bringing hope, healing, and long-term transformation to some of the world's most vulnerable communities.

Operating across more than 20 countries and supporting 50+ programs over the past 22 years, the ministry partners with healthcare specialists and community development practitioners to deliver sustainable, life-giving healthcare in resource-poor contexts.

From Call to Cause

At the heart of HealthServe Global's work is a simple but profound conviction: every person deserves access to compassionate, high-quality healthcare. This belief shapes the organisation's vision for a future where global health is transformed through accessible and equitable care for all. Our mission flows directly from this vision — to serve, equip, and resource those on the front lines of healthcare delivery in hard-to-reach communities.

> "We see our role at HealthServe as being a conduit to help Christian's connect their call to His cause…"

We believe strongly in the priesthood of all believers, holding to the principle that Christian healthcare workers are called to have a Kingdom impact in the places God has called them, using their unique gifts to serve and glorify Him. We see our role at HealthServe as being a conduit to help Christians connect their call to His cause in some of the most under-resourced communities in the world.

A Model Built on Service, Empowerment & Partnership

HealthServe Global's approach is intentionally collaborative. Rather than imposing external solutions, the organisation focuses on empowering local practitioners and healthcare missionaries who understand the cultural, social, and environmental realities of their communities. These partnerships include doctors, nurses, midwives, public health workers, and grassroots development leaders who share a call to serve in places where health resources are scarce and access to care is limited.

This model of equipping and resourcing local leaders ensures that programs are not only effective but sustainable. HealthServe Global invests in targeted education, resourcing, and capacity-building initiatives that strengthen local health systems and enable communities to take ownership of their long-term wellbeing. This

Medina Lamunu

emphasis on empowerment aligns with the organisation's commitment to wholeness — addressing physical, emotional, social and spiritual dimensions of health.

One such example is our partnership with Medina Lamunu (Registered Nurse and Midwife) who launched the Orison Medical Centre Project in Obbo, South Sudan.

Bringing Health and Hope to Obbo, South Sudan

After decades of civil war, the people of South Sudan are rebuilding from the ground up. For families returning to their homeland—many for the first time in a generation—life is marked by resilience, but also by deep challenges. In remote areas like Obbo, basic services like healthcare are virtually non-existent. Mothers give birth without skilled support, preventable diseases go untreated, and clean water is scarce. South Sudan has the highest maternal mortality rate in the world. Diseases like malaria, measles, and meningitis are widespread, and the lack of timely care continues to cost lives.

> "But there is hope! The Orison Medical Centre – meaning "a prayer" – is a community-driven project to change this reality."

But there is hope! The Orison Medical Centre – meaning "a prayer" – is a community-driven project to change this reality. Co-founded by South Sudanese Australians, Medina and George, and supported by HealthServe Global, the centre will provide essential care for mothers, children, and families who currently go without.

Thanks to the generosity of so many, the centre has now been built, and we are awaiting a shipment of donated equipment and furniture all set to leave Melbourne in February 2026. Once this shipment arrives, the clinic will be fully operational and open to the local community. This amazing project is a testament to people like Medina and many others who have followed God's call to transform health outcomes for some of the most disadvantaged people in the world.

You can find out more and support this project here: https://www.healthserveglobal.org/orisonmedicalcentresouthsudan

Read more about Medina Lamunu in her article "Midwives as Hands of God".

Chris Dickons
Chris is the Executive Officer of HealthServe Global (formerly HealthServe Australia), where he has served for 18 months. Chris has over two decades of experience in senior leadership roles spanning ministry, education, and the not-for-profit sector, in Australia and internationally. He has also served on many not-for-profit boards. Originally from Middlesbrough in the UK, Chris migrated to Australia in 2012 and now resides on the Sunshine Coast with his wife and two young children.

Photo Shutterstock

Salt and Light at the Bedside – Carol Rowley, RN and Georgie Hoddle, retired RN

God is also a nurse...

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

The Lord nurses them when they are sick and restores them to health. **Psalm 41:3 (NLT)**

Christian nurses, along with Christian healthcare workers [1] in general, have the honour and privilege of caring for those God cares about greatly.

Genesis 1:26-27 reveals that humans were created in the image of God. But the wonder of each human life does not end there. Consider these words from Psalm 139:13-14 NLT regarding the bringing forth of human life: "You made all the delicate inner parts of my body and knit me together in my mother's womb. Thank you for making me so wonderfully complex. Your workmanship is marvellous – how well I know it."

While our focus can be on caring for the physical body, Christians recognise that people consist of "…spirit and soul and body…" (1 Thessalonians 5:23 NLT) and that God "…has planted eternity in the human heart…" (Eccl. 3:11 NLT).

Christian healthcare workers are privileged to care for God's precious, multi-faceted treasures – our fellow human beings. They should be sensitive to needs that go beyond the physical and provide for the whole person. Furthermore, they should be prepared to provide care in a way that presents patients with a picture of God's personal care for them.

> "In the midst of their professional duties, Christian nurses and other healthcare workers have the distinction of carrying the aroma of Christ (2 Cor. 2:14) into every interaction."

In the midst of their professional duties, Christian nurses and other healthcare workers have the distinction of carrying the aroma of Christ (2 Cor. 2:14) into every interaction. This can help facilitate scenarios in which patients can experience a sense of God at the bedside . By reflecting the character and heart of God in word and action, Christians offer patients encouragement that reaches their deepest, often unseen, needs.

Since they spend so much time at the bedside, nurses have a unique opportunity to share about God's gracious love and communicate that their patients' lives have meaning and purpose. Patients can also receive encouragement about reconciliation of broken relationships and hear about peace and hope that extends beyond their current circumstances.

The Saline Process™

Practically speaking, how can Christian healthcare workers maximise opportunities to provide patients with a picture of God at the bedside **?**

The Saline Process™, is a training program for Christian healthcare workers produced by IHS Global™,which provides practical insights into how.

One prominent theme in the Saline Process™ Witness Training (SPWT) course is that, based on Matthew 5:13-14, Christian healthcare workers have received the identity of being salt and light (IHS Global™ (Trainer's Manual) p.80).

Consider the impact of salt and light by imagining a world without them. Each is important, for sustaining life and adding flavour.

The right amount of each also matters. A portion of food that is excessively salted becomes distasteful; an infusion of a strongly hypertonic saline solution (like 3.0% saline) can be detrimental; people may flinch from an extremely bright light.

> "Our goal as Christian healthcare workers should be to interact in ways that reflect both God's truth and love, without creating more barriers…"

Our goal as Christian healthcare workers should be to interact in ways that reflect both God's truth and love without creating more barriers (IHS Global™, p.82). The SPWT course encourages Christian healthcare workers to build trusting relationships in which others feel safe, welcomed, and open to embark on a faith journey that addresses their deepest spiritual needs (IHS Global, p.131).

In the SPWT course, consideration is given to the characteristics and impact of both salt and light (IHS Global™, pp.93-95).

- It's well-known that salt adds flavour and can act as a preservative. Christian healthcare workers can bring the flavour of hope, encouragement, compassion and patience to the bedside as they care for the sick. Providing a smile or a gentle touch on someone's shoulder communicates care and concern. Christians can speak the truth with compassion in difficult situations whilst maintaining integrity in their conduct, with the perfect balance of truth and love.
- Light is important for vision. Physical light enables one to see who is coming into their room or even to locate needed items. This is especially important for those in a strange bed, an unfamiliar environment, or without family and the comforts of home.

> "If patients experience Christian healthcare workers consistently displaying the fruit of the Spirit, they may gain a better understanding of Jesus' character…"

If patients experience Christian healthcare workers consistently displaying the fruit of the Spirit, they may gain a better understanding of Jesus' character (IHS Global™, p.123).

Christian healthcare providers serving patients with excellence ("working wholeheartedly as though for the Lord," Colossians 3:23) is another way to reflect God's character (IHS Global™, p.125). As they provide holistic care, they may have the opportunity to answer anyone who asks them about the hope that they have (1 Peter 3:15).

Christian healthcare workers who intentionally incorporate the attributes of salt and light into their activities and interactions can have a significant impact on their work environment, on those they care for, and on those they collaborate with.

As Christian nurses and other healthcare workers approach those treasured by the Lord in the beds in front of them, may they always come with the perspective that each one is special to God.

May they remember they have the opportunity to provide care for them holistically, not just physically.[2]

May they also consider the difference they can make for eternity to those right in front of them, as they bring an appropriate amount of salt and light into their interactions.

May they also remember that it is ultimately God who changes lives, and their role is to be faithful while they trust Him for the results (IHS Global™, p.179).

Nurses and other healthcare workers are invited to contact the authors for information on future SPWT and Saline Process™ Training the Trainers courses:

Georgie Hoddle or Carol Rowley: saline@ncfi.org

Carol Rowley, RN

Carol Rowley RN, PhD, serves as Nurses Christian Fellowship International's Global Saline Coordinator. In this role, she has the opportunity to promote whole-person care by equipping Saline Process ™ trainers around the world. Through engaging those trained with content, coaching and community, many more nurses can be equipped and engaged.

Georgina Hoddle, retired RN

Georgie, as she likes to be called, is a retired Registered Nurse who volunteers on the pastoral care team of an aged care facility. Georgie is a Saline Process™ Co-Ordinator and a board member of the Nurses Christian Fellowship Australia (NCFA). She also works closely with CMDFA on Saline Process™ courses in accordance with a Memorandum of Understanding. Georgie has spoken at numerous national and international conferences. Her current interest is directed to compiling research on pastoral care for mental health.

References:

For this article, nurses are included each time the term healthcare workers is used.

1. Tyndale House Foundation. (2015). Holy Bible New Living Translation. Carol Stream, IL USA
2. IHS Global™. 2015 (updated 1.4). Saline Process Trainer's Manual.

Photo Pexels Fotoleo

Spiritual Assessment in Aged Care – Dr Michael Burke

Whole Person Care:
A Framework for Spiritual Assessment in Practice

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

Whole person care recognises the interconnected physical, emotional, and spiritual dimensions of patient wellbeing.

When aligned with culturally safe principles, this approach acknowledges the social, economic, cultural, historical, and behavioural factors that shape health across individuals, communities, and populations. It is characterised by deep respect for diverse cultures, beliefs, gender identities, sexualities, and experiences—encompassing patients, families, colleagues, and team members alike[1].

This article introduces a practical framework for exploring spiritual care with sensitivity, respect, and appropriate permission, particularly with older patients.

A Case Study: Mr CL

Consider Mr CL, a 73-year-old long-standing patient who arrives at your practice visibly distressed. He reports that a close relative is showing increasing signs of dementia.

Taking a Whole Person Approach

Embracing whole person care, attend to the interplay of physical, emotional, and spiritual concerns. Begin with a standard history, allowing CL adequate time to express his worries. Address immediate physical needs: reviewing medications for hypertension and osteoarthritis, and confirming his vaccinations are current.

CL appears unusually unsettled when discussing his relative. This could prompt further exploration through a social history:

- What support systems does the relative have?
- Is there a partner who can offer assistance?
- Are friends or family available to discuss these distressing changes?
- What community groups might provide support?
- Does the relative belong to a faith community?

The FICA Approach

Seeking permission to delve deeper, employ the FICA framework[2]:

- **F – Faith:** Do you have a faith?
- **I – Importance:** Is it important to you?
- **C – Community:** Do you belong to a faith community?
- **A – Address:** May I address these issues in your ongoing care?
  At this point, CL discloses that he has actually been describing his own health concerns, not those of a relative. Explain the diagnostic process ahead — various tests to clarify what's happening and determine how best to help. Schedule a follow-up appointment for this purpose.

Addressing Emotional Distress with HOPE

Yet CL remains emotionally upset, and you're concerned about his immediate well-being. Here, you might turn to the HOPE framework[3].

The HOPE model offers four domains of inquiry:

H – Sources of Hope: Explore what provides meaning, comfort, strength, peace, love and connection.
This open-ended approach works across the spiritual spectrum—accommodating patients who don't identify as religious or spiritual, those from minority faith traditions, and those wounded by religious experiences.

O – Organised Religion: Depending on the initial conversation, you may explore the patient's relationship with organised religion.

P – Personal Practices: Inquire about the spiritual practices most meaningful to them.

E – Effects: Finally, consider how spiritual beliefs and needs influence medical care decisions and end-of-life planning.

Ask CL: "What gives you hope?"

Building Understanding

Through this conversation, you will begin to understand what matters most to CL. You've started working through multiple dimensions – physical, emotional, and spiritual. While this is just the beginning, you're establishing a shared understanding of how CL's spiritual journey intersects with his emotional and physical challenges. Many steps lie ahead, but this conversation has been initiated with sensitivity, respect, and permission – the essential foundations of whole-person care. You can learn more of these skills and have a chance to practice them through Saline Process™ Witness Training at IHS Global.

Dr Michael Burke
Dr Michael Burke is a much-blessed member of the Christian Medical and Dental Fellowship of Australia (CMDFA). He facilitates the International Christian Medical and Dental Association (ICMDA) Creation Care and Health Training Track. He currently works at the Kilimanjaro Christian Medical Centre in Tanzania, East Africa, contributing in the areas of Family Medicine and Geriatrics. He is married to Jean and has three sons.
Michael enjoys being a Saline Process ™ trainer.

References:

1. Medical Board of Australia, Good medical practice: a code of conduct for doctors in Australia (October 2020)
2. Henry NL, Gilley N. Spiritual Assessment. [Updated 2024 Jan 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK599554/
3. Sleeth G, Gottlieb P, Srinivasan A, Thaddeus U, Mennillo M, Anandarajah G. Evaluation of the HOPE spiritual assessment model: a scoping review of international interest, applications and studies over 20+ years. BMC Palliat Care. 2025 Jul 7;24(1):191. doi: 10.1186/s12904-025-01809-z. PMID: 40624539; PMCID: PMC12236049.

Illustration by TaTa

Agonising over Death with the Dying Believer – Rev Tim Ravenhall

A suffering-free world? Not at the expense of meaningful relationships.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

In a society like ours, when wealth can buy just about anything, it can't buy life. Wealthy societies like ours believe they can buy a pain-free death. That's why we've succumbed to the idea that it is ok to assist people in their dying, to euthanise.

I'm not an expert in palliative care, but I understand it to be about treating a person with love and dignity and, to the best of our ability, reducing the pain a person might be experiencing in their dying, without over-medicating. As a theologian, I will say this: it is more important, wherever possible, to limit pain than to have zero pain at the cost of lucidity. I can't imagine everyone agreeing with this, and this is why I suggest "wherever possible."[1] God is a communicator, and he does so with words. His normal means of conveying his truth is through words to the hearer.

Whilst a person is able, let them hear. I am not saying that God is unable to reach a person when we no longer can, but whilst the ordinary means of conveying the truth of God to our friends remains, we should treat it as it is – the most precious means of His grace, both to us and to those who are suffering. The words of Jesus are life from the dead. We might not always realise it, but walking the journey with a friend who is dying is as much Christ ministering to us as it is to them.

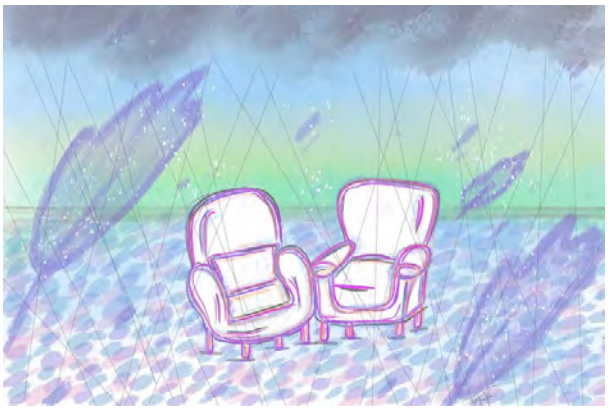


Illustration by TaTa

When I came to visit my friend Pearl*, I was shocked by her state, not what she looked like so much as her inability to hide her pain. I sat with her. Pearl had mouth thrush, and she was dry, thirsty and running a temperature, yet for all this, Pearl still seemed strong. I couldn't imagine her dying any time soon, but I knew she was in a lot of pain.

I sat with her whilst she spat out her words, a mature Christian wrestling with death. She would say things like, "I don't know what I believe anymore." I was her friend and her pastor. I was young, and she'd weathered some serious storms in life. What could I say? I said, "Pearl, you know Jesus is hanging on to you, even when you're not feeling like you're hanging on to him." She'd say, "I know, but it doesn't feel that way."

The context of this discussion was in an aged care facility, where Pearl was arching her back in her chair, asking me to take her clothes off because she was too hot. The nearest thing to this I can describe was like watching my wife in labour.

> "Pearl would say things like, "Why won't God just take me now," and "Does God hate me?" I'd say to her, "He loves you as only Jesus can.""

Pearl would say things like, "Why won't God just take me now?" and "Does God hate me?" I'd say to her, "He loves you as only Jesus can." And she'd say, "I know, but I can't help saying these things." I felt hopeless, and I was agonising with my friend. It was awful. But this great promise was a lasting comfort, "God works all things for the good of those who love Him and have been called according to his purpose" (Romans 8:28). There are many moments I fail to believe this, but as I've grown in my own faith and as I've looked back over my own life, the truth of this has been borne out, time and again.

I know another thing also, the dignity of a person is not in their individuality alone, but in community. We bear the image of God until we breathe no more (Genesis 1:26-28) . There is not a person alive who bears that image with the perfection of Jesus (Colossians 1:15-17) , but whilst we live, even if our condition limits our image-bearing capacity, to be human is to be an image-bearer. In fact, even when we don't know who we are anymore, God has got us. Even when dementia or Alzheimer's means we cannot remember that we are safe in Christ, we are safe, because God knows us fully.

Paul writes to Corinth, "Now we see but a poor reflection as in a mirror; then we shall see face to face. Now I know in part; then I shall know fully, even as I am fully known" (1 Corinthians 13:12) . Dignity is best experienced by knowing God and being in community. Our individualism drives us to think of dignity as a self-imposed posture. We hold our heads up high, and we don't show weakness. Yet biblical dignity is surely about sitting in the dust with the sufferer and weeping with them in the bitterness of their condition.

Job's three friends started well in this area, "And they sat with him on the ground seven days and seven nights and no one spoke a word to him, for they saw that his suffering was great" (Job 2:13). The incapacitated person derives the dignity of image-bearing humanity less from their individuality and more from God in Christ – and those who know them.

> "Though Job was not dying, the failure of his friends was that they did not treat him with the equality image-bearing demands."

Illustration by TaTa

Though Job was not dying, the failure of his friends was that they did not treat him with the equality image-bearing demands. In Job 12:3, Job reminds them of this, "But I have understanding as well as you; I am not inferior to you" (ESV).

I walked out of that room where Pearl sat, went straight over to the nurses' station and said, "Pearl is in a lot of pain. What can you give her?" They said, "She is alright." I said, "I think she needs some sort of pain relief." They assured me that she was ok and there wasn't a lot more they could do with her condition.

I don't believe they thought Pearl was in a great deal of pain, and I doubt they thought she was about to die. I sat in my car and I sobbed. I asked the Lord to take Pearl, even though I thought she was far too strong to die. The following morning, I received a call. Pearl had died during the night. My friend was released from her suffering, and she had gone to be with the Lord. God answered my feeble, sobbing prayer and possibly the prayers of others.

I don't do this much at all, and I can't imagine the difficulty of working in palliative care, dealing with people like me, telling them what the patient needs, when nine out of ten times, they have already thought of what the patient needs. But I do know this, that we have great words of solace for our friends who love the Lord Jesus.

Entering into someone else's pain and grief with the words of Jesus ringing in our ears is God's way of strengthening the sufferer and the carer alike. After the death of Lazarus, Jesus famously said to his sister Martha, "I am the resurrection and the life. Whoever believes in me, though he die, yet shall he live, and everyone who believes in me shall never die.' (John 11:25-26 NIV) .

As Christians, a healthy understanding of life in a sinful world makes us aware that though Jesus is our strength and shield, we are not immune to suffering and death. Neither are we cynical about suffering, like it is for nothing. Of course, we would love a suffering-free world, but not at the expense of meaningful relationships.

Finally, there is a time to let go of conversation, and prayerfully do all we can to ease the pain a person feels, to pray for their homecoming in the Lord and tend to our friend with kind actions and kind words, even when it may feel as though they are no longer listening.

*Pearl is not the aged care resident's real name.

Tim Ravenhall

Reverend Tim Ravenhall is married to the lovely Susan and is pictured here with their three children, Rex, Alfie (with an award) and Remy, their daughter. He loves hanging with the family, fishing, swimming in the ocean, coaching ball sports and his fabulous church family, Newcastle Central Presbyterian, of which he's been the pastor since 2018.

References:

1. This is no doubt a topic of serious intellectual discussion for another time. I recognise with humility my limited knowledge in the area and stand corrected on glaringly obvious deficiencies the reader may observe.

Image Peter Shirley

Broken Open – Anonymous

I was in the darkness when Love revealed His gracious, glorious face.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

I found love in a strange place
Away from the stages of success
Away from the sadness and the
Loud ideologies of unrest.
I was found in my failings
By a face not wrecked by beauty
That made the many vain.
I was found when I went looking
And could not find the mystery face…
Who fashioned like a master Artist
The design of every human face.
What is it to be found by the
Sacred face, no one has seen?
The face of God in a man,
With eyes lit & love sublime
With justice, truth & wisdom divine
While carrying a strange grief of
Dreadful darkness-bearing heart pain.

We like wild blind children ran
Racing after other gods & others
Like the mild child fearing by night The shadow of cold religion.
I was found by Love
When I knew so little love
In this self & when I looked in vain
For impostor love in those faces, Which brings one to despair.
Being warmed by Love by
The Son shining down his light
I was another lost son coming home,
One who didn't know the way…
I was in the darkness when Love
Revealed His gracious, glorious face
He rested quietly upon this soul, saving
Me from a litany of wandering days,
Whispering so kindly, I'll never be alone.

Anonymous
Anonymous is an author and poet with a deep understanding of grief, suffering, and faith, gained from years of serving as an educator and chaplain. Their calling is to walk alongside individuals facing hardship and personal struggles.

Photo Pexels Tara Winstead

Reflections on Love, Care and my Mother's Last Days – Decima Jones, RN

Fulfilling Mum's wishes was both challenging and deeply meaningful.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

Caring for someone you love at the end of their life brings together our professional skills, personal resilience and deep compassion. This reflection shares my experience of caring for my mother at home during her final days and the insights it offered into community-based palliative care.

Beginning the Journey

On Christmas Eve 2014, my mother began her final journey. Alzheimer's disease had slowly taken her memory and independence, but her gentle, kind, and faith-filled nature remained.

Five months earlier, I had arranged support from the local specialist palliative care team. At the time of her diagnosis, and before significant cognitive decline, Mum had clearly expressed her wish to die at home and avoid hospitalisation or life-prolonging interventions.

Providentially, the timing of her terminal decline allowed our family to fulfil her wishes. It was Christmas, and my sibling and I were on annual leave; her husband had recently retired. Surrounded by familiar comfort, Mum remained safe in the home she had known for fifty years.

> "Though she no longer knew who we were, she knew she was safe with us."

Challenges Along the Way

Caring for Mum at home during the holiday period came with unexpected difficulties:

- Access to equipment was limited, and caring for her on a double bed made repositioning and hygiene care challenging.
- The summer heat added to the physical strain.
- Basic clinical supplies — mouth care packs, absorbent underlay, slide sheets, washcloths — were surprisingly difficult to source in the community.

- Medications were dispensed in small quantities, which meant frequent pharmacy visits and accumulating costs.
- The emotional load of being both daughter and nurse was immense.

At times, I was exhausted and overwhelmed. The moment she was taken from her home after her death remains one of my hardest memories.

Unexpected Gifts

Despite the challenges, caring for Mum at home was a profound privilege.

Our family came together with a united purpose. Her grandchildren visited, and her favourite lap dog lay quietly beside her, offering gentle comfort.

I spent many hours lying next to her — reading Scripture, singing hymns, watching her favourite musicals, and using lavender oil during personal care. These moments were sacred and deeply personal.

After she died, I was able to wash and prepare her body one final time, without pressure or urgency. That time remains precious to me.

> "To accompany Mum on her journey home was a gift beyond measure."

Key Reflections for Practice

Caring for my mother at home reinforced several lessons relevant to community palliative care:

1. Access to equipment and supplies is vital.

Families often struggle to obtain items nurses take for granted in clinical settings.

2. Medication access and costs add to carer stress.

Frequent dispensing can intensify emotional and financial strain.

3. Family carers carry immense emotional labour.

Even experienced clinicians can feel overwhelmed when caring for their own loved ones.

4. Community palliative care teams are invaluable.

Their support made it possible for Mum to remain at home comfortably.

5. End-of-life care is sacred work.

Whether in hospital, hospice, or at home, it involves dignity, presence, and compassion.

Closing Thoughts

Fulfilling Mum's wish to die at home was both challenging and deeply meaningful.

She died where she wanted to be – surrounded by love. I remain grateful for the opportunity to be her daughter, her nurse, and her companion on the final steps of her earthly journey.

Decima Jones, RN
Decima Jones has a Bachelor of Nursing, Cert IV Family Counselling, and certificates in Oncology Nursing and Palliative Care. Decima is a retired Registered Nurse with 40 years of experience across oncology and palliative care. For the last 15 years of her career, she held the role of Clinical Nurse Consultant for Palliative Care. In retirement, she remains passionate about this work, supporting, educating, and mentoring healthcare providers to strengthen care for people with life-limiting illness.

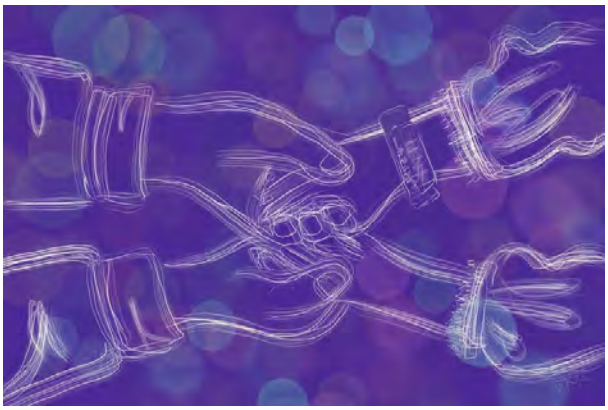


Illustration by TaTa

Pastoral Care for the Dying – Rev Tim Ravenhall

Context for the dying is as important as it is for the living.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

In my bio, I mentioned that my pastor, whilst I was training at theological college, said to me, "Have you ever sat with someone whilst they died?"

I hadn't.

I recall that conversation because he said, "If you get the opportunity to sit and hold someone's hand whilst they die, do it. It is an immense privilege." I was curious about it from that point on. I have been to the bedside of many people, but I have never held the hand of someone who has died on my watch. Yet it is constantly with me when a person is no longer lucid, to hold their hand – a final act of human solidarity and love, a kind touch, a warmth from which they are slowly creeping away – something that keeps hold of the dignity of humanity till it is no more. Love is the end of suffering eternally, but our attempts at love, rather than to end suffering, are to endure with the sufferer.

When asked to go to the hospital to visit a dying patient, I find it is usually because they at least have some connection with the Presbyterian Church. One of the most important questions I've found, even before I've entered the room, is this: "Who's asking?"

Illustration by TaTa

Illustration by TaTa

Who's asking?

Not to be blunt, and I don't imagine you'd ask the question like I have in this sub-heading, but finding out who wants you to visit will help with what you are going to say. Context for the dying is as important as it is for the living. When I'm called to the bedside, it's often not the patient who calls for the Minister. It is the family.

Unfortunately, we have become so accustomed to avoiding conversations about death that, when we realise it is upon us, there is no turning back the dial. We have left it too late for any conscious conversation to take place with the dying person.

Most people don't want anyone to say anything at all to their dying friend or family member, but they hope for some magic words from the Minister. Which we are, of course, in no position to give them, other than what God Himself has promised. We only have in our arsenal what every other Christian has in theirs. We have the Word of God and in this, the hope of eternity for all those who trust in the good news of Jesus, His death and resurrection for the forgiveness of sins. So, who am I speaking to in those last hours of life, when speech has been cut off, hands are limp, and breathing is shallow? Is there anybody in there?

Is there anybody in there?

I think the closest I have come to death was the local funeral director's house. It doubled as a mortuary. What was I even doing there? The connection was that my own father occasionally worked as a graveside attendant, and the son of the director was my brother's good friend.

In that house, I saw dead bodies, lifeless things with makeup on. They were just shells, and I was a fourteen-year-old boy. Even then, I knew there was nobody in there. But in the last hours of life, whilst we have the breath of God in us, the soul or spirit of a person is still at home in the body.

> "…if God can create the universe in a spoken word, then he can speak words of life into an unconscious person."

We don't ultimately know what a person can hear in their last moments. But what we do know is that if God can create the universe in a spoken word, then he can speak words of life into an unconscious person.

It is at this point that I am forced to reckon with my limitations as a communicator of the truth.

The question above, 'Who's asking?' demands that I address the dying and the family, but I address the family through the dying, because while there is breath, there is life, and while there is life, we can assume God is an able communicator, beyond our human limitations.

In this scenario, I hold the person's hand. I tell them who I am. I explain I'm going to read a few great words from the Bible and then I'm going to pray. Then I read a Psalm and a passage on the resurrection of Jesus. My favourite is John 11, when Jesus speaks to Martha about her brother Lazarus, who is raised from the dead. Jesus famously says, "I am the resurrection and the life. Whoever believes in me, though he die, yet shall he live, and everyone who believes in me shall never die.' (John 11:25-26) .

The Christian hope in death is found in Jesus and no one else. With an unconscious person, I like the family to be present for this moment. They get to hear the life-giving words of the Bible, and we can pray for the person who is dying and pray for their loved ones as well.

When there is clearly someone at home

Far easier and far more awkward at the same time is visiting the dying when they are clearly in their right mind. It's far more confronting to talk about death when you can look a person in the eye. Far more confronting to ask the person whether they would like time alone with the Minister to talk through any issues they're not comfortable with discussing in a room full of people. Far easier, though, to have a real conversation with a person about their life, their joys, their hopes and their worries.

I have not often been in a situation where this has been easy. If the person dying clearly has no understanding or interest in spiritual things, I don't push it. I might ask them about their life, where they grew up, what they did for a living, and how many children they had (if I got the sense, they had a family). If there was a genuine warmth from their end, I might say, "Do you mind if I ask you a personal question?" Only then would I venture to ask, "What do you believe about God and heaven and things like that?" And if that goes well, to speak further with permission about the Christian hope in death. I usually ask, regardless of beliefs, whether I can pray for them before I leave.

> "The best is when the person knows me, and I know them, and even better, knowing that they already grasp the eternal hope of Jesus."

The best is when the person knows me, and I know them, and even better, knowing that they already grasp the eternal hope of Jesus. I usually offer to read a Psalm. One of my favourites is Psalm 139:1-18 because it captures God's eternal knowledge of us and reminds us of our safety in him. These verses are lovely,

15 My frame was not hidden from you
when I was made in the secret place,
when I was woven together in the depths of the earth.
16 Your eyes saw my unformed body;
all the days ordained for me were written in your book
before one of them came to be (Psalm 139:15-16).

"All the days ordained for me," what a fabulous comfort for those who know God and have delighted to have God, in Christ, as the Shepherd and Overseer of their souls (1 Peter 2:25) .

You and I are not in control of our lives. We can be wise or foolish, which will often make a difference to the outcomes of each day, week or year. But not one of our days slips by without God knowing all about it, and even more mind-blowing, in our last moments, though we may struggle, God is not without purpose to each day of the believer's life.

Do we believe God when we read, "God works all things for the good of those who love Him and have been called according to his purpose" (Romans 8:28) ?

Tim Ravenhall
Tim Ravenhall, Presbyterian Minister/Pastor, Newcastle Central Presbyterian Church. (B. App. Sci. CSU, Wagga Wagga, NSW; B. Div. Moore Theological College, Newtown, Sydney; Dip. Min. Presbyterian Theological Centre, Burwood, Sydney.) Tim became a Christian at age 7, grew up in country NSW and began to take Christ seriously at age 18. He played a lot of sports, AFL, squash, tennis, cricket, and rugby union and loves 'river and estuary' fishing. Tim has been in full-time pastoral ministry in the Presbyterian Church for about 23 years. He met the lovely Susan at Moore College; they married in 2004, have three kids – all popped out in Young, country NSW. Whilst at theological college, my Pastor taught me that it was an immense privilege to sit with the dying; now I do.

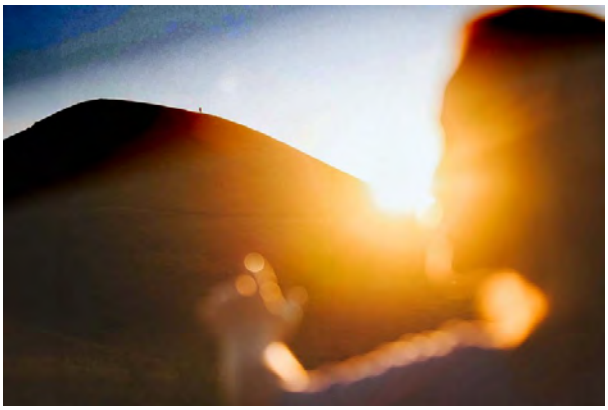


Photo by Maksim Romashkin, Pexels

The Last Goodbye – Anonymous

It happens just when you think it won't ...

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

It happens when the sun is sighing
When last light is slowing down,
Then leaving without permission.
It happens when you think it won't happen ...
To the ordinary people like you & I
It's when lovers are left alone grieving,
It's the deaths of suffering mothers & fathers ~
The demise of friends who quietly disappeared.
No one prepares anyone for that last goodbye,
When you're letting go of warm familiar hands
And you feel like you're the one dying.

We need the Love which scattered
Love to each human soul held fast
In the thrall of illusion & vainglory.
We need a love which will not abandon,
Which refuses to deceive & betray.
We need Jesus the sublime & supreme ~
Who died for Love (for all the darkness),
Who will never walk away ... we need
His redeeming Love which said,
There's no last goodbyes.

Anonymous
The writer lives in the Hunter and is married to a midwife. He has worked in Education and Chaplaincy and is still involved in Pastoral Care. He grew up as a devout Roman Catholic until his unexpected conversion at 21. He attends an evangelical Presbyterian church in Newcastle.

Illustration by Shutterstock

Ella: A Case Study in the Community – Dr Antonia van Loon, RN

Recognising the value of connection to God's family for our most vulnerable.

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

A snapshot of mental health in Australia[1]

- 1 in 5 adults (16-85yo) experience a mental health condition in any given year
- 1 in 4 people – 1 in 3 women and 1 in 5 men – will experience anxiety (2 million in a year!)
- 1 in 6 women and 1 in 8 men experience depression (1 million a year)
- 17 % of Australians experience an anxiety disorder
- 1 in 7 children aged 4-17 years experience a mental health disorder [2]

Let me introduce Ella: one Australian living with mental health conditions

Ella (not her real name) was a young woman who had been attending our church on and off for several months. She asked for prayer about her mental health and indicated she would value a pastoral care visit. As the Faith Community Nurse in my congregation, I visited Ella and then continued those weekly visits for several weeks when this conversation arose.

Ella said, "God can never forgive me. He may love people, but he can never love me! I've done so many bad things that I can't possibly go anywhere but to hell!" I could feel words jump into my mouth, wanting to respond "NO! God absolutely loves you…" but I knew that this would diminish Ella's feelings, and she clearly was not

experiencing God's love. I listened to her lament, and after some time, I hesitatingly responded:

"You know I don't know what you have done that might make you feel this way Ella, but I do know the Bible says that "God is LOVE" (1 John 4:8) and His love extends to everyone who believes in Him. I also know Satan is the "father of lies" (John 8:44) andthe "great accuser" (1 Tim 4:13). I think he is the one who deceives people into believing they are not worthy of being loved. I believe it is Satan's voice that says to us, "You're helpless, you're hopeless, you're useless, and you're worthless… You can never be forgiven, and no one can ever love you!"

> "I explained to Ella that I understood she was having difficulty believing God loved her and noted that she had said some difficult things about herself in our time together."

I explained to Ella that I understood she was having difficulty believing God loved her and noted that she had said some difficult things about herself in our time together. I sought to reassure Ella that God loved her regardless of her past. He also wanted to forgive her for whatever it is was she had done, and what's more – He wanted her life to be amazing – not just an ordinary existence but an amazing life as John 10:10 says, "The thief (Satan) comes only to steal and kill and destroy; I have come that they (you/us) may have life, and have it to the full."

Over time, Ella felt safe enough to share her story, and it was a life laced with serious struggles with family violence, sexual abuse in childhood, sexual assault as a teenager, domestic violence in early adult relationships, substance addiction, and criminal activity to sustain that addiction. Ella hit rock bottom and decided to try to move out of 'the pit' she had found herself in by coming to church. That was where our journey together began.

Over months of weekly meetings, Ella began to see the need to address her addiction if she was to reclaim her life. We discussed 12-step programs and other recovery options. I promised to journey the course with her, and Ella commenced a 12-step recovery program with Alcoholics Anonymous (AA). Step 2 required Ella to face the fact that she needed to believe that a Higher Power greater than herself could help her recover. Ella knew she was powerless over her addiction and that she needed God to help her recover.

> "At this point, Ella gave her life to Christ, and for a time she felt intense peace, relief and joy in knowing Jesus, proclaiming loudly that she felt like a 'new person'!"

At this point, Ella gave her life to Christ, and for a time she felt intense peace, relief and joy in knowing Jesus, proclaiming loudly that she felt like a "new person"! However, her old story of shame, blame and guilt resurfaced, and Ella fell back into old coping patterns. Sadly, this led to her experiencing deeper shame, because she now felt that she was also a 'failure' as a Christian. Her fear of failing God and being 'sent to hell' increased the torment she was experiencing. Ella was suffering spiritual and mental anguish, her anxiety and depression increased and her health spiralled downward.

Feelings of depression and anxiety are real and often lead to isolation and loneliness

As Ella's mental health deteriorated and her anxiety increased, she isolated herself more. This often happens as mental health declines – the person tends to withdraw from social connection and isolation increases. The psalmist confirms the dreadful nature of depression, with a third of the Psalms categorised as Psalms of lament. Psalm 88 ends with "darkness is my closest friend," and has lines like "I am overwhelmed with trouble" (Psalm 88:3). These feelings are real, and Ella attested to the deep darkness she was experiencing.

The renowned theologian Charles Spurgeon experienced depression and is quoted by Eswine as saying, "The mind can descend far lower than the body. For [the mind] there are bottomless pits. The flesh can bear only a certain number of wounds and no more, but the soul can bleed in ten thousand ways and die over and over again each hour."[3] Dying the thousand deaths of the dark night of the soul is a lonely and isolating experience. The longer people are ill, the more isolated they tend to become.

> "Dying the thousand deaths of the dark night of the soul is a lonely and isolating experience. The longer people are ill, the more isolated they tend to become."

Social isolation is considered an objective absence of social relationships,while loneliness is said to be the subjective feeling of social disconnection, where there is a discrepancy in the quality and quantity of a person's

desired and actual relationships. Research undertaken during the COVID-19 pandemic found physical isolation alone did not always lead to increased loneliness; rather the experience of loneliness involved factors such as the "quality of social interactions" and the availability of "supportive social networks" which played a "crucial role in alleviating loneliness."[6] What appears to be important is social connection "whether or not people stay in touch with friends, family, and their community – rather than physical proximity."[7]

The health risks of loneliness

Loneliness and social isolation are associated with reduced physical exercise and a greater prevalence of smoking and excessive alcohol consumption. More than half of women and men aged over 65 who feel lonely report having poor health – that is around twice the rate of those who don't feel lonely.[8]

The intense experience of loneliness triggers the release of cortisol, our human stress response hormone. Cortisol triggers the body's fight-flight-freeze response, which leads to greater production of glucose so our body can get the energy it needs to run or fight. Prolonged feelings of loneliness can lead to protracted high cortisol levels, and this can trigger the body's immune system to have an inflammatory response. Chronic inflammation is a recognised contributing factor in diseases such as Alzheimer's, diabetes, cancer, arthritis and heart disease.[9]

> "Loneliness is correlated to health concerns, including cognitive decline, increased dementia risk, mental health disorders and heart disease."

Loneliness is correlated to health concerns, including cognitive decline, increased dementia risk, mental health disorders and heart disease. It is said to increase a person's risk of early death at a level comparable with smoking and alcohol consumption and exceeds the well-established early mortality risk of physical inactivity and obesity![10] So being lonely is bad for one's health – it was definitely bad for Ella's health! In order to facilitate Ella's ongoing healing and recovery, it was essential for our faith community to help Ella stay connected to the church community because this would be core to her recovery.

There were many learnings gained from supporting Ella with her recovery journey to reclaim holistic health of body, mind, spirit, and relationships after four turbulent years. Her recovery journey was a forward and backward trajectory that required consistent, focused and compassionate care to achieve the stable mental health that Ella now enjoys. This article presents six key learnings from journeying with Ella:

1. Reflect Jesus in your words and actions

The journey with Ella continued for four years. Ella relapsed from time to time, and there was a definite pattern in the relapses. They always came when her internal self-talk repeated Satan's old life-script of 'useless, worthless, helpless and shameful'. These feelings triggered old coping responses used to numb her pain such as drug use or excessive alcohol intake. It was difficult and profoundly sad to watch Ella struggle to believe God's word was real for her. Keeping her faith in God's love alive was a challenge.

The quickest and most effective way to support Ella to get back on track with AA, and also to get her to claim her identity as a loved child of God and a new creation in Jesus Christ, was to work with her on her self-talk. This was achieved by reflecting to Ella the truth that Jesus loved her. It was done by reading God's word together, sharing Scripture on post-it notes and in cards, and sharing Christian poetry and music. Ella shared about her childhood and early life experiences, and we discussed the meaning of love and how that had been shaped by her lived experience.

Ella also saw a counsellor to work through these past traumas. One important factor in her recovery was her experience of God's love through the compassionate presence and boundaried actions of her Christian family at church. We determined that we were not going to give up on Ella, and that encouraged Ella not to give up on herself. Encouragement propelled her forward and silenced Satan's lies that sought to consume her hope and deplete her internal resolve to continue the challenging work of recovery.

2. Meditate on God's word together

Ella used to read the promises in God's word and say, "Yeah… but those promises are for you, not me!" She'd add, "How many people like me do you see in church?" We would remind her, "We all fall short, and we are all going

through stuff. No one is without struggles." We encouraged her to pray, just talk to God and tell him everything. We would read God's word from a Recovery Bible, which was helpful because it highlighted specific verses for each recovery step.

We would repeat Scriptures aloud so Ella could hear the truth herself. She found these were two of the best things that helped her to get through the tough work of recovery. In 1 Timothy 4:15, it says, "Meditate on these things, give yourself entirely to them, that your progress may be evident to all," so we began to write promises from Scripture that Ella found encouraging on post-it notes. She stuck them on her mirror and spoke them aloud as she brushed her teeth and washed her hands!

> "Ella found speaking God's word aloud helped her hear it, ponder it, and she could then form a mental picture of herself as 'strong in the Lord.'"

Ella found speaking God's word aloud helped her hear it, ponder it, and she could then form a mental picture of herself as "strong in the Lord." It helped Ella focus her mind on her recovery goals. This targeted Scripture was renewing her mind as Romans 12:2 declares, "Do not be conformed to this world, but be transformed by the renewing of your mind, that you may prove what is that good and acceptable and perfect will of God." God's will for Ella was an abundant, awesome life (John 10:10) and she needed to hear this often, so it was reinforced until she began to believe it as true for her.

3. Don't be like Job's friends

Ella experienced attitudes and words from people who professed to be Christians that confirmed the lies Satan had spawned in her mind! Those well-intentioned people sought to find a cause for Ella's ongoing struggle with illness and saw her addiction as a self-inflicted illness. Others associated her mental health conditions with a lack of faith and personal sin. Some told her she was under demonic influence.

It was reminiscent of Job's plight. We read the book of Job together, and Ella saw how Job's friends got Job's causal conditions wrong. They accused Job of insufficient faith and said the reasons for his suffering were the sins of his family.

Sadly, in working with people living with mental health conditions, we still witness Christians who peddle the inaccurate theology that assumes spiritual deficiency as the cause of illness. This leads the ill person to feel as if they do not belong within the church, and that is simply not God's truth. Every Christ follower needs to remember Romans 3:23 "…for all have sinned and fall short of the glory of God."

None of us has our act together all the time. If we can remember this, we will respond in ways that reflect Jesus' compassionate grace and mercy when we interact with others with both our words and our actions. How we reflect God's love to the suffering person is key to how that person will see themselves. We want the recovering person to see themselves as Jesus sees them; therefore, it is up to each one of us to demonstrate that in our compassionate care.

4. Mental illness is not God's will for anyone

We all need to 'trust in God' for healing and restoration to health, but doubts will arise, especially when recovery is elusive. Our challenge is to keep bringing our burdens and the burdens of the sufferer to the Great Physician – Our Lord – in prayer.

We don't ignore the issues. Instead, we faithfully approach God amidst all the suffering. We can protest to God, we can lament our situation to God, but we should always act with compassion toward ourselves and others, even when the problem seems overwhelming.

As Christians, we are called to compassionate action in the midst of a broken and fallen world, calling to God for 'His kingdom to come' and 'His will to be done' (Matthew 6:10). That's what Job did. He kept talking to God. Job said, "Even now my witness is in heaven; my advocate is on high. My intercessor is my friend as my eyes pour out tears to God; on behalf of a man he pleads with God as one pleads for a friend." (Job 16: 19–21).

> "We had to remind Ella that her trust was not in people, not even ones at church, but her advocate and intercessor was Jesus Christ!"

We had to remind Ella that her trust was not in people, not even ones at church, but her advocate and intercessor was Jesus Christ! He was trustworthy. He was her reliable friend. He was the one to whom she could cry out about anything and everything, and He would hear her and plead her case before God, and she would be answered.

To bring the Lord's comfort, we needed to acknowledge that Ella was suffering and had many major traumatic experiences to acknowledge and reconcile. We needed to bring compassion to her in person and let her know and experience that she was not abandoned but connected to a family who cared about her. We had to intercede for her in prayer when she could not find words to pray, and help her to see Jesus was her hundred-percent-reliable intercessor.

We were informed friends who understood her illness and sought to ignite hope within Ella. That meant hoping with and for Ella when she had little hope for her own situation. Ella has since said this was the only way she could keep getting up and working on her recovery. As Christians, we have a reason for hope because we have a certain future in Jesus. Be prepared to tell people the reason for your hope, "But those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary; they will walk and not be faint" (Isaiah 40:31). This verse became another one that Ella repeated in her recovery.

5. The implanted word of God facilitates healing

Ella clung to several Scriptures as a word for her life, but her favourite was 2 Timothy 1:7, "For God has not given us the spirit of fear; but of power, and of love, and of a sound mind" (NKJV). When Paul wrote the second book of Timothy, the early Christian church was experiencing gruesome and cruel persecution by the Roman Emperor, Nero. Timothy was pastoring the church of Ephesus, and he was fully aware that if Nero came to find him, he would be killed in a most barbaric way. Needless to say, when Timothy let his mind dwell on that possibility, he was afraid! That's why Paul encourages him in writing the letter of 2 Timothy.

So, what does a 'sound mind' mean? It comes from the Greek word sophroneo, which combines the two Greek words sodzo and phroneo. Sodzo means to be saved, healed, and delivered. It suggests notions of being rescued, revived, salvaged, and protected to a future that is safe and secure.[11] The second part of the phrase 'sound mind' comes from the Greek word phroneo, which refers to every part of the human mind and the processes that enable it to function and come to decisions. So even if our mind falls into a pit of despair and fear, as Timothy's and Ella's did, we can speak God's Word into that situation: asking the Spirit of God living within us to heal our minds and to shield our emotional health from the untruths that otherwise fill our mind and lead to illness, helping us make right and healthy choices.

> "God's word works in our minds as mental health protection, safeguarding our emotions and defending us from the 'father of lies' who tries to arouse fear and doubt..."

Ella had discovered that revelation for herself, saying to me, "I am going to protect my mind by speaking God's Word, and that will help me think differently!" God's word works in our minds as mental health protection, safeguarding our emotions and defending us from the 'father of lies' who tries to arouse fear and doubt inside us with self-talk like, "You know you can't do this!", "That doesn't make any sense!", "You are crazy!", "No one can ever love you!".

So, what Ella did when she was confused, and the old story started derailing her thoughts, she would proclaim 2 Timothy 1:7 aloud. Then she would go to Jesus with the problem and share it with Him, as the story of Job had taught her. Ella knew she had the power of God's Spirit within her, but it was easy to succumb to anxiety, doubt and fear when she had a setback or a difficult issue to deal with.

Many of us are like Ella. We would love to function in life always brimming with confidence, free of doubt and fear; but then intimidating things happen that throw our world into chaos, and our self-talk can become negative, our thinking repeating Satan's lies.

Some translations use the word 'self-control' or 'self-discipline' in place of 'sound mind'. God gave each person free will to choose their thoughts and their actions. Paul reminds us that a disciplined mind, one that is controlled, ordered, educated and exercised, can ensure that our emotions do not reactively drive our responses when we experience difficult times. As Ella said to me, "In the old story, I would just react and do whatever came into my mind, but in my new life, I can ask God to help me make the right choices."

It was helpful for Ella to bounce ideas around with others so she could make choices that would help her. Ella had never experienced being able to share open, honest, and safe communication, so it was important that she went to God's word and could then speak about it with others and with God in safety and without judgment.

The Spirit of God is powerful. He gives us the strength to persevere during times of struggle when things can look hopeless. God gives us His power through His Spirit, but that power must be exercised with self-control, and the essential characteristic of God, which is LOVE. God wants us to ,"Love one another, and ourselves as he has loved us" (1 John 4:8; John 13:34).

6. The 'weaker parts are indispensable' to the body of Christ – the church

God created every person as a relational being. As Christians, it is God's design that we live life as a body joined together by God's love. In 1 Corinthians 12:27, "Now you are the body of Christ and individually members of it. Each part has a unique purpose; each has a part to play for the well-being of the whole. The eye cannot say to the hand, 'I have no need of you' nor again the head to the feet, 'I have no need of you.' On the contrary, the parts of the body that seem to be weaker are indispensable, and on those parts of the body that we think less honourable we bestow the greater honour…"

Ella may have appeared to be 'weaker' or 'lesser', but she is a most valued and essential part of God's family. As health practitioners, we need to recognise the value of connection to God's family for our most vulnerable community members. Such a perspective ensures we work from an ethos of 'how good FOR us to support Ella' rather than a perspective of 'how good OF us to support Ella'!

Ella has found healing and has recovered, and her story demonstrates, "All things are possible with God" (Matthew 19:26).

Points to ponder

Ask yourself:

- Am I practising as a health professional who reflects Jesus Christ in ways that enable and empower the transformative change that brings a full and abundant life to the recipients of my care?
- Are my words and actions actively or unconsciously discriminating against people living with mental and spiritual distress?
- Is my perspective, 'How good of me to do this' or is it 'How good for me to do this'?
- How do I show the 'weaker' members of my church/community that they are 'indispensable' and not just tolerated?
- How am I 'honouring' those 'weaker' parts of God's body in my words and actions?

As people participating in the body life of a Christian church, we need to be mindful of how all the body parts work together to create a healthy faith community. We need to convey a strong message to every person that they belong to this body, and that everyone has an important role to play in the health of the whole church and the whole community. In so doing, we will facilitate healthy, vibrant communities that restore physical, mental and spiritual health to everyone and enable people to live thriving, full and abundant lives.

After all, that is why Jesus came to earth: "The thief comes only to steal and kill and destroy. I have come that they may have life and have it to the full" (John 10:10 NIV).

Dr Antonia van Loon RN, BN, MN (Research), PhD

Antonia is the current chairperson of the Australian Faith Community Nurses Association. She is a Registered Nurse who has worked in Emergency departments, tertiary education of nurses, community nursing, health research with vulnerable populations, and Church-based healthcare and education. Antonia was a volunteer Faith Community Nurse for 15 years in her Baptist church. She is passionate about seeing Christian health professionals provide whole-person care. She also wants churches to recognise the theology behind, and the value of, health-focused pastoral care that offers compassionate, holistic support within their congregations and reaches out to local communities.

References:

1. AIHW, Prevalence and impact of mental illness [Internet]. [updated 2025 June v36.0; cited 12 July 2025] Canberra (AU): AIHW; Available from: https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness
2. Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR, The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing [Internet]. Department of Health, Canberra; 2015.Available from: https://www.health.gov.au/resources/publications/the-mental-health-of-children-and-adolescents?language=en
3. Eswine Z. Spurgeon's Sorrows: Realistic Hope for those who Suffer from Depression. Scotland (UK): Christian Focus Publications; 2014. [Loc 238 of 325 kindle vers]
4. de Jong-Gierveld J, van Tilburg TG, & Dykstra PA. Loneliness and social isolation. In Perlman D, & Vangelisti A. (Eds.), The Cambridge handbook of personal relationships. pp.485-500. Cambridge (UK): Cambridge University Press; 2006.
5. Ibid. 486
6. Kong N, & Lam J. Physical isolation and loneliness: Evidence from COVID lockdowns in Australia. Jnl Ec Behav & Organ. 2024; 224:598-623. Available from: https://doi.org/10.1016/j.jebo.2024.06.034.
7. Ibid. p.600.
8. Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med. 2010 Jul 27;7(7): Available from: https://www.researchgate.net/publication/273910450_Loneliness_and_Social_Isolation_as_Risk_Factors_for_Mortality_A_Meta-Analytic_Review
9. Ibid.
10. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Persp in Psych Sc. 2015;10(2):227-237.
11. Walsh M. God has given us a sound mind. Perspectives; Powell Tribune., [updated 2020 June 4; cited 2025 July 22], Available from: https://www.powelltribune.com/stories/god-has-given-us-a-sound-mind,25654

Illustration by Shutterstock

Equitable Healthcare for the Elderly – Dr Michael Burke

Preventing high-risk scenarios associated with environmental challenges

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

The day was hot and growing hotter. Mr Charles, a delightful man in his late seventies, had rushed to attend church. His wife, Prudence, was away. Mr Charles had left home in a hurry without having eaten breakfast or drunk water. He was not carrying a water bottle. After the hour-long church service, he stood waiting on the roadside in the heat of the midday sun without the mitigating effect of a shading tree.

Dehydrated, he collapsed and friends rushed to support him. Water was found, he was placed in the recovery position under a nearby shaded area and was urged to rehydrate. He made an encouragingly quick recovery. A tragedy averted.

Later that week, Mr Charles visited me in my clinic room. We worked on ways of preventing similar high-risk scenarios associated with environmental challenges (where the elderly are recognised as more at risk).

We discussed the following strategies: to protect against the health impacts of climate change, older patients should prioritise staying cool and hydrated during extreme heat, monitoring air quality, and creating a personal emergency plan with a strong support network.

Managing Extreme Heat

Older adults are especially susceptible to heat-related illness due to the body's reduced ability to regulate temperature and potential implications for their medications (e.g. use of diuretics).

- **Stay in a cool environment**: Spend as much time as possible in air-conditioned (AC) spaces. If you do not have AC in your home, know the locations of local public centres that are cooled (e.g. libraries, senior centres, shopping malls) and have a transportation plan should temperatures rise.
- **Stay hydrated**: Drink plenty of water or fruit juice regularly throughout the day, even if you do not feel thirsty. Avoid alcohol and hot drinks.
- **Dress appropriately**: Wear loose-fitting, light-coloured clothing and a wide-brimmed hat when outdoors.
- **Limit sun exposure and exertion**: Minimise time outdoors between 11am and 3pm., the hottest part of the day, and avoid strenuous activity.

- **Cool down**: Take cool showers or baths or use a damp cloth to cool your skin.
- **Monitor indoor temperatures**: Check the temperature of main living areas, especially bedrooms, to ensure they are safe.
- **Be alert for symptoms**: Watch for signs of heat exhaustion or heatstroke, such as dizziness, nausea, confusion, or heavy sweating. Seek medical help immediately if they occur.

Addressing Air Quality and Other Environmental Shifts

Climate change contributes to both worsened air quality (e.g. from heat-related pollution, wildfires) and the spread of vector-borne diseases.

- **Monitor air quality**: Check the daily Air Quality Index via phone apps or local news.
- **Stay indoors when necessary**: On days with poor air quality or high pollen counts, stay inside with windows and doors closed, using portable air filters if available.
- **Use protection if going out**: If outdoor trips are necessary during bad air quality days, wearing an N95 mask can offer protection.
- **Prevent insect bites**: Use insect repellent and wear protective clothing to help avoid bites from disease-carrying ticks and mosquitoes. Check your home for potential mosquito breeding sites (e.g., stagnant water).
- **Practice food safety**: Store food properly to prevent spoilage, as warmer temperatures increase the risk of food-borne illness.

General Preparedness and Community Support

1. **Create an emergency plan**: Develop a personal emergency plan and kit that includes adequate supplies of food, water, and all necessary medications and medical equipment.
2. **Establish a support network**: Set up a network with family, friends, and neighbours who can check in on you regularly, especially during extreme weather events.
3. **Stay informed**: Pay attention to local weather forecasts and severe weather alerts.
4. **Maintain social connections**: Social support is vital for mental and physical well-being, especially during and after a climate-related disaster.
5. Keep emergency **contact devices** charged and readily available to call for help.

Discuss with your doctor

Discuss your vulnerability and any existing conditions or medications with your healthcare provider to ensure your care plan is adapted to climate risks.

Your doctor can provide personalised advice on staying safe and healthy as the climate changes. In the United Nations Decade of Healthy Ageing 2021-2030, let's ensure that we provide the very best care to our highly valued older patients.

Dr Michael Burke
Dr Michael Burke is a much-blessed member of the Christian Medical and Dental Fellowship of Australia (CMDFA). He facilitates the International Christian Medical and Dental Association (ICMDA) Creation Care and Health Training Track. He currently works at the Kilimanjaro Christian Medical Centre in Tanzania, East Africa, contributing in the areas of Family Medicine and Geriatrics. He is married to Jean and has three sons.

References:

1. National Centre for Equitable Care for Elders. (2025, April). The impact of extreme weather on older adult patients: Considerations for preparedness [Issue brief]. https://ece.hsdm.harvard.edu/sites/g/files/omnuum4891/files/2025 04/NCECE%20Extreme%20Weather%20Pub%20April%202025.pdf Retrieved 29/12/2025
2. United Nations General Assembly. (2020). United Nations Decade of Healthy Ageing (2021-2030) (Resolution No. A/RES/75/ 131). https://digitallibrary.un.org/record/3895802 Retrieved 29/12/2025.

Image Peter Shirley

Omniscience – Anonymous

Over the horizon you came, to put darkness to death

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

You saw him in the light
You saw her in the darkness
You saw us in the shifting
Shadowlands, of light half dying
Half grieving and of darkness
Creeping like a snake along.
You saw us in the murky, muddy
Greyness, in an opaque world
Where no light penetrates
And darkness can never
Understand.
You are shimmering light
In the darkness of
This deceiving,
Baleful world.
You are the light,
Which fails to be
Extinguished by
The darkness which
Hides in deepest night.
Over the horizon you came
To put darkness to death
What we have done,
What was done to us,
You see everything,
You see everyone,
The good & evil,
Every kindness &
Each vengeful plan,
Evidence under the sun.
You have absorbed our
Darkness upon yourself,
In your hour of darkness.
You broke through ours …
Bestowing sacred medicine
More ancient than silmaril light ~
You took the death of our death
And ended all our terrifying nights.

Anonymous
The writer lives in the Hunter and is married to a midwife. He has worked in Education and Chaplaincy and is still involved in Pastoral Care. He grew up as a devout Roman Catholic until his unexpected conversion at 21. He attends an evangelical Presbyterian church in Newcastle.

Illustration by Shutterstock

Christian Caring: The Heart of Nursing – Diana Marshall, retired RN/midwife

Cultivating Christ's example of care at work

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

I have been a Christian as long as I can remember, having grown up with a Christian mother and grandmother. I felt a call on my life to become a nurse so I could follow Jesus' example.

My early love of God's word opened my eyes to Jesus' love and the many ways He cared for people in their physical, emotional and spiritual suffering. Many were miraculously healed, but every person He approached saw His compassion, felt His concern, and experienced the touch of His hand.

All nurses, not just Christian nurses, can show this compassion to their patients – "even if the sense of calling is felt within, the actual call comes from other people – and ultimately, we trust as believers, from God."[1]

Hospital Training and Nursing Education

Nurses are taught the value of good eye contact (where culturally appropriate) and person-centred care. We value each person for who they are and treat them with dignity and respect, remembering as Christians that each person is created in God's image – Imago Dei. This applies to all patients, clients, residents or others.

It also covers patients who suffer from cognitive impairment or are unconscious due to an anaesthetic or life support. Christ-like love from others and practical expressions of care and support can really help to ease suffering and bring comfort, encouragement and hope.[2] Nurses can provide this care; however, they need to be validated and encouraged in their role and given opportunities to debrief.

> "Nurses can provide this care; however, they need to be validated and encouraged in their role and given opportunities to debrief."

During my hospital training, which I found very confronting, I was supported by colleagues, family and friends. I also had the support of the Australian Nurses Christian Movement (founded in Melbourne, 1913), the precursor to Nurses Christian Fellowship Australia. Understanding from fellow Christian nurses made all the difference between persevering with my nursing training or finding an easier road to travel. Nurses today can also feel isolated and lonely, and since good nursing care is sometimes invisible, they need and deserve recognition and support.

Christ's love in modern nursing times

I have felt my efforts validated by grateful patients, residents and students. When we see their smiles, hear their words of thanks, and even observe their peaceful attitude, we know we have achieved our goal. This all takes place at the patient's bedside, not looking at a computer screen. We can be truly present with the person and show Christ's love in our words and actions. We can pray for them as we care for them and show Christ's love through the gentleness and confidence of our touch, appropriate eye contact, and not flinching from massive wounds or deformities, etc..

Nurses show compassion to those who are suffering, to those who might be labelled as 'difficult' when they are fearful, and to those who suffer from cognitive impairment or translocation stress. The physical presence of a real person can bring reassurance to patients and alleviate their feelings of loneliness.

> "The physical presence of a real person can bring reassurance to patients and alleviate their feelings of loneliness."

Love, then, is central to the types of relationships that Tom Kitwood has shown in his model for understanding dementia and providing person-centred care.[3]

Carrie Dameron, from Nurses Christian Fellowship International, explains this further: "A few years back, I found a study about how the simple act of a kind facial expression can alleviate fear and calm someone with dementia. The person sees a calm expression and bright smile, and their fear is changed to trust and calmness. The same can be said for contrast. When the caregivers are rushed or frustrated, the person with dementia sees their face and feels threatened and fearful."[4]

Empathy in the age of modern nursing

Education, too, has had a significant impact on nursing as a profession. Beginning in 1978, following the recommendations of the Sax Report,[5] there has been a transition of nursing training from hospitals to Colleges of Advanced Education and Universities. This has resulted in a culture of best practice and evidence-based learning, which has also enabled research opportunities and career pathways for nurses. Reflective practice has equipped nurses to consider their actions and responses, engendering insight and showing more effective ways of responding in similar situations.[6]

Theological reflection allows nurses to engage in a dialogue between their faith and their practice.

Christian nurses may also be aware of the writings of the Catholic priest, Henri Nouwen, particularly The Wounded Healer: "What makes us human is not our mind but our heart, not our ability to think but our ability to love."[7] All nurses need to practise this connection with patients so that person-centred care is given professionally and accurately to the best of our ability.

> "As nurses gain experience in their role, they can learn to develop empathy for their patients."

As nurses gain experience in their role, they can learn to develop empathy for their patients. The Cambridge Dictionary describes empathy as "the ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation."[8] Empathy does not drain us emotionally or physically, but is extremely comforting for the patient since they know they have been heard.

Personal Experience as a Patient

Recently, I was on the receiving end of nursing care. I contracted Dengue Fever whilst on a trip to Vietnam and, thankfully, made it back to Sydney before the symptoms became evident.

I spent most of the next two weeks in my local hospital and literally experienced the pointy end of acute nursing care. After a barrage of tests until 3 am, I was taken to a ward. One of the night nurses greeted me and, after I looked at the bed, I asked her for a flat pillow. She returned triumphant and beaming at fulfilling my request. I thanked her then, and she saw me again before she went home the next morning.

> "Her faith and her enthusiasm for nursing made such a difference to my care, and to the culture of the ward…"

As soon as this nurse arrived for her next shift, her first stop was at my bedside. I learnt that she was a Christian and also that she had studied at one of the colleges where I had taught. Her faith and her enthusiasm for nursing made such a difference to my care and to the culture of the ward, which was peaceful and harmonious.

I thank the Lord for sending her to me and pray that our paths will cross again in my new role as Volunteer Chaplain. This nurse cared for me as Christ cares for us. She was professional, thorough and compassionate. I felt truly cared for and made a steady recovery. This nurse cared for me with Jesus' love and compassion. She was chosen and equipped by God to serve his people. "Whatever your calling is, you have been fitted for it."[9] I pray that other nurses cultivate Christ's example of care – the heart of nursing.

Diana Marshall, retired RN/midwife

Diana began hospital nursing and midwifery training in the 1960s. Following a move to the Hunter Valley, she completed a Bachelor of Nursing and a Graduate Certificate in Advanced Nursing. She then returned to Sydney, achieving a Master's in Nursing, a Master's in Chaplaincy, and then a Diploma of Theology. More recently, Diana attained a Graduate Certificate in Pastoral Care for Mental Health at Mary Andrews College. She is currently Chairperson of Nurses Christian Fellowship Australia Ltd and is passionate about Christian faith and lifelong learning.

References:

1. Prior, K.S. You Have a Calling. Finding Your Vo cation in the True, Good and Beautiful . Brazos Press Grand Rapids: Michigan 2025
2. Sims, S. Together Through the Storm. Matthias Media: Sydney 2016 p.59
3. Kitwood, T. Dementia Reconsidered: The Person Comes First . Open University Press, McGraw Hill Educationb, UK, 1977
4. Dameron, C. The Face of Kindness. https://ncfi.org/wp-content/uploads/2023/03/NCFI-Cares-1-November-2025-The-face-of-Kindness.pdf 14 November 2025
5. ANMJ staff, Transitioning nursing education into higher education. anmj.org.au accessed 10 December 2025
6. Ingham-Bloomfield, B. A Nurse's Guide to Using Mo accessed, 15 October 2025
7. Nouwen, H. The Wounded Healer. Doubleday New York: NY 1972
8. Cambridge Dictionary https://dictionary.cambridge.org/dictionary/english/empathy Accessed 14 November 2025
9. Prior, K.S. ibid p.135

Illustration by Shutterstock

God at work in the moment! – Rosemary Bulman, RN

Responding when God says, "Go the etra mile."

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

"There is a time for everything and a season for every activity under the heavens" – Ecclesiastes 3:1 NIV

As I write this note, I am reflecting on this verse, recalling when in early 2005, I needed a change from shiftwork to a nursing role that allowed me to work standard daytime hours.

Wonderfully, God provided a new context for my work, allowing me to carry forward the knowledge and experience I had gained as a paediatric nurse into my role as a nurse immuniser, caring for infants, children, and their families in community-based settings. The role also involved caring for the adolescent cohort in school-based settings.

> "For we are God's workmanship, created in Christ Jesus to do good works, which God prepared in advance for us to do" – Ephesians 2:10 NIV

Previously, while working in hospital paediatrics, I experienced amazing God-given opportunities to care for and build long-term professional relationships with children and their families. Sometimes it was for extended periods, sometimes just a single stay in hospital and in some cases, during repeated admissions. However, due to the nature of my new role in Community Immunisation Services, I only occasionally saw the same child, or children from the same family, more than once. Generally, over the course of childhood vaccinations, encounters are brief.

> "…There have been many God-given moments of responding to His prompting and provision to go the extra mile…"

Fortunately, even in the context of these short encounters, there have been many God-given moments of responding to His prompting and provision to go the extra mile in providing compassionate and empathetic care.

One of many scenarios that comes to mind is of an encounter I had with parents presenting with their first child

for his routine six-week vaccinations. I introduced myself and ascertained the relevant background information on the baby from the parents. While going through the pre-immunisation check, I observed that the mother became quite teary and anxious. As it was a quiet session, I decided to provide the parents with some extra support and reassurance. I was able to respond thoughtfully to their questions and concerns about the vaccinations and any possible reactions. Additionally, I explained why they should wait in the clinic for fifteen minutes after the vaccinations. I reassured them that if they were happy with their baby after that time they could leave, but also that they were welcome to stay longer.

> "Both parents kindly expressed their gratitude for the care they had received and were very positive about their experience…"

I was so pleased to sit with the family for a few minutes during the waiting period, offering a supportive presence that appeared to help the mother relax. Both parents kindly expressed their gratitude for the care they had received and were very positive about their experience at a council immunisation session.

What a God-given joy and privilege it was, in that moment, to provide the extra supportive care this family needed!

Rosemary Bulman, RN
Rosemary qualified as a New Zealand (NZ) Registered Nurse in 1985 and specialised in Paediatrics at the Royal Children's Hospital in Melbourne from 1990. In 2005, she completed the Accredited Nurse Immuniser Course at La Trobe University and secured a position as a Nurse Immuniser with a local council. Rosemary became a Christian during her nursing training, which she saw as more than just a job but a calling to care for others with Christ-like compassion. She has been involved in Nurses Christian Fellowship since her graduation in NZ, serving in a variety of leadership roles since 1987, and is the current NCF Australia Secretary.

Photo by Karolina Grabowska, Pexels

Meet the Directors of Nurses Christian Fellowship Australia Ltd

Support, spiritually and professionally, for nurses and midwives

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

Nurses Christian Fellowship Australia's mission is to equip and encourage Christian nurses and midwives to live out their faith by integrating Biblical principles and Christ-centred values with professional clinical practice, leadership, education and research.

So who's behind the vision? Here's a little bit about the NCFA Directors and the passion, faith and leadership guiding our fellowship.

Diana Marshall – Chairperson

Diana began hospital nursing and midwifery training in the 1960s. Following a move to the Hunter Valley, she completed a Bachelor of Nursing and a Graduate Certificate in Advanced Nursing. She then returned to Sydney, achieving a Master's in Nursing, a Master's in Chaplaincy, and then a Diploma of Theology.

More recently, Diana attained a Graduate Certificate in Pastoral Care for Mental Health at Mary Andrews College. She is currently Chairperson of Nurses Christian Fellowship Australia Ltd and is passionate about Christian faith and lifelong learning.

Jane Cooper – Director

Jane Cooper attained a General Certificate in Nursing at Royal Prince Alfred Hospital, Mothercraft at Tresillian in Willoughby, and Midwifery at Bethesda in Marrickville.

She attended The Royal Melbourne Hospital for a Coronary Care course and Concord Hospital for a course in Intensive Care Nursing. Jane completed her nursing career at Hornsby Hospital.

A reflection on meeting God in a hospital setting

I committed my life to Christ when I was 14, and He has led and directed my life ever since. Starting my nursing career at just 17 was an overwhelming experience. I had never been in a hospital before, but the Lord had clearly led me onto the path of nursing. It led me to connect with the **Australian Nurses Christian Movement** (founded in Melbourne in 1913) at the hospital, where the Organising Secretary arranged regular meetings with other Christian women. I still have my ANCM Membership card, with the inscription: "We serve God and Humanity."

As I reflect on God's healing power at work in the hospital, there are many experiences I could share, but the telling would take too long. It was a joy to see patients improve and leave the hospital, and to pray for them. I especially remember a small boy who said to me as I walked into the ward, "I can walk Nurse Cooper, I can walk!"

Rosemary Bulman – Secretary

Rosemary qualified as a New Zealand (NZ) Registered Nurse in 1985 and specialised in Paediatrics at the Royal Children's Hospital in Melbourne from 1990.

In 2005, she undertook the Accredited Nurse Immuniser Course at La Trobe University and gained a position as a Nurse Immuniser at a local council.

Rosemary became a Christian during her nursing training, which she saw as more than just a job but a calling to care for others with Christ-like compassion. She has been involved in Nurses Christian Fellowship since her graduation in NZ, serving in a variety of leadership roles since 1987, and is the current NCF Australia Secretary.

Georgina Hoddle – Director

Georgie, as she likes to be called, is a retired Registered Nurse who now volunteers on the pastoral care team of an aged care facility. Georgie is a Saline Process™ Co-Ordinator and a board member of the Nurses Christian Fellowship Australia (NCFA). She also works closely with CMDFA on Saline Process™ courses in accordance with a Memorandum of Understanding.

Georgie has spoken at numerous national and international conferences. Her current interest is directed to compiling research on pastoral care for mental health.

Caterina Pooke (Scarazza) – Director

Ambitions and God's call

Caterina became a Christian in early 1991, during her nursing studies at the University of Western Sydney. She has been a member of the Christian Nurses Fellowship (NCF) since her registration, and has become involved in the organisation of NCF Australia Ltd as a member of the Board of Directors.

In 2014, she attended the 2014 Pacific and East Asia (PACEA) Conference and the Saline Process™ Witness Training. Caterina's experience includes working on the Mercy Ship in Sierre Leone and Madagascar; this experience was presented at the NCFA Annual General Meeting in 2019. Caterina currently works in the perioperative area as an Anaesthetic/Recovery Nurse.

Charity Foo – Director

80% introvert, 20% extrovert!

Born and raised in Malaysia, of Chinese ethnicity.
Pursued nursing education in Adelaide, Australia 2013.
Currently working as an RN in Melbourne, Australia.
Enjoys reading, listening to Christian music, long walks, café hopping and people watching, exploring scenic nature views and having 1:1 catch ups.
Love cold weather (autumn and winter is my season).
Passion for GOOD DELICIOUS FOOD, hidden love for matcha.

Lyall Weaver – Treasurer

Lyall is a chartered accountant (CA) who has held various financial roles in Australia and the Asia Pacific region. He has extensive experience in the not-for-profit and commercial sectors.

Our NCFI 4-yearly regional conference is happening in Katoomba, NSW, October, 2026.

We eagerly anticipate nurses, midwives and allied health professionals from across the country joining us to be encouraged in their Christian walk. Our conference is shaping up to be a vibrant, faith-filled and fun gathering, set within a beautiful bushland setting. So rally your colleagues, save your pennies and get ready to pack your bags for something truly special.

Photo by Shutterstock

God at the bedside… How? – Charity Foo, RN

The inner musings of an ordinary nurse

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

PICTURE THIS: you arrive at work and sit in the staff room – the chair looks like it's seen better days. You take a moment and scan the room. Collectively, your colleagues exude the vibe of 'the lights are on, but no one is home.' Maybe an occasional soft and tired hello **is heard. More than half the room has their eyes glued on their mobile devices, scrolling away at mindless entertainment with devices resembling hearing aids in both ears.**

Suddenly, an exhausted-looking nurse-in-charge from the previous shift enters the room and tells a story of how the shift went in a monotonous tone. Handover is complete. Congratulations!

You just managed to swallow an enormous amount of information about a few strangers, their endless medical histories, along with their current presenting health concerns… even though you probably do not recall what you had for dinner last night.

Your fatigued brain, left and right hemispheres, is trying to process the day ahead: endless tasks, potential behavioural risks, unhappy and dissatisfied patients, and possibly a barrage of complaints and questions to follow.

All that will come knocking, nay, I should say, 'self-invited', barging through your front door.

Don't forget that coffee in your hand, its aroma, barely anchoring you to reality.

Photo by Shutterstock

Somewhere in between, you have unconsciously let out a silent sigh or two. You have already identified some medication errors, and let's be honest, no one wants report on that! The nurse-in-charge gives a final summary – a reminder of your main responsibilities and what the day will look like, before everyone disperses to their allocated patients.

You have just made a mental five-minute list of 'to-do' items on a checklist that never seems to end.

The warmth from your coffee has diminished. Your nose informs you of a possible continence aid that has not been tended to for millennia. At a glance, the hallway is in a sordid state. Hazards in each corner, or what we nurses label 'potential risks'.

Dirty linens stacked in overflowing laundry trolleys, used venepuncture needles stuffed in overfilled sharps containers, IV lines still attached to empty fluid bags, and the list goes on!

Perhaps, we are already immune to this chaotic environment.

From your peripheral view, a patient who is wobbly on their legs pokes their head out of their room, trying to catch your attention, forsaking their mobility aid. You whisper to yourself, "Please DO NOT FALL."

The equipment that you will need in five minutes is not fully restocked, or worse, nowhere to be found! Already, a few patients' call bells appear on the wall, requiring a nurse's attention – not to mention the ridiculously loud alarms of infusion pumps blaring away down the hallway! From a distance, you also hear a distressed patient calling out for help.

To add more stimuli, you just received your first task from a doctor – one of your patients needs immediate attention. Then another message, this time from radiology, requesting another patient to be brought down for a barrage of investigative scans. Oh, don't forget about the admission from ED that is arriving soon !

Let's not forget about the looming possibility of phone calls from families. It is called the 'quest for medical updates'. You can't help but stare at the clock and the exit door… Relatable? Anyone? I bet!

Though you are fortunate if you did not start your shift with a MET call (Medical Emergency Team) on any of your patients.

Take a moment to internalise everything… breathe and start.

Dear reader, was that an eyeful? Did all that happen in an hour?

Unfortunately, this often occurs in just thirty minutes or less. At times I ask, "God, where and how are you in all this?"

Remembering my student nurse years, cramming all the learning on the fundamentals of nursing into my brain in the classroom days, semester after semester — sometimes I pondered if I had made the right decision in choosing nursing as a career. Would I ever be good enough? How could I make an everlasting impression? At times, my mind would drift and conjure up scenarios of how God would even use me in the workplace to the point of exaggeration and self-pride!

God, how do you fit in this area of my life? Actually, how do I fit into Your grand plan?

I finally received that expensive degree paper that qualified me, a round of applause, and a registration record proving that I was now officially able to practice as a Registered Nurse.

What was next? Go save the world? Find a job? Where do I even start? To be honest, I felt overwhelmed and a little unsure of what to do or where to go.

> "What was next? Go save the world? Find a job? Where do I even start? To be honest, I felt overwhelmed and a little unsure of what to do or where to go."

Did I subconsciously want to achieve great things like Mother Teresa? Emulate Florence Nightingale? Absurd! These were the wild thoughts of an ignorant and naïve young nurse.

Snap out of it, Charity **!** I found myself in front of my computer, asking the Holy Spirit to help me take my first step in nursing. I started typing out a prayer on a Word document called "Prayer Menu." Sounds cheesy, right? Believe it or not, I still have that on file… here's a picture.

THE PRAYER MENU

Entrée

Father God

Thank you for Your guidance, patience, grace and love. As a new day begins, I am reminded of Your goodness for it is new every morning.

Mains

As it is said in the Lord's Prayer, '*not my will but Your will be done*'. I bless my body, soul and spirit with every good gift You have given me. I bless my workplace with fruitfulness and favour. May people encounter Your love through my words and actions. I bless my hands where I place them to work will prosper. I bless my health, finance and family, may they be blessed to bless others. I trust You are with me *Father God* in every step of my journey. You are Jehovah Jireh. You are all I need. As I learn from the people around me, I declare open heaven over them in their life. I declare that '*I can do all things through Christ who strengthens me*'. I bless my mind by renewing it with the washing of the word. Great is Your faithfulness! The joy of The LORD is my source of strength. One thing I know is that I choose to dwell in His courts all the days of my life.

Dessert

Our Father, who art in heaven,
Hallowed be Thy Name. Thy Kingdom come. Thy will be done in earth. As it is in heaven.
Give us this day our daily bread.
And forgive us our trespasses. As we forgive them that trespass against us.
And lead us not into temptation. But deliver us from evil.
For Thine is the kingdom.
The power, and the glory.
Forever and ever.

This I pray in Jesus Christ name
Amen

I remember job searching. Those two words on their own carry the weight of pressure and anxiety, but when put together, they're nerve-wracking.

Suddenly, I had to learn how to present at job interviews, explain my competencies, and elaborate on what I could possibly contribute to the nursing workforce. Maybe only then could I secure my prospect as a nurse at the bedside. I remember sending countless resumes and praying that the 'right door' would fling wide for me. Somebody, please, pick me!

Fresh out of university, with barely any real-time experience as a nurse, most of my clinical experiences were spent on mannequins in a simulation room. It's where educators observe your every move, marking off on a sheet of paper to check if you were safe and competent in your nursing practice.

Job experience? Ridiculous! I had not handled a real sickly human by myself; I was shielded and guided by people whom they refer to as Clinical Preceptors (they are an amazing breed). All I knew then was to ensure that my patients were kept alive and safe and that I would survive at the end of the day.

Finding your feet and groove in new experiences or challenging environments is mind-boggling for most of us. There is no definitive manual or guideline for them. There is a saying amongst nurses, "Fake it till you make it." I wonder how much of this is true.

I know I had to fumble around at times and learn quickly to stand on my own. I was jobless for nearly a year. I was scared and desperate. I asked God countless times: "Lead me to only where You want me to be." That simple statement in itself can be daunting.

> "Then, a door opened. And so, it began. No one could have ever prepared me fully for this career called NURSING."

Then, a door opened. And so, it began. No one could have ever prepared me fully for this career called NURSING .

There are 3 key memorable encounters in my nursing career. Each helped in shaping my understanding of how God was at the bedside (I am still a student of His ways, Amen) . Each encounter was humbling, and all equally testify to the goodness of God.

We are often told to, "Bite the bullet and soldier on," leaving little to or no room for reflection, or time to mull things over, celebrate or sometimes grieve properly and healthily. I still have many unanswered questions; however, there is a deep peace within that can only come from Jesus.

Encounter 1: THEN – Graduate Year – Aged Care

APPROXIMATELY 9 YEARS AGO: Like any other ordinary day, I was organising my residents' charts. Oddly, I came across one folder with no signed DNR (Do Not Resuscitate) form. Usually, that form is completed on admission.

Shortly after, I received a call from the facility's doctor directing me to call for an ambulance for that same resident – her blood results were worrisome. Just after calling for the ambulance, a trusted nursing assistant frantically urged me to dash to the resident's room, as she was "not looking very good."

I burst into the room and found her slumped on the bed. I rang the ambulance again.

With the emergency operator giving me instructions on loudspeaker, I found myself on her chest, doing compressions! My mind went absolutely blank. Adrenaline kicked in. Even to this day, I can still hear that distinctive sound of bones being snapped like twigs as I applied force to her chest. Her eyes were wide open, staring into space. Her pupils became fixed and dilated.

> "Once directed by emergency services to stop compressions, I left the room, hyperventilating. Uncontrollable shaking came over me. I went numb and stiff (yes, I went into shock)."

Once directed by emergency services to stop compressions, I left the room, hyperventilating. Uncontrollable shaking came over me. I went numb and stiff (yes, I went into shock). Time stood still.

I thought to myself: Where did it all go wrong? Did I miss something? I did what I could, right? She was fine earlier in the day. God, why? I remember the calmness of a senior fire brigade officer who helped me process the aftermath. Thank God for him. You never forget your first death, he said… It's true.

How was God at the bedside in this case? This was my first experience of a traumatic death. Up till then, I had only ever heard people talking about it. It's entirely different when you experience it first-hand.

I had to seek my own answers to questions like: Why did it happen the way it did? Why did God not bring her back to life? Perhaps God knew that I had to be exposed for growth before my graduate nurse chapter came to an end? Even when the outcome was undesirable, I am confident that He was there.

Looking back, I found solace knowing that God had placed the necessary people around me on that day to safeguard me when I least expected it. His ways are higher than mine. Was it a coincidence: from the folder document to the doctor's call, to the frantic call for help? I don't think so.

Encounter 2: NOW – Hospital

I briefly met a young palliative Christian lady battling with end-stage cancer. The ward was busier than usual. Her continuous pain relief pump needed replenishing. She was in an isolation room (with no windows!) due to a respiratory viral illness. Sigh.

A palliative nurse educator kindly assisted me with the medication and pump change. Upon entering the room, I was greeted by the patient's family – along with declarations for miraculous healing and blaring praise and worship songs. The patient, on the other hand, was lying in bed, looking terminal. Pale and swollen all over, in pain and, dare I say, almost lifeless.

> "…deep within me, was a sense that she would soon meet with the person whom she calls her Beloved."

Honestly, it was great to witness the family's enthusiasm and faith as they believed God for a complete

turnaround. However, deep within me, was a sense that she would soon meet with the person whom she calls her Beloved.

Standing by her bedside, I was conflicted. Should I have faith in the miraculous? Or just watch how it unfolds? I did not want to 'quench' their faith in that given moment. We are trained to see things as they are, but I worship a living, miracle-working God. How do you marry these together?

I remember quietly asking the Holy Spirit: What is your will in this? It was then that I was prompted to pray for peace. Yes, you read that correctly. Not healing but peace. It was a very sombre moment, but I knew that God was present in that room. The atmosphere in there was intense. Exiting was much welcomed! Talk about the mechanics of ventilation . Pressure indeed.

I learnt from my colleagues a few days later that the patient passed on to glory, and her family had a hard time processing her passing that day. I wondered, how would the family grieve? What were they thinking about God now? I found myself praying for a community of believers to surround them. I remember leaving work that day needing to call a prayer partner to debrief immediately.

> "What do you do when your miracle does not happen? When your prayers feel so distant from God's ears? Were those prayers not good enough?"

What do you do when your miracle does not happen? When your prayers feel so distant from God's ears? Were those prayers not good enough? Did you lack faith? Did you miss the mark before saying Amen? Are you not His child? Is God still good?

Yes. God is good. God is not a stranger to human suffering. Jesus is very well acquainted with suffering and grief.

"He was despised and rejected by mankind,
a man of suffering, and familiar with pain.
Like one from whom people hide their faces
He was despised, and we held Him in low esteem".
(Isaiah 53:3)

Encounter 3: NIGHT SHIFT

With the hallway lights turned off, silence descended on the ward. I received a handover of a young lady who just received a devastating diagnosis of cancer. I was informed that she had been 'low in mood' all day.

I introduced myself to her and asked if she required anything… mainly pain relief. She softly responded with a flat, "No" and turned to her side. Before leaving, I gave her a routine, gentle reminder that if she needed me, I was a 'call bell away'. Not long after, a soft sob escaped from the room, then silence.

Towards the end of my shift, I returned for a routine vitals check. She was wide-awake in the dark – music playing on her mobile. I enquired about the music (my poor attempt to start a conversation). She replied, "It's Christian music, it keeps me calm." I could only respond with a sad, "Oh, nice." I asked if she was able to sleep. She said, "No." Recent events had kept her awake and on edge. Her voice was burdened with worries and hope for a miracle.

Sometimes, I think to myself: What right or capacity do I have to offer someone words of encouragement or comfort to ease or alleviate worries and pain? Especially in a health crisis. Phrases like, "It will be alright", "You are doing so well", or worse, "I understand" seem insufficient… irrelevant even.

> "So, how does one person really comfort another in their time of real struggle and need?"

So, how does one person really comfort another in their time of real struggle and need? All I could do was to give her a gentle touch on her shoulder and sigh silently.

This is where I believe God is so brilliant! He intervenes in a situation, gets up close and personal. As soon as I bid

her goodbye and headed for the door, a thought dropped into my mind, actually more like intruded! It went "Why don't you pray for her ?" (Confession: I try to avoid these a lot). I knew then it was the Holy Spirit.

No surprise, with lightning speed, my human mind wanted to override it. Surely, this is a job I should just breeze through… right? I should just carry on to the next patient; there is a ton of documentation to be done!

See, obedience is key. I left the vital machine at the door and went to her bedside. I knelt and sheepishly whispered a question to her, "May I pray for you?" and she agreed right away! (I was anticipating rejection – talk about courage and faith from this nurse here…) .

No eloquent words of a healing crusade preacher were needed. The Lord was in that room. God knew what He was doing. I did not need to know the answers, nor what her outcome might be, but that His will be done.

> "What is God showing you or challenging you to do or learn? Are you just going through the motions in your work or actively seeking His face?"

Dear readers, how does God at the bedside look to you? What is God showing you or challenging you to do or learn? Are you just going through the motions in your work or actively seeking His face? The struggle is real, I know.

You may be starting your career, or in the middle of climbing the ranks, or you may well be preparing to say farewell after serving others for a lifetime. Your journey may look more chaotic than mine. Whatever it is, know that in whatever you do, do it unto God.

Those who are willing to follow His leading, God will use mightily! He may call you to something big, or He may just ask you to do something simple like pray . I believe God is championing health care workers to be watchmen on the walls. Those who hear His heart and seek His face. The struggles, frustrations and mundaneness you face at work, He sees it all. He sees you.

I will end with this famous scripture.

"The steps of a good man are ordered by the Lord,
And he delights in his way."
(Psalm 37:23)

Thank you for reading this crazy long entry!
I pray this will bless you. It was a pleasure and an honour.
Now… coffee anyone? Ha ha…

Charity Foo, RN
Born and raised in Malaysia, of Chinese ethnicity.
Pursued a nursing education in Adelaide in 2013 and is currently working as an RN in Melbourne.
Enjoys reading, listening to Christian music, long walks, café hopping and people-watching, exploring scenic nature views and having 1:1 catch-ups.
Loves cold weather (autumn and winter is my season).
Has a passion for GOOD DELICIOUS FOOD, hidden love for matcha.
80% introvert, 20% extrovert!

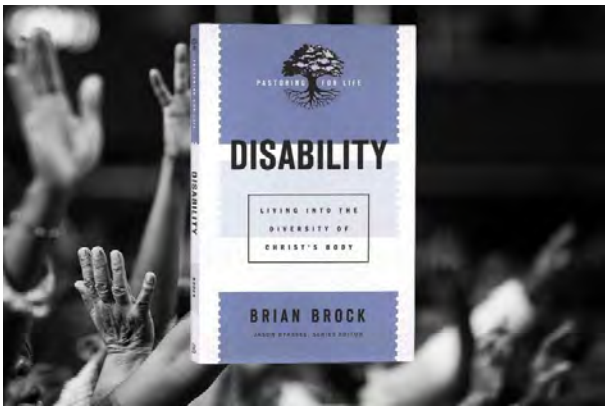


Photo by Luis Quintero, Pexels

Book Review. “Disability: Living into the Diversity of Christ’s Body” by Brian Brock

Reviewed by Georgina Hoddle, retired RN*

From Luke’s Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

In his book, Disability: Living into the Diversity of Christ’s Body , Brian Brock offers creative insights into the changes our churc hes need to make in engaging people with disabilities, drawing on biblical threads and theological claims about disability.

Brock draws on his own authentic, lived experience with a temporary ‘acquired’ disability to help the reader understand what it feels like to be referred to as ‘disabled’ or as someone who ‘has’ a disability and how that impacted his daily life.

The question is posed: Is a person limited by a condition or a disability? (The latter is a wide and more diverse term).

The five chapters of the book present both theology and academia which can lead to the churches’ rediscovery of the power of the Gospel and how it applies to people with disability.

In Chapter 1, some of the contributors to Brock’s work address the fact that most churches are not prepared to welcome people living with disabilities. It opens with the theme of friendship, proposed by John Swinton in his book Becoming Friends of Time . Eric Carter’s contribution to Chapter 1 includes a review of research literature and other publications, which are balanced with lived experience from people with disability; for example, the blind theologian John Hull is cited in nearly every chapter. The work of Bethany Fox is worthy of note. Her book Disability and the Way of Jesus is drawn on extensively.

> “Brock leads the reader to an understanding that our neighbours’ disabilities are theologically and pastorally significant…”

Twenty-eight books of the Bible are quoted, with a wide sweep from Genesis to the four Gospels and the letters of Paul. Brock leads the reader to an understanding that our neighbours’ disabilities are theologically and pastorally significant (1 Corinthians 12:22-26), as they provide a way of following Jesus that gives true life.

Brock cites Jean Vanier of L'Arche, who states we cannot live without the weakest parts of the body, even if we feel uncomfortable around people with a disability such as cerebral palsy. Moreover, the stance where deaf people, or those with autism, do not consider themselves disabled can also be challenging.

There are robust discussions about why Jesus did not heal everyone he met, and if living with a disability was what God chose for them as he knew they could meet the challenge.

Whether the Fall has caused disability is discussed, but it is made clear that Jesus was concerned with healing relationships, for example, the leper who begged to be 'made clean' so he could return to his religious community. Jesus understood his suffering.

> "In Australia, as in the US, many people with disability feel they are not welcome in church. This poses the question: aren't we supposed to bear each other's burdens?"

Brock advocates for a theological framework for disability ministry and/or disability theology that is structured around learning to listen to those who speak of experiences with disability, because the majority of people do not even think about it. Pastors are often unaware that they need to take time to meet the challenge and rectify the incorrect interpretation of the Christian gospel that affects more than themselves. In Australia, as in the US, many people with disability feel they are not welcome in church. This poses the question: aren't we supposed to bear each other's burdens?

The theology is that God has allowed disability, which makes people different, but that does not necessarily mean they require healing or need to be changed, as Damon Rose explains. This invokes a couple of questions: Who is Jesus to those people whose lack of success in life is caused by either physical or intellectual disability? Who is Jesus to those who are not healed of their disability?

The central spiritual challenge facing us Christians is whether these 'unsuccessful' people are a problem. The presence of a child with severe autism in a church congregation is not seen as a blessing nor an answer to prayer. The child is loved by Christ, not for what they do, but because they are made in the image of God – Christ died for all. Christian theology developed from the earliest times since the first Christians were faced with disfigured lepers and other outcasts. The apostle Paul wrote that despite many thinking they are weaker, they were clothed with greater honour (1 Corinthians 12:23-26, NIV).

> "We are all one accident away from being disabled…"

To think Christianly about the language of 'disability' leads us to breaking down what is 'normal'. Disability defines a shifting set of human experiences, as Brock says, "We are all one accident away from being disabled" (p.37). We should not make assumptions about what is 'normal,' which in modern-day thinking means 'typical people.'

The ageing process leads many of us to acquire some disabilities, such as hearing loss. Many of us slow down; we need more time to do things, to formulate our thoughts, recall words, and maybe remember hymns. Here, mercy, not healing, is needed. Our theological thinking has to adjust to respond to those we meet who live with 'disability', welcoming them into our communities as members of the body of Christ.

John Swinton (on p.46 of Brock's book) tells Monica's story, who lived a shalomic life with Jesus despite having cerebral palsy that affected her speech. It illustrates how the Bible can be misused and become embarrassing to some, even a threat. Both segregation and stigma stem from the suppression of Biblical truths. Pastors living with a disability, such as Jason Forbes (who lives with cerebral palsy) and Lamar Hardwick (who lives with autism), provide examples of God's love healing more than just human bodies.

> "We can learn from disabled readers, as they may see things in Scripture that we do not."

If a church is unable come to grips with illness and disability, it is not serving Jesus Christ. We can learn from disabled readers, as they may see things in Scripture that we do not. John Hull asks us to stop and think Christianly about a blind man walking into a church; how awkward does he, or other members of the congregation, feel?

Brock explains that many people with disabilities are non-verbal. Hull, who is blind but accepting of his disability, states he is attuned to non-verbal communications. Deaf and blind people will tell you that they know when others are lying.

Readers with a disability can teach us about subtleties in the Bible, such as non-verbal messages (e.g., Proverbs 16:30, messages sent by winking or pursing one's lips). We also have the example in the Gospels of Matthew, Mark and Luke, who record Jesus stopping in a crowd because a bleeding woman simply touched his garment. She was cured by her faith, without using words.

Finally, a reminder of the story of Bartimaeus (Mark 10:46-52) who asks Jesus for mercy. Jesus does not assume he wants to be healed of his blindness, but restores his sight and thus his place in society; we are aware that modern medical science would view it very differently. The current biomedical model of curing and healing does not lead to holistic care. A modern interpretation of the Gospels could lead to the assumption that Jesus should heal everyone he met.

> "Has it ever occurred to you that when Jesus refers to some people as 'blind,' some non-sighted people may take offence?"

Has it ever occurred to you that when Jesus refers to some people as 'blind,' some non-sighted people may take offence? Jesus was blindfolded during his passion; in his last moments, he would not have been able to see as the world went dark. Jesus also underwent mockery and derision, as many still do today.

To be a Christian entails embodying the truths and narratives of Scripture through lived experience, which includes support for people with disabilities, particularly within the Church. This book provides a constructive framework for both disability theology and disability ministry, which Brock articulates with clarity and supports with practical entry points for churches.

Disability: Living into the Diversity of Christ's Body
by **Brian Brock**
ISBN: 1540962970
Baker Academic, May 2021

Georgina Hoddle, retired RN
Georgie, as she likes to be called, is a retired Registered Nurse who now volunteers on the pastoral care team of an aged care facility. Georgie is a Saline Process™ Co-Ordinator and a board member of the Nurses Christian Fellowship Australia (NCFA). She also works closely with CMDFA on Saline Process™ courses in accordance with a Memorandum of Understanding. Georgie has spoken at numerous national and international conferences. Her current interest is directed to compiling research on pastoral care for mental health.

Bibliography:

1. Gan, C, Powell R. And Pepper M. Disability inclusion, provision and care: trends in local churches from 2016 to 2021. NCLS Research Report 48. Sydney. NCLS Research. 2023 https://www.ncls.org.au/articles/disability-inclusion-provision-and-care-2021-ncls-report/ accessed 21 August 2025
2. Gosbell, LA. "For Families Living with Disability, Churches Mustn't Go 'Back to Normal' after Covid-19." ABC Religion and Ethics. 3 December 2020. https://www.abc.net.au/religion/for-those-with-disability-church-mustnot-go-back-to-normal/129486 accessed 21 August 2025
3. Hardwick, L. Disability and the Church: A Vision for Diversity and Inclusion. Downers Grove, IL: IVP, 2021
4. Hull, J. In the Beginning There was Darkness: A Blind Person's Conversations with the Bible. London, SPCK, 2001
5. MacKinlay, E. (Ed.) Ageing, Disability and Spirituality . Jessica Kingsley Publisher, pp.1-272, 2008
6. McKinney Fox, B. Disability and the Way of Jesus: Holistic Healing in the Gospels and the Church. IVP, 2019.
7. Swinton, J. Becoming Friends of Time: Disability, Timefulness and, and Gentle Discipleship. Baylore University Press, pp. 1-, 2016

(* This Book Review has been adapted from Assignment 2 (Unit: Disability and the People of God, Lecturer, Dr Louise Gosbell; submitted to Mary Andrews College, Sydney, August 2025. Printed with permission)

Christ, the one true myth of this world

In memory of Marcelle Jane Hoddle, who died 4 March 2023

What she learnt through her suffering
'The story of Christ is not only religiously and historically true, but also the only medicine for each romantic heart which searched for love, and the key for every philosophical head which searched for truth; the story of Christ is the grand narrative of all narratives, for Christ is the one true myth of this world.'
– Anonymous

Illustration by Shutterstock

Seeking What's Lost – Philip McGann

My stroke story

From Luke's Journal March 2026 | Vol. 31 No. 1 | God at the Bedside (see page 2)

Our church's fifteenth anniversary was Sunday, August 4, 2024. I'd been there since the start and had been a pastor for the past seven years. It was meant to be a day of celebration.

As we drove to church, our daughter Junie was nearly six months old and sleeping in her capsule. Serena was driving. Just before 9 am, driving along the Riverside Expressway, I was about to reply to a message, but I couldn't lift my left arm. "I can't move my arm."

"What do you mean? Like you slept on it?"

As I tried to explain, the left side of my face began to fall, my speech slurred, and my left leg went dead. Even at 34 years old, something in me knew the signs. "I think it's a stroke."

There was a traffic jam ahead. Serena pulled onto the on-ramp, and we were at the Royal Brisbane Hospital in a few minutes.

We pulled into emergency, and Serena ran in to get help. For some reason, I tried to get out of the car on my own and fell face-first onto the pavement. A minute later, I was on a stretcher, surrounded by doctors. As I was lifted onto another stretcher and eased into the CT scanner, I prayed the first words that came to mind, on repeat, with half my mouth fallen: "I lift my eyes to the mountains. Where does my help come from? It comes from the Lord, the maker of heaven and earth." The words of Psalm 121 had always been a comfort to me, but the question posed in it seemed more real than ever.

> "I remember thinking: I don't care if I can never work again. I just want to be able to hold my daughter."

When they wheeled me back, Serena placed Junie on the bed beside me, and I broke. I couldn't hold her. I could barely smile. I remember thinking: I don't care if I can never work again. I just want to be able to hold my daughter. And: If I die right now, Junie won't remember me. They were live questions.

Although nothing showed up on the CT, considering my age and symptoms, they were sure that I had a clotting stroke and not a hemorrhagic stroke. They asked me to sign a form to administer thrombolysis.

"I just have to tell you that there's a two percent chance that this will make you get worse, and there's a one percent chance that you'll die, but considering your symptoms, we think that this is absolutely your best chance."

Photo by Shutterstock

Half an hour previously, I had been changing songs on Spotify. Now, with the left side of my body completely paralysed, with my wife and six-month-old daughter by my side, I was signing a form with the consideration of death on the table. I signed it. They administered the lysis, and we waited.

> "The MRI confirmed a lacunar infarct in my basal ganglia. None of those words meant anything at the time, but now each is laced with explanatory power and significance."

The MRI confirmed a lacunar infarct in my basal ganglia. None of those words meant anything at the time, but now each is laced with explanatory power and significance. The blood clot was in the centre of my brain, in the tiny communication hub between the left and right sides – the fragile space that holds everything together.

We sat, waiting for the thrombolysis to loosen the clot. I remember in those hours, as absurd as it seems now, going into my Google Drive and giving Serena access to the novel I'd been writing. It was called Maple Diction, and it was about a father writing a letter to his infant daughter, because he was afraid that he might not be alive for much longer.

I felt two things in that moment: I wanted to make sure that Junie could read it one day, and I felt sure that, if I could ever write again, that this moment was a line in the sand. Everything I'd written was the first half of the story, and the book would start again from there.

It took about eight hours for me to feel any movement in my left side. First, I could swing my leg from the thigh; then, I could twitch my thumb. After a long and sleepless night in the neurology ward, little electric jolts began to travel down my arm and leg, and muscles came back online. By morning, without even standing yet, I knew I could walk again.

Telling the Story

There's a power in hearing other people's stroke stories. Not because they're the same –they never are – but because they help us orient ourselves. They remind us that what feels singular and isolating might still be shared.

After having Junie, I was struck by how many mothers (and women hoping to become mothers) have said to me, "I love hearing birth stories, because every one is different." It isn't just variety that draws them in. These stories echo our own. They help us knit our experience into something larger. They help us feel understood, known, and located.

> "…grief must always be expressed – if not through our words, then it will always boil over in other areas of our lives."

The writer Meghan O'Rourke describes chronic illness as "camouflaged grief ." [1] When what has happened to us is invisible, when it isn't immediately legible on our bodies, we're forced to carry the grief inside us. Strokes leave scars on the brain, the heart, and the soul that can remain unseen even to the person who carries them. But they still ask to be spoken to, because grief must always be expressed – if not through our words, then it will boil over in other areas of our lives.

I spent six days in the hospital. A few days after the stroke, almost all the damage of the stroke was invisible. I went from health to paralysis to walking again in less than a day. But I know that it will take me years to process what happened that day.

On my first night home, I insisted on bathing Junie again. Sitting beside Serena as she fed her to sleep, the week finally caught up with us. We cried tears of grief, but also of gratitude.

Six weeks after the stroke, I cracked. I was trying to push myself, to do the kinds of things we used to do. Serena and I were meant to meet friends for lunch. Halfway there, my body told me I couldn't go. Speaking required intense focus. My left arm felt leaden. My leg felt dense. I started crying uncontrollably. It wasn't really about lunch. It was about powerlessness. About the fear beneath it all: that my brain will recover when it recovers, that my life will crawl toward equilibrium when it decides to, and that there may be scars I will never fully locate.

> "The lingering beast of stroke recovery, and the word that never seems to quite capture the experience is fatigue."

The lingering beast of stroke recovery and the word that never seems to quite capture the experience is fatigue . I used to work long days and get home and collapse. But this was something else altogether.

For me, it's always the same progression. First, I notice that my left arm feels like it's made of lead. Then, if I keep pushing, it becomes like a hand is trying to pull down the force-shutdown lever on my brain. When that happens, it's as though gravity has doubled. My left side feels doubly heavy, and it's a battle to keep moving. I'm having to realise that my battery has been replaced. I used to have a new battery – fast-charging and able to hold its charge. But it's been swapped with an old battery from the back of the cupboard – one that takes a long time to charge and drains very quickly. That's what my life is like now.

"I'm not sure if this body is my home, and I'm not sure if it ever was my home." Maple Diction

Just like I knew that I could walk before I stood up for those first few months, I knew that I couldn't write. I could write words. I'd jot down phrases, sentences, poems. But I knew that I couldn't write my book.

"These words are my refuge… they're an affirmation to myself that there is humanity in me and beyond me, and it can still find coherence." Maple Diction.

After a few months, though, I returned to the book, and it became a powerful voice in my recovery. The line in the sand meant that I had freedom of narrative. I had to complete the story – I gave myself permission to write whatever I needed. It helped me to articulate my griefs and my fears, and my place within a larger story.

About a year after the stroke, I gave a sermon where I reflected on the stroke. The passage was Ecclesiastes 3, a meditation on the seasons of life, and it was verse 15 that struck me: "That which is, already has been that which is to be, already has been, and God seeks what has been driven away." The hope of the Christian story is not that our past will be erased, but that it will be gathered. As James K. A. Smith put it, "Jesus' redemption gathers up the broken fragments and makes something of them. The God who saves us is a mosaic artist who takes the broken fragments of our history and does a new thing: He creates a work of art in which that history is reworked such that the mosaic could only be what it is with that history. God's grace goes back to fetch our pasts for the sake of the future."[2]

Every loss, every deficit, every lunch you couldn't make, every cell that's died in the stroke. There's hope for those broken fragments to be gathered up into a new thing, into a whole, into a greater story.

Or, as the father in Maple Diction writes:

"A part of my brain has permanently died, and another area has taken over its function. That much is true. But even that seems absurd, that we're capable of such things. The new brain tissue knows its role, and what's dead can become alive again – what's dark can find its way back into the light. That's my great hope."

The Great Hope

Even within that small dead space in my brain, something astonishing has taken place – another area has takenc over its function. The new tissue has learned its role, and muscles have come back online. What was dark hasc found its way back into the light. "Redemption does not sweep away the past; Christ's redemption gathers up thec broken fragments and makes something of them."[3c]That doesn't mean God will sweep over the loss. But the hopec of the Christian story is not that our past will be erased, but that it will be gathered.

The cells that have died, the things I haven't done, the nights I couldn't hold Junie; God seeks what has beenc driven away. God has done a work, and is doing a work, and will do a work in the resurrection that will wash backc over history and breathe new life into it.

Jesus' resurrection washes back over history, such that one day, God will seek out every one of those momentsc and give them hope.

Philip McGann
Philip is a pastor at Village Church in Brisbane and a writer in his spare time. He's a husband to Serena and a father to Junie. He loves patting doggies and watching old movies.

References:

1. P. O'Rourke M. The invisible kingdom: Reimagining chronic illness. New York (NY): Riverhead Books; 2022. (1, p. 266)
2. Smith JKA. How to Inhabit Time: Understanding the Past, Facing the Future, Living Faithfully Now. Grand Rapids (MI): Brazos Press; 2022. (1, p. 63)
3. Ibid.

Transform Lives

CMDFA welcomes and unites Christian doctors, dentists, students, and associated healthcare professionals from all denominations.

We strive to integrate faith in Jesus Christ with our professional lives, supporting each other to present the life-giving message of God's love, justice and mercy in a tangible way to a hurting world.

We seek to transform Healthcare by:

- Providing fellowship and pastoral support for our members right across the country.
- Standing up for Christian Healthcare values where they are challenged by today's secular society.
- Encouraging medical and dental students in their faith and providing fellowship where they study.
- Publishing LukesJournal.com.au three times a year.

Please join us and make an impact. Visit:
cmdfa.org.au/getting-started/become-a-member/

Christian Medical and Dental Fellowship of Australia