Luke's Journal

of Christian Medicine & Dentistry
Vol. 26 No. 1 February 2021
ISSN 2209-9441

Christian Medical and Dental Fellowship of Australia

MORAL INJURY CONFERENCE

CMDFA WEBINAR PRODUCED BY THE NSW STATE COMMITTEE

- *"What keeps me awake at night?"*
- *Conversion Therapy*
- *Voluntary Assisted Dying*
- *The Hospital Furnace*

Poverty: It's Not What You Think

Towards a theology integrating creation, providence and redemption in our daily work, rest and family

Fire in the Belly 2021

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"As a medical student, I was challenged to see theological education as akin to secular education. Prior to this I had felt it was only for those considering full-time vocational ministry. We study and train for years to work as a doctor, but we are called to be followers of Jesus 24/7. I had intended to do a short stint of theological study after completing medicine but, with work, family and continued lay ministry, this decision was delayed until this year. As I became a father and more involved in church, I realised that studying the Bible in depth has value for every facet of life. As a doctor it will shape and mould the way I approach my work, but more importantly it will equip me to understand and teach the Bible better. Ultimately, it will allow me to serve God effectively wherever he places me. After proclaiming I'd had enough of study forever, this year has been the most rewarding, enjoyable and life-changing study I have done. It's never too late!" **SMBC student, Julian**

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Themes for Next Editions:

Until the Very End: Dying and Palliative Care
copy due 30 Apr 2021

Children of God
copy due 30 Aug 2021

Dr Catherine Hollier
Catherine is a part-time GP in Newcastle, NSW. She is proud to have been involved with the high quality content of Luke's Journal since 2016 and enjoys leading a team of enthusiastic volunteers in its publication. She is greatly pleased with the transition to digital format, allowing greater dispersion of its content to a wide and varied audience.

EDITORIAL

Wow! 'Fire in the Belly'.

Impulsive? Idealistic? Irresponsible? Or reasonable opinion? That is for you to decide.

Moving. Challenging. Passionate. Definitely.

With the digitalisation of *Luke's Journal* and the extended reach of its readership, there has been an increase in *Fire in the Belly* articles – self-submitted and grounded in the passion of the author. The views expressed in these articles are those of the authors and not necessarily those of the CMDFA or *Luke's Journal*. As such, these articles have less editorial input and should be read as passionate expression rather than academic treatise. However, they will no doubt stimulate thought and robust debate as we seek to mature in Christ, and interact meaningfully with the world.

Luke's Journal is excited to publish what is likely to be the first of many issues comprising only *Fire in the Belly* articles. Authors have been inspired from all ages and many different backgrounds. Some write from a theological perspective integrating faith in daily work, e.g. Alan Gijsbers' "*Towards a theology…*" or from a desire to guide the younger generation, e.g. Maria Haase's "*Decision-Making and the Will of God*". Others share from many years of faithful work in the mission field (see Anthony Radford's "*A Treatise in Health*" and Ross Farley's "*Poverty – it's not what you think!*"). There are pragmatic issues such as Monique Peris' "*Teamwork*" and personal stories like Shazza's "*Touched by Cancer. Touched by Love.*"

We report summaries and presentations from the recent NSW 'Moral Injury Conference', which has become more pertinent as the surrounding culture presses ever more loudly against Christianity. The age-old topics of abortion and voluntary assisted dying are joined by the growing clamour around gender dysphoria, conversion therapy and the idolisation of medical career in the hospital environment. Recordings can be accessed online by contacting office@cmdfa.org.au

> ***"[The articles] will no doubt stimulate thought and robust debate as we seek to mature in Christ, and interact meaningfully with the world."***

There are also reports from long-standing affiliates of CMDFA – HealthServe Australia and ICDMA. It is timely to be reminded of our partnership around the globe with the common link of healthcare in our Christian family, especially as COVID-19 unites the world and the church in so many ways. An invitation is extended to join with others beyond our borders. Other mission focus includes Thomas Lu's "*YWAM Medical ships*" and practicalities on "*What to take with you on Mission Trips*".

And finally, a response to a previous *Luke's Journal* article by Andrew Williams, "*Do We Really Save Lives?*" which prompted Alan Gijsbers to write an alternative view.

We have a broad church in the CMDFA membership and it is with great joy that *Luke's Journal* shares encouragement and inspiration across the nation and beyond.

A/Prof Alan Gijsbers
Alan (MBBS FRACP FAChAM DTM&H PGDipEpi.) is a Specialist Physician in Addiction Medicine, Melbourne, and President of Christians in Science and Technology (ISCAST). He has a particular interest in a studying neuroscience and theology, the philosophy of the self, and spirituality, topics which underpin his approach to addiction care.

Towards a theology integrating creation, providence and redemption in our daily work, rest and family

"[God's] creation is not an end, but a beginning – complete in itself as such, but still a beginning. It is not, therefore, an end in itself. Nor is it simply conditioned by what might happen further between God and man on quite different presuppositions…the creation of God took place for the sake of the covenant and that itself it was the beginning of the covenant…"
(K Barth, *Church Dogmatics part IV the doctrine of reconciliation*, p 131, Continuum edition 2004).

Integration

This paper seeks to move us as Christians to integrate a creation theology with our redemption theology. Where they are separated, we tend to separate our Sundays from our Mondays, our walk with God from our daily tasks. But our salvation impacts the whole of our life. We cannot separate our salvation from what we do every day. As Barth indicates above, creation is the stage on which God continues to express His covenant of love to His people. As well as integrating our theologies, this paper seeks to integrate our understanding of work (both paid and unpaid work) with leisure, to integrate work life with home life, and to integrate work with worship. Further, it seeks to integrate being and doing, and to integrate mission and evangelism. It seeks to integrate what we do in church with what we do in our secular pluralist society. My overall aim is to integrate faith and practice so that there is a broad two-way street of ideas and actions between the world we live in, and the Word of God we live out of.

Creation and Redemption

Fundamentally, creation is the theatre in which God interacts with God's people. While in some ways God's creating work was completed on the sixth day, and God rested the seventh, in another way God continues to work (John 5:17). God's act of creating is the start of God's providence over the whole created order. This providence, expressed in God's covenant of love towards creation, continues over the just and the unjust equally, even to today. Humans disobeyed God in creation. Human sin occurs within creation. Further, in spite of human sin, God still cares for and provides for His creation. Even further, God calls a people to Himself within creation, and those people express His rule over the created earth. That is how God's covenant develops. It came through the call of Abram, through the patriarchs to Moses and to the children of Israel. Israel was called to be a holy people, expressing God's righteous rule in the world. Israel was called to be a light to the nations, so that all the families of the earth would be blessed. This covenant was renewed in Christ through whom God has called a new people, the church, to express God's rule in creation. Evidence of renewal can be seen in the way that the body expresses Kingdom values by the way it lives and loves.

"We cannot separate our salvation from what we do every day."

This promise of the rule and reign of God, as expressed in the theology of the Kingdom of God has been fulfilled and renewed in Christ who is also the promise of a further salvation for the whole created order. Christ came and lived in this world showing God's love for the world by word and deed towards all, including the poor, the marginalised and the oppressed. Christ lived as the obedient suffering servant who by His life demonstrated His worthiness of

being the true man and true son. By His life He demonstrated practically how God seeks out, loves and transforms the marginalised. He suffered His obedient death in the flesh and rose in a new and glorious body. Further, He formed His body, the church, on earth. He made a covenant with His church that she might be a holy people living for God and spreading God's blessing throughout the world. The church is called to proclaim a Kingdom in which all will become one under the headship of Christ. This promise will one day be fulfilled when Christ comes again in glory to judge the living and the dead. He will then judge our deeds, done in our bodies, and bring us to glory. That glory will be that the New Jerusalem will come down from heaven to create a new heaven and a new earth in which God will dwell with His people and so redeem the whole of creation.

God invites humankind to search out the hidden wisdom of God in creation and to wonder in awe at its power and beauty. God invites us to enjoy its goodness, to be awestruck by its mystery and to be challenged to enter more fully into the wisdom which created it all. We only perceive this wisdom dimly; there is so much in creation we still cannot fathom, in spite of all we know. Further, God has given humankind the responsibility to govern creation as stewards of creation, and as such the more we know about creation, the better we can fulfil our mandate to govern it well. Theology is about encountering God and God's Word. This we do when we look into the book of nature, and discern God's hand in history, as well as reading the other book, the book of Scripture.

Why do we work?
To be fruitful, to multiply, to fill the earth, to subdue it and to have dominion over it.

Do we always work?
No, God has ordained that we should rest on the Sabbath.

With these two simple statements, not only do we develop a theology of work but also a theology of family (raising a family IS work – and pleasure) and a theology of rest and leisure. (And lurking behind all this is a theology of pleasure, but that is for another paper!) Nor is that all, but it is also a theology of mission and a theology of blessing the world!

How can we bring creation, providence, redemption and mission more closely together? We integrate them first through the concept of holiness and righteousness, and secondly by considering the nature of the Gospel.

> ***"God ... is worshipped in our work, in our leisure, and in our relations."***

Righteousness and holiness

Righteousness is not just an imputed or an imparted quality (or more correctly, a forensic status conferred on God's people by the atoning death of Jesus Christ) – although it is gloriously that, and I bless God that I can stand with my fellow believers in that righteousness. However, more fundamentally, righteousness expresses an understanding that there are right ways of living and acting. Righteousness is more than a forensic quality; it is fundamental to a right way of being and doing things. Thus, a screwdriver is used righteously when it is used to drive in screws and a hammer is used unrighteously when it is used to hammer in a screw. Secondarily, righteousness has developed a forensic quality in that legislation has come in defining what constitutes righteousness and unrighteousness within society. Thus the concepts of righteousness and justice became intertwined.

God called Israel to be God's holy people, who would live his way in the world, thus showing the world the ways of God. God calls his people to live righteously. The Torah contains within it what right living would be in an agrarian society living to the glory of God.

The word *holy* means 'set apart' and God's people are set apart to live an alternative righteous lifestyle under the command and covenant of God. Leviticus 19 shows how wide-ranging and practical such holy living might be. It involved caring for the poor by the way the people harvested the crops, it involved respecting elders and welcoming strangers and aliens. It involved respecting one's neighbour, indeed to love one's neighbour as oneself. It also included some curious rubrics like not boiling a kid in its mother's milk, and not cutting the fringes of a man's hair. This is not the only description of ethical living in the first Testament but it is a provocative and comprehensive list directed towards honouring God in every aspect of life. However, it is more than ethical living because it is living in response to the goodness and providence of God, who is worshipped in our work, in our leisure, and in our relations.

One of the mistakes the Pharisees made reading the first Testament was to think that a meticulous keeping of the minutiae of God's laws exhausted what the Lord required from the people. The tithing of mint, dill, and cumin became more important than justice and mercy. By contrast, Christ called on a deeper and richer righteousness and spelt that out in His teaching about the Kingdom of God, a kingdom of justice, mercy, and humility. Here humankind, even God's people, and especially those who tried to be righteous by following the minutiae of God's law, stands condemned because they did not acknowledge that their lives and their work was unrighteous and that they needed divine mercy.

But those who bowed themselves before the Father and who confessed their sin,

found forgiveness and cleansing. They also found a new power through the Holy Spirit to live righteously, mercifully and with faith expressing God's love in restored relationships. These restored relationships were expressed in their families, in their church, in their workplace, in society, and in the world.

Gospel and Kingdom

When considering the nature of the Gospel, the Kingdom of God is a key theme. Accepting the Gospel is not only to accept Christ's alien righteousness as one's own, it is also to submit oneself to the Lordship of Christ and to become part of the Kingdom of God. The New Testament clearly describes a strong relationship between the Kingdom of God and the righteousness of God, because the Kingdom is a righteous kingdom. It also strongly implies that such righteous living is like a city on a hill, a light out from under a bushel. Such righteous living would be costly and those who live like this face persecution.

God's Kingdom is a kingdom of love, of a derivative love expressed in response to the love of God. By its very essence the Kingdom is relational. We are called to love God, love ourselves, love our neighbour, love the world, and love creation. Hence very deeply there is a relational dimension to all we do, in our work, in our leisure and in our rest.

Our prayer 'Your kingdom come" is a very comprehensive prayer. It asks for God's Kingdom to come by supplying our daily bread, by seeking to be forgiven and to forgive, and by asking God to save us from temptation and to deliver us from evil.

This Kingdom is embodied in the Church of Christ, for here we gather as God's people, hear the word of God and seek to apply that word in our lives in the community. Further, the church exists for the twin purposes of glorifying God and serving the world, loving it as Christ loved it.

We live in the in-between-time where the Kingdom has come in Christ but it has yet to come with Christ's coming again. When it comes, Christ will judge all that humankind (including ourselves) has

done. 1 Corinthians 3:10-15 gives us the clearest picture of the testing at the end time of what we have done. That which is consistent with the Kingdom will last – the gold, silver and precious stones – and that which is incompatible with the Kingdom – the wood, the hay, and the stubble – will not survive. All we do, and especially the religious things we do, will come under the judgment of Christ. Hence what we do now – everything we do now – is provisional awaiting the verdict of the King.

> ***"We are called to righteous living and that righteous living is a witness to the Kingdom of God in the world."***

So, we are called to righteous living and that righteous living is a witness to the Kingdom of God in the world. As we act and speak, we present the Gospel of the Lord Jesus Christ in our daily work and in all our relationships. As we live and explain this, we integrate our worship, our work, our home life, and our public life, all done to be a blessing to the world in need of the Gospel. This is the theological environment in which we work.

Implications

Work to honour God

The Christian lives in the light of the freedom of God's forgiveness and grace. We do not need to work to prove anything about ourselves. We are not workaholics using work for self-actualisation or self-expression, or to avoid the insecurities of not doing anything. Our security comes from God and we do not need to prove anything to anyone. God has accepted us, and loves us. Consequently, we work for God in gratitude for His love and care over us. Work then, is an expression of our love for God. It is also a commitment to service, for that is how the Master worked. Our goals and ambitions then come under the lordship of Christ and are directed by Kingdom values and Kingdom aims.

Work to be a blessing

God's covenant to Abraham was that through him all the families of the earth would be blessed. All God's work of grace towards humankind was directed to this end of blessing, – to the honour of His name. With the coming of the Kingdom of God, God's blessing would be poured out on humankind, on the poor in spirit, those who mourn, those who are meek, those who hunger and thirst after righteousness, those who are merciful, those who are peacemakers, those who are pure in heart and those who stand for righteousness (Matthew 5:1-16). These

blessed people will be a blessing to others. We express God's blessing in the way we work and in the work we do.

Work as a proclamation of the Gospel
The Gospel is expressed in many and varied ways. It is a proclamation of the Kingdom of God, it is the confrontation with evil, it is the story of Jesus Christ who came from God and who lived, died, and rose again to secure salvation for all creation. It is the story of divine love in the face of human indifference. It is the story of the indwelling power of Christ as the hope of glory. Christians live out and tell these stories in their daily work and in their relationships with their colleagues. There is no Sunday-Monday disconnection, there is no redemption theology separate from a creation theology. We as Christians live as one. As we live righteously, we set standards that will be a witness and a rebuke to others. When we fail, we personally witness the grace and forgiveness inherent in the Gospel. In all we do, we witness to the righteousness of God, and to God's mercy.

Work as seeking after God's wisdom
God invites us to enjoy His creation. As we grapple with it, we seek to come to grips with the order and chaos that is inherent in creation and we see more deeply the divine design and divine mystery in creation. This is the basis of the scientific enterprise, which is but one of a number of ways of reflecting on the mystery of personal people like ourselves encountering the impersonal vastness of the order and disorder of the world in which we live. And as we discover the wisdom of creation we then understand and live less fearfully in the world God has made.

Work in with God's community
If divine love is the basis of all there is – love that was there from the beginning in the Trinity, a love that spilled over into the created order, and a love that expressed itself even more fully when that creation rebelled against its creator, and that was still more loved by being redeemed – then the redeemed express that love in their work, paid and unpaid. Invariably that is a relational thing – we cannot just love God without loving God's people,

and without loving our neighbour, or our enemy. This love then will be expressed in the church, the body of Christ to which we belong whether we like it or not. There is no room for isolated Christians, we express our faith and love communally.

> ***"We in our workplace need that same imaginative flexibility, and tell the story of Christ by telling His stories."***

Not just what you do but how you do it
If our witness is in the world, it expresses itself not just in what we do, but how we do it. There is a loving humanity about mature Christian expression, a human connectedness that is often missing from impersonal transactions. Elizabeth Kubler-Ross in her book *On Death and Dying* observed that sometimes hospital chaplains would not engage with the humanity of the dying patient. High Church chaplains would hide behind the sacraments, Low Church chaplains would hide behind the Scriptures. In neither case would there be a true human engagement. It can happen in medical care – I have seen it happen in psychiatry; it can happen in education; it can happen, in fact, in any occupation, even in theology. How refreshing when your humanity is acknowledged in the transactions you encounter.

And how do you explain the Gospel?
We need to be prepared to explain our good works so that the glory for them goes to the Father, and not to us. When Paul gives potted summaries of the Gospel, they vary greatly from an explanation of the righteousness of God, to an explanation of who Jesus is, to a comment like, "Christ in you the hope of glory" (Colossians 1:27). When Matthew, Mark, Luke, and John tell the Gospel, they tell stories of who Jesus is by what He did and what He taught. Jesus Himself proclaims the Kingdom of God and describes the nature of that Kingdom in many and varied ways that stimulate the imagination. We in our workplace need that same imaginative flexibility, and tell the story of Christ by telling His stories, like the Good Samaritan, the Prodigal Son, the Woman at the Well, and the story of Him Washing his Disciples' feet. One of my favourite phrases (which resonates with my patients with addiction) is the statement, "There is no fear in love for perfect love casts out fear" (1 John 4:18). There is a winsomeness about those words.

Conclusion

Work-life balance is not simply about juggling different priorities but about integrating all we do in gratitude and to the glory of God. It is not something separate from our redemption but something that integrates our work with our salvation. We seek first the Kingdom of God and His righteousness at home, at work in the church and at leisure, and we will do that till He comes.

Dr Maria Haase
Maria is a GP working part time in Private Practice. She and husband, David, relocated to Toowoomba, QLD in February 2019. She attends VISION on the Gold Coast to mentor students / lead workshops and thoroughly enjoys the wonderful fellowship with students.

Decision Making and the Will of God

Much has been written on the will of God, both what it is and how we might discern it. Nevertheless, it remains a perennial topic, as we all have to grapple with this issue to find a comfortable position for ourselves. Our understanding is significantly influenced by our upbringing, denomination, worldview, discussions and most importantly, our knowledge of Scripture and the guidance of the Holy Spirit. There is a perplexing array of ideas and many different stances taken on this subject.

My goal in this article is to highlight differing views, summarise opinions, challenge concepts and encourage thoughtful consideration. Our views determine the impact on daily decision-making. Factored in is the challenge to continue to review previous beliefs, allowing room for change through growth and maturity. In this article, I have posed more questions than given answers as I would rather stimulate thought and encourage personal reflection than proffer a firm opinion.

How do we make decisions?
How does God speak to us?
What is our concept of God's guidance?
Do we wait for a direct word from God?

Do we "put out a fleece", or ask for a sign, or flip pages of Scripture until we find a verse to support our own desires?

Or do we use our God given intellect in the light of application of correct Biblical principles of hermeneutics, plus learn from the wisdom of reputable scholars, prayerfully asking the Holy Spirit to guide us "in the truth"? (John 17)

Initially, clarification of definitions is required. (I love definitions!)

Firstly, to define the word "decision":

> ***Decision*** *[noun]: the act or process of deciding; determination, as of a question or doubt, by making a judgment; the act of or need for making up one's mind; something that is decided; resolution.* (dictionary.com)

"God has planned His course from the beginning and will accomplish His unalterable purpose."

This indicates an active process. Work must be done. Thinking is involved. Discomfort might be required!

Scripture has much to say on this subject.

Romans 12:2 says,

> *"Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is – his good, pleasing and perfect will."* (NIV)

Secondly, before looking in more detail at the "decision-making" aspect, it is necessary to clarify the term "the will of God".

What is "the will of God"?

How do we know this "will of God"?
How do we find it?

Most authors classify the will of God in to:

- The sovereign will of God
- The moral will of God
- The personal will of God

The sovereign will of God. God has planned His course from the beginning and will accomplish His unalterable purpose. It is absolute and not necessarily revealed to us.

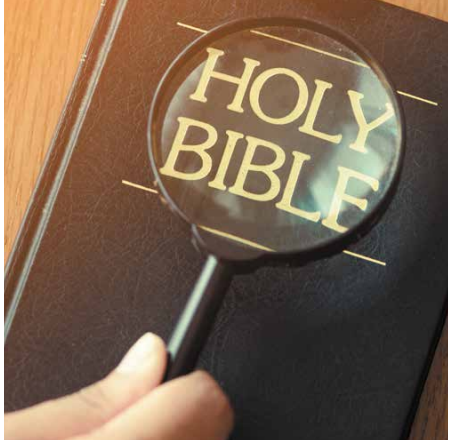
I am God, and there is none like me, declaring the end from the beginning and from ancient times things not yet done, saying, "My counsel shall stand, and I will accomplish all my purpose." (Isaiah 46:9–10)

The moral will of God. This is what **is revealed** in The Holy Bible. The Scriptures are a "Lamp to our feet and a light to our path", (Ps 119:105), providing some clear rules on how we are to live. It would be unwise to violate them. "But as for you, continue in what you have learned and have firmly believed, knowing from whom you learned it and how from childhood you have been acquainted with the sacred writings, which are able to make you wise for salvation through faith in Christ Jesus. All Scripture is breathed out by God and profitable for teaching, for reproof, for correction, and for training in righteousness, that the man of God may be complete, equipped for every good work." (2 Tim 3:14-16).

In some circumstances, there are specific directives. For example, on whom to marry - "Do not be unequally yoked with unbelievers. For what partnership has righteousness with lawlessness? Or what fellowship has light with darkness?" (2 Cor 6:14). Similarly, Timothy and Titus give sound advice for living. In such circumstances, we can be clear on what is a right and firm decision, without anxiety, as it is already spelled out for us. Such commands are for us to obey.

God has a will for man which is revealed in His law. It also reveals what God desires from man. Ephesians 5 specifically directs our course for godly living: "Therefore be imitators of God, as beloved children. And walk in love, as Christ loved us and gave himself up for us, a fragrant offering and sacrifice to God… Walk as children of light (for the fruit of light is found in all that is good and right and true), and try to discern what is pleasing to the Lord."

After that, there is freedom to choose according to wisdom (Proverbs is replete with wisdom and commands us to beget wisdom), wise counsel and the desires of our heart.



God-given wisdom is protective and helpful for decision-making. Some people pray earnestly for help with decisions but fail to follow the moral will of God clearly written for us! If a decision is outside of Scriptural injunction, then it is certain that this will be the **wrong** decision. Our decisions must not violate scriptural principles.

The personal will of God. Does God have a plan for my life?

Many have heard the popular statement "God has a wonderful plan for your life." It reads as though this plan is perfectly mapped out and has to be sought and followed to "the dot". This is commonly termed "the dot theory".

"What if we concentrated more on seeking God and seeking first 'the Kingdom of God' than seeking the individual will of God?"

Is a belief in a "personal will of God" a cultural question? Did previous generations or other cultures twist themselves in knots trying to determine if there is an individual, personalised plan from God? Are we getting ourselves distressed because of an incorrect theological perspective?

What if we concentrated more on seeking God and seeking first "the Kingdom of God" than seeking the individual will of God?

So, does God actually have a plan for my life?

".....even as he chose us in him before the foundation of the world, that we should be holy and blameless before him. In love he predestined us for adoption to himself as sons through Jesus Christ, according to the purpose of his will, to the praise of his glorious grace, with which he has blessed us in the Beloved. In him we have redemption through his blood, the forgiveness of our trespasses, according to the riches of his grace, which he lavished upon us, in all wisdom and insight making known to us the mystery of his will, according to his purpose, which he set forth in Christ as a plan for the fullness of time, to unite all things in him, things in heaven and things on earth." (Eph 1:4-10)

Firstly, yes! "Chosen in Him before the foundation of the world to be holy and blameless before him" sounds like a plan! It seems like the big plan is "to unite all things in him, things in heaven and things on earth." How that plan fleshes out in daily life pales into insignificance in the light of eternity.

Does He have a specific plan for every minute of our day? That is the conceptual challenge. Do we have a plan for every minute of our days? That would probably lead to anxiety, exhaustion and frustration. I wonder if we really need God to micromanage us. Is it necessary to seek His guidance as to which coloured shirt to wear each morning, or to ask His help when choosing from a menu? We are free to be creative! I wonder if this is a misunderstanding of "spirituality" as taught in some organisations and sectors of the church. That is to ponder.

Ephesians is basically a book on "how to". How to know, how to grow..... "to mature manhood, to the measure of the stature of the fullness of Christ; so that we may no longer be children, tossed to and fro by the waves and carried about by every wind of doctrine. Rather, ...we are to grow up in every way into him who is the head, into Christ." (Eph 4:13-15). To be **grown up** means accepting responsibility for decisions and actions, not immobilised by uncertainty and insecurity.

Bob Goff in his book *Everybody Always* states,

> *"I've met a lot of people who are waiting for God to give them a "plan" for their lives. They talk about this "plan" like it is a treasure map God has folded up in His back pocket. Only pirates have those. People who want a reason to delay often wait for plans."*

So, does God have an individual will for each believer, fully mapped out (the dot theory), or is His primary will for us to become mature followers of Christ and be His in eternity? Would He guide us along the way allowing room for individuality but quicken our spirit to respond to kingdom issues i.e. to lead us to fervently pray when an important event in the spiritual realm is occurring, or lead us on the path where a decision will determine the next important step in our journey? This is a challenging question. We humans grapple with the cut-off point, the balance between the mundane, where reason and common sense are sufficient, but also the understanding of supernatural intervention of a living, loving, relational God who is there directing our paths during great need or uncertainty. Then, why does He seem to intervene sometimes and not others? Is there an actual cut-off point? I doubt that we will know this side of eternity.

So how are we to apply this to our lives?

Garry Friesen, in *Decision Making and the Will of God* states:

> *"The Bible must be understood according to the original intent of the author when he wrote to the original readers. In other words, it must be interpreted historically and grammatically as it was originally intended to be understood. To twist the original meaning of the text in an attempt to discover God's individual will for me is a misuse of Scripture and will prove to be misleading."*

Here are Friesen's basic principles on knowing and doing the will of God:

1. Where God commands, we must obey.
2. Where there is no command, God gives us freedom (and responsibility) to choose.
3. Where there is no command, God gives us wisdom to choose.
4. When we have chosen what is moral and wise, we must trust the sovereign God to work all the details together for good.

On a practical note, it is handy to have some strategies to assist in making wise decisions. This checklist is helpful… (*The Decision-Making Process*, thebalancecareers.com)

1. Define the problem, challenge, or opportunity.
2. Generate an array of possible solutions or responses.
3. Evaluate the benefits, or pros and cons, associated with each option.
4. Select a solution or response.
5. Implement the option chosen.
6. Assess the impact of the decision and modify the course of action as needed.

Also, take a look at the Black Dog Institute's *Structured Problem Solving* decision-making plan.

- Don't make narrative normative, i.e. in choosing a marriage partner, don't ask for God to cause a specific person to come to a well and water your camels! Also, don't count on a fleece!
- Beware of choosing verses to support your argument, especially if this is outside of the moral will of God, logic and advice from trusted friends.
- Seek wisdom and knowledge from Scripture.
- Be prepared to challenge your views in the light of further study, personal growth and reflection and alter your path if appropriate. A person can only make decisions based on the best knowledge available at the time and stage of growth.
- Rejoice that God allows trust in the relationship with Him. We are developing an eternally-long relationship with our Father. Godly children can be trusted!

All of the above can seem very cognitive and prescriptive, lacking in joy and a sense of intimacy with God. So, as a contrast to the more prescriptive writing of Gary Friesen, whose tome on the topic is huge, Dallas Willard encouragingly writes:

> *"The ideal for divine guidance is finally determined by who God is, and who we are, and what a personal relationship between ourselves and God should be like. Failure of competence in dealing with divine guidance has its deepest root in a failure to understand, accept and grow into a conversational relationship with God: that sort of relationship suited to friends who are mature personalities in a shared enterprise, no matter how different they may be in other aspects.*
>
> *It is within such a relationship that our Lord surely intends us to have, and readily to recognise, His voice speaking in our hearts as occasion demands. I believe that He has made ample provision for this in order to fulfill His mission as the Good Shepherd, which is to bring us life and life more abundantly. The abundance of life comes in following Him, and "the sheep follow him; for they know his voice"* (John 10:4)
>
> (Dallas Willard *In Search of Guidance*, pp. 26-27)

I think that this is a most uplifting note on which to close. Ultimately, it is our relationship with our Father through Christ and our response to His love by obedience to Him, that allows us to delight and trust in His will.

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Prof Anthony Radford
Anthony has been a long-time member and was formerly national chairman of CMDFA and an international vice-president of ICMDA.

Treatise on Health

This article arises from Anthony's extensive expertise around the globe encompassing health work in many cultures. He proposes a new definition of the multifaceted concept of HEALTH and seeks a greater understanding of the inter-related environments that determine the health status of individuals and groups.

***Health* like *love* and *pain* are difficult to define but that makes them no less real.** *Health* comes from the Old English word *hal* or *hale* meaning 'whole'. *Health* (Anglo-Saxon) is the condition of being safe, sound and whole. It is the same concept of health that is encapsulated in the Hebrew word, *Shalom*. This adds a special dimension in a religious context to the question; 'Would you prefer to be cured' or 'made whole' (Mark 2:8-12). The People's Charter of Health sets out health with a secular perspective as a 'social, economic and political issue and above all a fundamental human right'.

There are many definitions and perceptions of *health* that have been proposed over the past 2500 years, probably longer. Undoubtedly the most well-known of these is that put forward by the World Health Organisation (WHO) in 1946-7, namely, that

> 'Health *is a state of complete mental, physical and social well-being, and not merely the absence of disease and infirmity'.*

A potpourri of definitions of Health:

> *...a condition or quality of the human organism which expresses adequate functioning under given genetic and environmental conditions. (WHO, 1957)*

> *...that state of moral, mental and physical well-being which enables a person to face any crisis in life with the utmost grace and facility. (Pericles, C5 BC)*

> *...the state in which the individual is able to mobilise his or her resources – intellectual, emotional and physical – for optimum daily living. Encyclopaedia of Educational Research, National Education Association, (USA)*

> *...that quality resulting from the total functioning of the individual that empowers him to achieve a personally satisfying and socially useful self. (E B Johns, source unknown)*

> *...not a state, but a potentiality – the ability of an individual or social group to modify himself or itself continually, not only in order to function better in the present but also to prepare for the future.*

> *...physical, intellectual and emotional performance which is acceptable to the individual or to society. (Maddocks I & Maddocks D, 1978)*

> *...wholeness – it is the complete integration and perfect functioning of body and mind maintained throughout every phase of activity. (Maharishi Mahesh Yogi)*

> *Whatever is eaten, unless there is rice, there is no life in the body.*

> *...assured more by an orderly life and wise behaviour at the table than by those boxes with long, beautiful and mysterious names in the shops of the apothecaries. (Francesco Redi, born 1926)*

> *...a positive state of being able to do the things they enjoy, and participate in meaningful social relationships. (Baxter M 1991 in Labonte R. International Perspectives on Healthy Communities.)*

Health is the power to live a full adult living life in contact with what I love – the earth and the wonder thereof – the sea, the sun – I want to be all that I am capable of becoming. (Katherine Mansfield quoted by Rene Dubois.)

Health designates a process of adaptation. It is not the result of instinct, but an autonomous yet culturally-shaped reaction to socially created reality. It designates an ability to adapt to changing environments, to growing up and to ageing, to healing when damaged, to suffering and peaceful expectation of death.

Health embraces the future as, and therefore includes anguish and inner resources to live with it. (Ivan Illich, Medical Nemesis).

Health as a normal condition of the body does not mean absence of disturbance but rather an effective bodily reaction toward them which continuously re-establishes the precarious equilibrium between different physiological functions. (H.P. Drietzel).

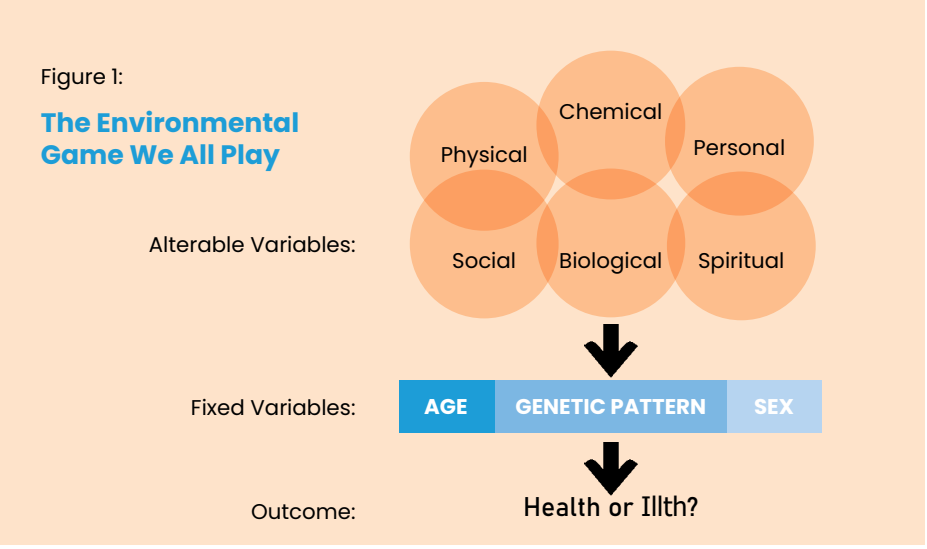
Health is the natural order of things and a positive attitude to which men [and women] are entitled if they govern their lives wisely. (Rene Dubos, 1959)

The original 1947 WHO definition was very restricted, and expresses a kind of utopian wish, perhaps coming so soon after the Second World War. As expressed, almost none of us ever achieve such a state and therefore the definition has very limited use. For example, an amputee who has adjusted to his or her state can certainly be 'healthy', even if they have a persisting disability or handicap. Similarly, a community can be said to be healthy with minimal but adequate material resources, such as some of the Pacific islands.

Two important dimensions in considering a definition of 'health' include, firstly, the level of containment or control of any pathological process such as hypertension or diabetes, or level of rehabilitation of an injury, such as that following an amputation and, secondly, how well the individual or group relates to those conditions.

Figure 1:

The Environmental Game We All Play



Much less well known is **the revised WHO definition** put forward a decade later, and which added the importance of environmental conditions in determining health status. The original WHO definition may have been based on that put forward by the Greek philosopher Pericles in the 5th century BC, but Pericles specifically identifies that effective functioning **with ease** is an essential component of good health.

WHO again revised its definition in 1998, at last recognising the importance of the 'spiritual' component which was incorporated into the 1947 version. This recognises that the patient or their community recognises a spiritual dimension to their lives irrespective of what their health professionals and the society around them believes. And I would add that failure to take this into account may fail to provide the template required for their best pathway of care.

I have developed a new definition of health which identifies its major components, and which can be considered from both an individual and a group or community perspective

HEALTH is the level to which, as individuals and groups, we can adapt to and live in harmony with, the inter-related spiritual, mental (or personal), social, physical, chemical and biological environments, in which we live, work and recreate, without disease and without dis-ease. (Radford 1979).

This definition can be illustrated (Figure 1).

Various societies and cultures may have very different perspectives on what are the criteria for a healthy individual or community. This is illustrated in the following table.

Table 1

HAWAIIAN	WESTERN
Love of the people for the land	Primacy of the self: reproduction of profit
Interdependence of people and nature	Domination of humans over nature
Protection of nature	Exploitation of nature
Sacredness of nature	Instrumental view of nature
Conservation of nature	Endless consumption of natural resources
Respect for the inherent value of each living (and non-living) object	Modification of nature by man for profit
Use and sharing among people of all resources	Individual ownership and individual benefit
'Ohana' (extended family, the collective) as central	Individual as central
'Laulima': cooperation among people; working together in harmony	Competition: class against class, individual against individual
'Lokani': unity	Conflict, class antagonism
Polygamy	Monogamy

Source: E Ola Mau. The Native Hawaiian Health Needs Study, *Hawaii: Alu Like Inc., 1985*

In summary, the present western-based health delivery practices are predicated on the values of secular-definition, specialisation, and individualism. This is often in opposition to many communities whose values are more holistic, familial, and spiritually embraced (Look, M. et al. *Pacific & Health Dialog*, 5(2): 296, 1998).

The following photograph illustrates the social significance of conditions such as head lice, which in some communities of Papua New Guinea and of Australian Aborigines is not necessarily regarded as an illness.

Photo: A J Radford

Illness and Disease

There are also numerous definitions of illness and disease that are often as imprecise as those of health.

> *An ILLNESS is a state of the organisation that fulfills the requirements of an appropriate reference group for admission to the sick (and sometimes other, e.g. criminal), role. It is not, per se, sickness. (An appropriate reference group is the social group most able, most willing or both, to underwrite the social cost of the sick role). (I Pilowsky, Adelaide). See also Maddocks & Maddocks definition of health above.*

> *SICKNESS has been found to be a relative state [and like 'health'] capable of almost infinite interpretation by both potential patients and the medical profession. (M. Cooper in M Perlman, The Economics of Health and Medical Care, 1974, p.105)*

> *A DISEASE is a series of clinical appearances found in association with special morbid anatomical, biochemical and physiological findings, but presents us with the dilemma of 'at what point in a continuously variable parameter do we leave normality and pass to abnormality'? (H Dudley, 1969) For example, when does blood pressure become high enough to be labelled hypertension?*

Figure 2 is a summary.

The above is very much 'a medical model' of disease that does not address the issues of 'social lesions'. In its concentration on the political determinants of health the People's Charter for Health identifies 'inequality, poverty, exploitation, violence and injustice' as the root causes of ill health and death, especially for the poor and marginalised.

The International People's Movement for Health believes that globalisation and war are currently the major social determinants of ill health. For example, UNICEF identifies that over half a million children deaths resulted from the sanctions imposed on Iraq after the Gulf War in the 1990s.

HEALTH is not something one does or does not have.

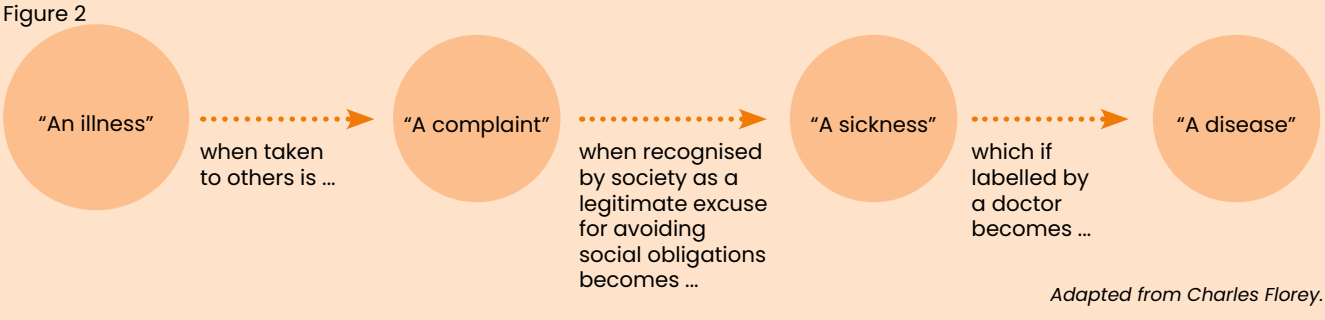
- **Health is a level**, that is, it is a state that may change from day to day or month by month. It is not something of which you have 'all' or 'none'. It is a dynamic or changing state. You may be very healthy today, able to function well and with joy, but tomorrow you may develop pneumonia, or exhibit tinea or schizophrenia, or feel depressed. The same may be true of your family, workplace or community. An individual may be 'healthy' but their family, church, soccer team or community may be quite 'unwell'.

- **Health relates both to individuals and to groups.** And the level of health exhibited by one person may well affect the level of health of others, either positively or negatively.

We all belong to several groups: family, office, football team, church or religion, class, bingo club, village and city, even nation. Any of these groups may be dysfunctional – 'unhealthy'. Clearly, if the family is functioning well, the individuals in it are much more likely to feel good about life and themselves, and conversely, if the family is dysfunctional then that is more likely to alter the state of health of its individual members. During the 1990s there was a strong movement which extended this concept to addressing the issue of 'Healthy Cities' and later 'Healthy Islands'. And if one can have healthy cities, nations and islands you can have unhealthy ones, for example, the social ill-health on Pitcairn Island, the unhealthy Nauru Islanders with their very high level of Type 2 diabetes, or Scotland and its level of ischaemic heart disease compared with other western nations.

- **Health is fundamentally about adaptation.** Health status is the outcome of a number of stresses to which the human organism or group is subject; from conception

Figure 2



Adapted from Charles Florey.

to consolation (death). How well we adapt to these stresses determines our level of health. This will depend in part on the level of stress and its rate of change and our capacity to adapt to it.

- **Health presupposes some level of harmony or contentment**, expressed so well by Pericles in his definition quoted above. Health is not a matter of mere existence.

- **Health is essentially environmentally determined.** There are at least six readily identifiable categories of environment – spiritual, mental (or personal), social, physical, chemical and biological. These environments are variously inter-related with each other in the expression of any illness or disease state. Each of these six environments can be further subdivided into a number of component parts, which are also variously inter-related. See below.

- Health relates to what we **do** – living, working or in recreation.

- By comparison, ill health expresses itself in either **disease or dis-ease.**

These six inter-related environments can almost all be changed, either by the action of an individual, or by society or its groups e.g. by consensus, by committee or by law or lore. For example, by personal or group consensus or committee decisions, or it may be enshrined in legislation such as tobacco, food and road safety issues. The age, sex and hereditary components of the biological environment, while discrete variables, are virtually unalterable, and all the other components impinge on them in an interactive manner.

The outcome of these interactions determines whether we are *'healthy'* or *'illthy'*.

For example,

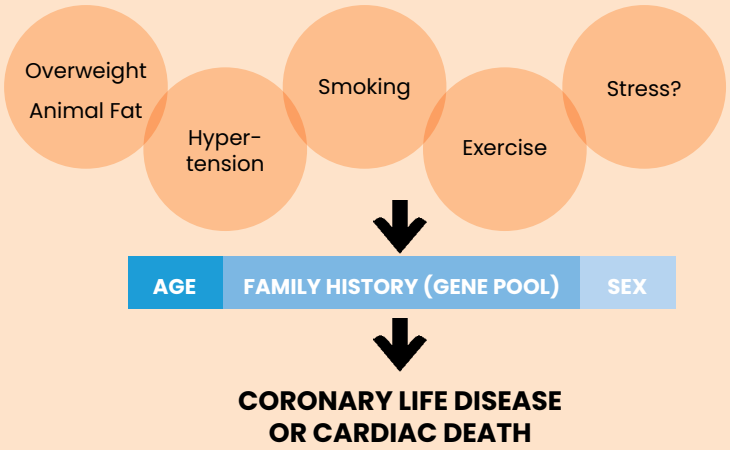
- what I eat, drink and breathe,

- whether or not I am able to control any other disease variables associated with, say, heart conditions, such as high blood pressure and diabetes, levels of blood fats, and

- whether or not I exercise, smoke or can successfully adapt to the level of stress to which I am subjected, whether I have a family history of high cholesterol, and certain gene patterns know to be associated with ill health.

- all influence whether or not I have a coronary life disease or a cardiac death.

Figure 3

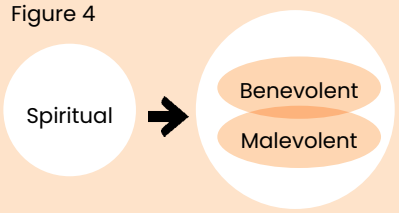


These factors interacting may have more influence on my 'heart health' than the fact that I am a middle-aged male with a family history of heart disease, even though all of the above factors are risk factors per se for heart disease. Figure 3 illustrates this.

Let us look in more detail at these inter-related environments that determine our health status.

The spiritual environment

Figure 4



D'Souza (2001) says that "spirituality is the generator that sources the energy within and enables a person to search for meaning through connections with the environment and in relationships. It represents 'a dialogue within ourselves' through which we weigh up the meaning of our life – visible and invisible – past, present and future."

Most people believe in the power of the spiritual world to influence in some way the state of health of individuals or groups. WHO now recognises that most, probably all, cultures have a set of spiritual beliefs held by a varying proportion of their populations.

Spirit worlds may have both 'good' and 'bad' dimensions. For example, to Christians the Holy Spirit empowers the work of God for good and Satan with all his spirits, seeks to throw chaos into the world.

'Every Christian would agree that a man's spiritual health is exactly equivalent to his love for God' (C.S. Lewis, *The Four Loves*, Collins, 1960, p.8).

To the animist, there are also good and bad spirits – of fertility and the forest, gardens, rivers and fields. It is believed that *Health* exists when there is joyful conforming to the will of God and 'binding' Satan in the case of the former, and successfully placating or appeasing those of the latter groups.

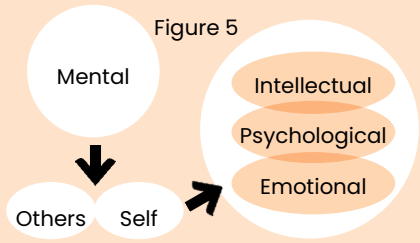
Irrespective of their own belief system, health care workers working in a culture or subculture different from their own, need to gain an understanding of the spiritual world of the communities in which they work, and the ways they believe it may influence their lives.

Their beliefs may significantly determine whether or not they will

seek care (e.g. abortion), comply with advice (e.g. control smoking or drinking), or undertake medication (e.g. immunisation) or surgery (e.g. Jehovah's Witnesses).

The mental (or personal) environment

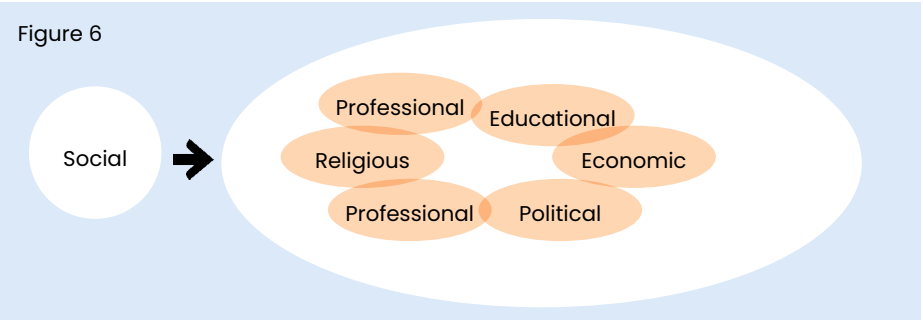
Figure 5



This environment relates to how I feel about myself and others – our relationships. Its components include the psychological and emotional states which interact with each other, and with our state of being: for example, the level of tiredness; or hormonal state – pre-menstrual, pregnancy, menopause; employment status; family harmony and so on. And here we can identify the potential influence of the biological and social environments on the mental one.

The social environment is perhaps the most important category when considering health services and their effect on health status, both of groups and individuals.

Figure 6



Like other environments, the social environment has a very complex and interactive set of component parts.

Example 1. Whether an individual or community uses technologies for child spacing depends firstly on their knowledge of methods and their capacity to access or purchase the method of their choice. The availability of the technologies relates not only to knowledge and cost but also to religious beliefs, political legislation and professional attitudes (and skills, for example, ability to perform a sterilisation procedure), local customs and beliefs.

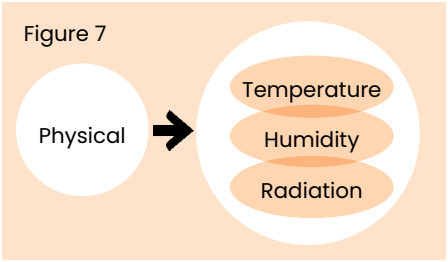
Example 2. Whether or not an individual smokes relates not only to availability of tobacco products, but also to the consequences – cost, political constraints such as tax, advertising, laws regulating use in public places, wages, efforts to influence our choice by health professionals, peer pressure, family environment and so on.

The potential interaction of these first three 'environments' and their relationship to health status is well demonstrated in the perception of ill-health of much of the developing world. Professor Ogunlesi of Nigeria stated many believe that ill-health is related to a 'disturbance of relationships between individuals or groups, or between an individual or groups and the supernatural'. Increasingly in industrial societies, we are recognising that disturbances in relationships are a major factor in the incidence and prevalence of illness, both mental and physical (e.g. depression, RSI, PTSD).

Example 3. Poverty of itself is not an absolute correlate with ill-health, for example, of Cuba and the state of Kerala in India, both of whose populations are very poor. However, both have high levels of education and a political system which promotes equity of access to services such as health and education. Kerala, although one of the poorest states of India has one of the highest standards of education and best set of health indicators – it is also the most communist and holds the highest proportion of Christians!

The physical environment

Figure 7

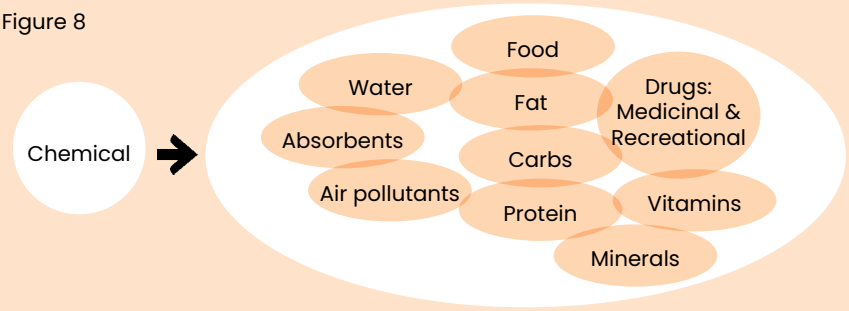


The effects of temperature: burns (water, steam, sun, frost, and electricity) and radiation (cataracts, skin and other cancers) are obvious. Interactive with the physical environment and many skin cancers is the genetic component of the biological environment, comparing white and dark-skinned races and family genotypes. Less obvious are those influences resulting from high barometric pressure: the bends in divers and low pressure: altitude sickness in mountain climbers. Adaptation has a major role in the expression or otherwise in many of these conditions (e.g. the story of frog and its response to water of different temperatures)

The chemical environment

The chemical environment includes what we eat, drink, inhale, and absorb through the skin. Fluids may contain elements

Figure 8

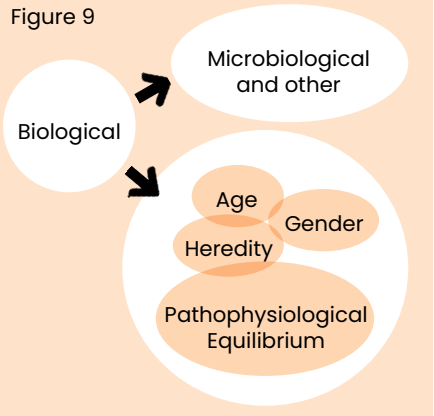


positive for health, such as adequate but not excessive levels of fluoride, low levels of alcohol and iodine, or negative ones including toxins such as arsenic, mercury, alcohol or lead.

Our food has many items such as water, vitamins, protein, fats and carbohydrates as well as essential elements such as iodine and iron. A correct balance is essential for health, while deficiency and excess can both cause disease, e.g. Vitamin A. Similarly, our diet may contain potential elements that can damage health e.g. high saturated fat or low fibre intake.

The biological environment has two major subgroups: the external and internal.

Figure 9



The **external environment** includes organisms which may cause illness (such as viruses, bacteria and protozoa), the animals which can inflict injury (such as crocodiles and snakes) or transmit illness, such as mosquitoes and parasitised sheep, pork, prawns and fish.

The **internal biological environment** has three components, which we cannot change, namely, age, heredity (well, almost!) and gender (though some try), but also consists of our immunological state (due to gene patterns, immunisation, previous disease and nutritional status), current medication and to various pathophysiological conditions that we may have, such as diabetes or hypertension.

These internal and external states interact with each other and with other environments. For example, if you have had designer influenza immunisation (a chemical), you will probably be immune (internal environment) from this year's flu virus strain (external biological environment). If you do not know about influenza vaccine or cannot afford it, or the government does not supply it (education and economic and political components of the social environment), then your health is at risk, as is that of the rest of the community, as the level of population (herd) immunity will be reduced with low immunisation coverage, thereby increasing the risk of disease and death to others, especially the very young, elderly people and those who are immuno-compromised.

Let us look at the cultural aspect of the Social Environment in a little more detail.

Each society has differing beliefs which may be positive or negative with respect to health. They may be related to anthropological or sociological factors, which in turn may be derived from the dominant culture, one of its minority cultures, or from any of the subcultures within them (eg social behaviour of some bikie and age-specific groups. Perceptions of health and illness are a major issue when it comes to advocating beneficial behaviour change to an individual (such as encouraging exercise or wearing a crash helmet or seatbelt) and to minimise risk of a behaviour (such as weanling diets). Perceptions are also important when encouraging a population to access health services and adopting health behaviours likely to improve or reduce health status.

Time is an important factor in changing health behaviours in groups (e.g. smoking, cost). The whole area of consequences and benefits may be important.

Examples include criteria for seeking or not seeking care, such as the age, gender or ethnic or social group of the health worker and their attitude to traditional healers or complementary medicine or beliefs by individuals or groups regarding the capacity of the health service to manage a particular condition such as goitre or cataracts, or the value of alternative or complementary medicine. Smoking or not smoking, or the chewing of betel nut or eating a particular food may be forbidden by either a religion or group pressure, and societal norms may be formulated by legislation (e.g. vitamin-

enriched foodstuffs). For example, among Adventist, Muslim, or Jewish groups, there is no incidence of pork-related diseases such as *Taenia solium* or trichinosis. In countries where there is a high level of education, this can be used to influence legislation aimed, for example, at tobacco and iodine-related diseases, fluoride in toothpaste and traffic injuries and use of helmets or seatbelts as evidenced by the falling incidence of the prevalence of tobacco-related diseases. Motor vehicle accidents and those with iodine deficiency have been reduced. Varying eating patterns in one cultural group such as fat intake may result in marked differences in disease such as in the gradient of ischaemic heart disease incidence among the Japanese in Japan, Hawaii and California.

Such changes are not exclusively related to the use or non-use of a particular aetiological agent such as tobacco or fatty foods, but may include changing the coverage of a preventive measure such as exercise or immunisation. Change may also be the result of participation rates such as in screening for diabetes or hypertension followed by the use of effective and acceptable remedies such as hypertensives for high blood pressure. Many of these interventions may be multiple and interactive, such as those which have contributed to the decline in ischaemic heart diseases and stroke incidence rates in industrialised countries.

Cultural patterns which are positive for health can be used by health workers to encourage other healthy behaviours such as breast-feeding, or ensure that there are female health workers as well as male in Muslim societies. Where foreign health workers are used, such preclusions for attendance may be acceptable. Behaviours may also be bad for health and need to be discouraged. Some examples of such behaviours would include female circumcision, rubbing dirt on the birth cord stump, and the prohibition of certain nutritious foods especially for women and children.

With respect to its health value, any particular behaviour or custom may be:

i) **good:** such as breast feeding and care of the elderly.
ii) **bad:** such as rubbing dirt or dung on the birth cord stump, or smoking cigarettes.
iii) **neither good nor bad:** such as pre-chewing food for babies, the gypsy custom of placing an onion in a sock to treat fevers or wearing a copper bangle to help arthritis.
iv) **both good and bad:** for example, low and excess alcohol use.
v) **not known.**

Those that can be identified as 'neither good nor bad' may be so only while the wearer is not compromised. For example, the lucky charms or talismans that are common in many cultures and usually worn around the neck may be harmless in themselves, but are not so if they delay seeking care for significant conditions. The charm needles or *susuks* of Malays are inserted subcutaneously into the face and chest. They may or may not have a spiritual significance. Copper and other types of bracelets to ward off arthritis also fall into this category.

The good can be used to affirm a cultural trait that is good for health such as breastfeeding and used as a basis for changing those behaviours that are detrimental for health. We can observe those behaviours whose value we don't know until we can place them in another category. For 'foreign' health care workers, it is a good idea to establish a file of different health behaviours, to which you can refer in developing new programs, and leave as a record so that the person who follows does not have to start again from the beginning.

Failure to pass on acquired knowledge may have undesirable health outcomes. In the Oro Province of Papua New Guinea, people believe that the milky sap from the skin of the pawpaw (papaya) that irritates the human skin is the cause of scabies. Without knowing about this local belief, foreign public health nurses working in the area, tried to encourage the use of pawpaw as a weaning food because of its high content of vitamins A and C. The mothers attending the clinics admonished their daughters, who were used as interpreter nurse aides, 'You know papaya causes scabies, maybe the other stories you are telling us are equally stupid!'

Thus, health is a multidimensional concept which can be influenced both positively and negatively in the incidence and prevalence of disease. The health worker, the community and politicians need to develop an understanding of how the many components of the environment can be changed to improve the health and quality of life of individuals and groups.

Looking back through some old papers I came across the following which a student produced in a class exercise exploring definitions of health at a YWAM School of Primary Health Care in Perth in 2000. I think it is the most succinct description of health I have found. *"Health is the expression in body, mind, and spirit as God meant us to be."*

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Extended Biography:
Emeritus Professor Anthony J Radford AM completed undergraduate training in Adelaide in 1969 and postgraduate study at the Universities of Liverpool, Edinburgh and Harvard.

He has undertaken health work in 45 countries working with WHO, UNICEF, the World Bank, World Vision International and numerous NGOs in areas of Primary Health Care, especially in Maternal and Child Health. His also worked as a rural locum GP in remote and isolated South Australia. He has two autobiographies, namely *Singsings, Sutures and Sorcery* and *Have Stethoscope, Will Travel.*

He has been a long-time member and formerly national president of CMDFA and an international vice-president of ICMDA.

Dr Monique Peris
Monique is a General Paediatric Advanced Trainee working in Melbourne, Victoria. She completed her medical training in NSW, joining the CMDFA community in her first year of medical school in 2007 through Transfusion camp.

Teamwork

"I am not looking forward to today."
"Why?"
"X is on today, you know what they're like."
"Yeah, I was on with them last week. Nightmare. I thought about saying something but what's the point?"

Have you ever been in a conversation similar to this one? Most people can relate to a situation where they have worked with a difficult person or team. In the strange and uncertain times of the COVID-19 pandemic, unspoken tensions are more likely to surface.

Just as illness stems from a part of the body not functioning properly, so medical teams can become less functional if there are issues within the team.

> *"Even so, the body is not made up of one part but of many. Now if the foot should say, "Because I am not a hand, I do not belong to the body," it would not for that reason stop being part of the body. And if the ear should say, "Because I am not an eye, I do not belong to the body," it would not for that reason stop being part of the body. If the whole body were an eye, where would the sense of hearing be? If the whole body were an ear, where would the sense of smell be? But in fact God has placed the parts in the body, every one of them, just as he wanted them to be. If they were all one part, where would the body be? As it is, there are many parts, but one body."* 2 Corinthians 12:14-20

Just as tension between parents can influence children, so dysfunction between team leaders and senior clinicians affect junior medical staff. Just as we diagnose and manage the illnesses of our patients, we need to recognise and address the behaviours that may cause injury to our teams, and ultimately compromise the care of patients.

So, as Christians in our workplaces, what can we do? Here are a few questions to ask yourself when reflecting on the situation.

> ***"We need to recognise and address the behaviours that may cause injury to our teams."***

Have you prayed?

The Bible is very clear about praying for our enemies. This isn't excusing the behaviour, but bringing it and the person before God and allowing Him to give you His wisdom and strength for the situation.

> *"You have heard that it was said, 'Love your neighbour and hate your enemy.' But I tell you, love your enemies and pray for those who persecute you, that you may be children of your Father in heaven. He causes his sun to rise on the evil and the good, and sends rain on the righteous and the unrighteous. If you love those who love you, what reward will you get? Are not even the tax collectors doing that? And if you greet only your own people, what are you doing more than others? Do not even pagans do that? Be perfect, therefore, as your heavenly Father is perfect."* Matthew 5:43:48

Working with a difficult team member can take its toll. Know that Christ came to set us free, which includes not feeling oppressed or dominated in this life.

"Jesus returned to Galilee in the power of the Spirit, and news about him spread through the whole countryside. He was teaching in their synagogues, and everyone praised him.

He went to Nazareth, where he had been brought up, and on the Sabbath day he went into the synagogue, as was his custom. He stood up to read, and the scroll of the prophet Isaiah was handed to him. Unrolling it, he found the place where it is written:

"The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free, to proclaim the year of the Lord's favour."

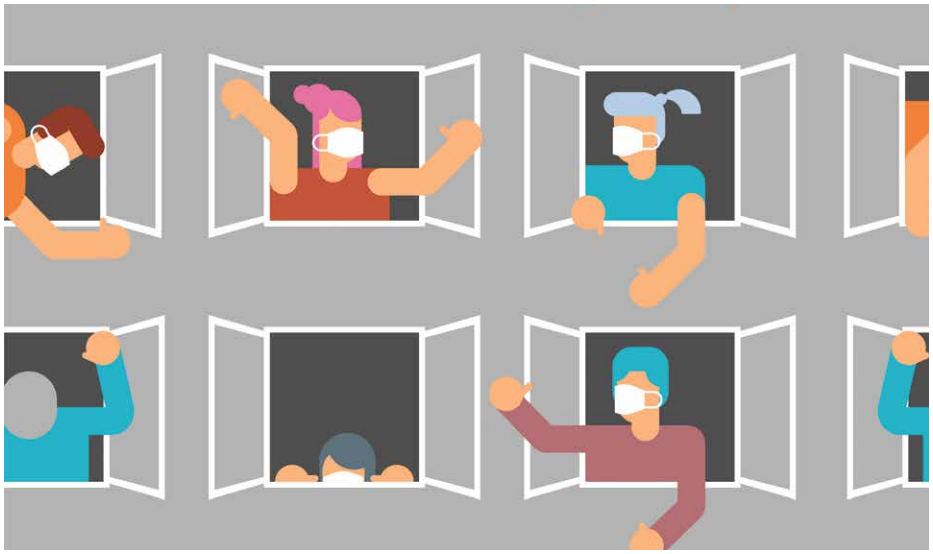
Then he rolled up the scroll, gave it back to the attendant and sat down. The eyes of everyone in the synagogue were fastened on him. He began by saying to them, "Today this scripture is fulfilled in your hearing." Luke 4:14-20

Remembering that Jesus is the ultimate Saviour, setting the oppressed free brings a heavenly perspective to the situation.

Is it one person or a culture?

Cultural shifts can be as difficult as managing one person. Often once battle lines are drawn and sides are chosen it can be difficult for a group to see what started the divide in the first place. The first point is to recognise that the team *has* become dysfunctional. This may be evidenced by subtle indicators such as lateness to important meetings or increased sick days. At other times, it may become obvious through clear disagreement in regards to patients and differences in opinion regarding management.

External processing or "venting" is a way of processing a situation with the aim of coming to a solution. It is a recognised form of mental processing. The problem develops when the instances of venting do not reach a solution endpoint. It then



may become a vicious cycle that can ultimately infect a team and further isolate the person or persons involved. If this occurs it is often a sign that conflict resolution needs to take place. One way to move forward is to consider a third party mediator - just as couples may seek out a marriage counsellor, a third party may assist mediation in teams.

"Continue to acknowledge and respect the expertise of each individual in the team."

Is there a power differential?

In the work of medical training, there will be occasions where a person who was previously the junior then becomes the senior. This can cause contention amongst team members. Ultimately, it is important for team members who are now in the more junior position to recognise that the responsibility of the patient or decision is now on that person's shoulders. Also, it is important for the person in the new senior role to be sensitive to the power shift without feeling guilty for what they have achieved. It is helpful in moving forward to continue to acknowledge and respect the expertise of each individual in the team, just as they would have as a junior. Depending on the personalities involved, sometimes stating the obvious awkwardness is a good way of acknowledging that it exists.

Is there illness/burnout?

Staffing shortages seem to be an ongoing pattern in medicine that will continue if we don't look after the workforce we have. This starts with looking after each other. Sometimes we are so close to the problem, that we can't see the forest for the trees. Consider bringing in a third party such as a financial adviser who can crunch the numbers and review the number of patients to be seen and the ideal staffing. Present these findings in a structured way to your hospital review board or budget committee. You may want to encourage your staff to log the extra hours they are required to work so that there is evidence of the need. Working outside our means is ultimately not sustainable, and compromises our ability to care for ourselves and our patients.

As Christians, we all have a part to play in spreading the gospel and being the hands and feet of Jesus. We serve a God who will not leave us or forsake us and for whom no challenge is too great, no situation too difficult, no person he cannot reach.

"May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit." Romans 15:13

Ross Farley
Ross works for TEAR Australia as an educator and Bible teacher. He has decades of ministry experience with several organisations and churches. Ross has lectured in a number of theological colleges and training programs and is author of *Strategy for Youth Leaders*, *Following Jesus and Leading People* and *Strategy for Youth Leaders for the 21st Century*. He is co-author of *Incite, Making a World of Difference*. Ross is a graduate of the Brisbane School of Theology.

Poverty: It's Not What You Think

People once believed the world was flat until someone explained, "It's not what you think." Many Australians think they know what poverty is, but they misunderstand it. The Bible, however, points us in the right direction.

Poverty in Psalms 10 and 12

In Psalm 12:5 David wrote, "'Because the poor are plundered and the needy groan, I will now arise," says the Lord. "I will protect them from those who malign them."' Psalm 10 observes how powerful people trample the poor.[1] These psalms describe poverty and challenge common perceptions. They don't focus on 'stuff'. When Australians describe poverty, they focus on what poor people don't have. These psalms focus on how the poor are treated. The poor are powerless and lose out to the more powerful. The poor are not poor in isolation but other people contribute to their poverty, intentionally or unintentionally.

The poor are described as: hunted (Ps 10:2, 9); victims of greedy schemes (10:2, 3); lied about and threatened (10:7); victimised and ambushed (10:8); helpless, crushed, disempowered, afflicted and oppressed (10:9, 10, 12, 14, 17); trapped in relationships that don't work or that disadvantage them (10:7-10); needy, plundered and groaning (Ps 12:5, 7)

Those who oppress the weak are described as: arrogant and scheming (10:2), boastful and greedy (10:3), proud (10:4), liars (10:7). They think they are invincible (10:6) and unaccountable (10:11, 13). They have no regard for God and don't believe that God will call them to account. They think they are superior to others and entitled to behave this way.

There are many causes of poverty. The Bible teaches that some are poor because they are foolish (Proverbs 22:26) or lazy (Proverbs 10:4). However, when whole people groups live in poverty for generations, the issues in Psalm 10 are probably involved; greed, lies and oppression lurk in the background. The causes of poverty are spiritual and moral, not just economic.

> ***"When Australians describe poverty, they focus on what poor people don't have. These psalms focus on how the poor are treated."***

Perceptions of poverty in the developed world[2]

Our modern understanding of poverty emerged in the aftermath of World War II. Much of Europe had been destroyed but had been rebuilt and was progressing. The idea developed that, what we did for Europe, we can do for the developing world. Poverty became seen as not having enough stuff and the solution as giving people 'stuff'. However, this 'solution' did not produce the same results as it had done in post-war Europe. The developing world saw significant improvements but many serious problems still remained, and some countries received considerable aid yet nevertheless got worse.[3]

A turning point came in the 1990s, when research conducted by the World Bank, called *Voices of the Poor*, asked the poor themselves to define poverty. Over 60,000 of the world's poorest people were surveyed with surprising results. The World Bank found that "while the poor mention having a lack of material things, they

tend to describe their condition far more in psychological and social terms. Poor people typically talk in terms of shame, inferiority, powerlessness, humiliation, fear, hopelessness, depression, social isolation and voicelessness."[4]

The poor were less concerned about 'stuff' but were much more concerned with how they were treated. When the poor were asked to describe poverty, they raised the same issues that David wrote about in Psalm 10. Poverty is not about 'stuff' but powerlessness.

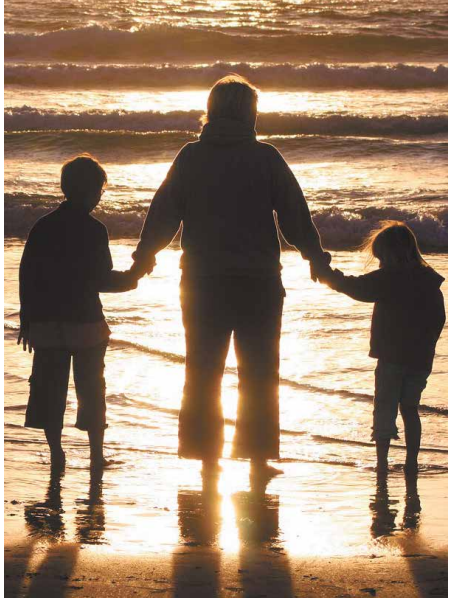
What is poverty?

There are two basic views:[5]

Poverty as deficit: the Twentieth Century view.

This view sees poverty as 'stuff that's missing'. The poor don't have enough food or access to safe water, schools, health care, etc. Of course, this is true as far as it goes: the poor don't have these things and people need them. However, this confuses the symptoms with the disease. Measles comes with spots, but the spots are symptoms, not the disease itself. So, yes, the poor lack 'stuff' but that is a symptom. We need to ask, 'Why don't the poor have the stuff they need?' The answers to that question will vary but they will include the sorts of things David wrote about in Psalm 10 (see above). Responses that don't address those underlying causes are inadequate. That is true in Australia. There are good reasons why some Australians are poor: family breakdown, death of the breadwinner, unemployment, etc. You can give people 'stuff' as a response, but unless the reasons behind the poverty are addressed, those people will soon be in the same position again. The same is also true in developing countries.

Furthermore, if we see poverty as the absence of 'stuff', and offer as a solution provision of what is missing, we reduce the poor to being passive recipients. This demeans and devalues the poor, who we then see not as being in the image of God but rather being defective and inadequate. Sadly, a view of the poor as being deficient can easily become their view of themselves. On the flip side, we will then see ourselves



as superior: perhaps even as saviours, who save the poor with *our* 'stuff'. This, in turn, promotes materialism and presents possessions as the solution to life's problems. It is an approach that promotes unbiblical views of the poor, us and material things.

Poverty as disempowerment: the recent and ancient view[6]

• **The poor are disempowered.** The poor don't have what they need because they lose out to more powerful people and lack recourse to justice.

The poor lack social power and are less able to resist unfair treatment by politicians, police, the courts, landowners and businesses. They become easy prey for companies, who take their land for logging, mining or whatever, and they are less likely to receive proper compensation or income. The poor are often excluded from community decision-making and their voices are not heard.

The powerful live on the best land and the powerless try to survive on the least-productive lands like flood plains, deserts or high-altitude mountains. As a result, they have less income, poorer nutrition and are more prone to disasters. The city poor often have to squat illegally on vacant land or under bridges and to live with the constant threat of eviction. All this leads to reduced physical strength and mental capacity due to poor health and hard labour. Physical weakness becomes both a cause and result of poverty, leading to further disempowerment.

> ***"Unless the reasons behind the poverty are addressed, those people will soon be in the same position again."***

• **The poverty of the poor is linked to the behaviour of the non-poor.**
Proverbs teaches that the poor can be exploited, crushed (22:22); oppressed (28:3); mocked (17:5); denied mercy (18:23); shunned and avoided (19:7). Psalm 10 and other scriptures teach that the non-poor significantly contribute to the poverty of the poor.

Many of the non-poor see themselves as superior and believe they are entitled to do what they like with the poor. Psalm 10 refers to the 'arrogance' and 'pride' of people like this. They have a sense of entitlement, believe they are anointed to rule and have the right to do to others what no one else must ever do to them. The poor are often oppressed by people with vested interests in maintaining low wages and other injustices.

Oppression evokes images of guns and armed militants, but it can also be the work of accountants, lawyers, company boards and political rulers. Such people use words and numbers rather than guns, but they can be just as destructive.

• **The instrument of disempowerment is deceit.**
There is an African tribe which believes that God has given all the cattle in the world to them.[7] They believe that cattle owned by other tribes must have been stolen at some point and that they are entitled to raid other tribes and steal cattle because all cattle are rightfully theirs. They have a sense of entitlement driven by a lie. This happens in the developed world as well as in Africa. In the debate around the Iraq war, someone is reported to have said, "Why did God put our oil under their sand?" Many in the West believe that they are

entitled to take the resources of other countries if they can get away with it.

Psalm 10:7 suggests that lies are used as an instrument of oppression by the proud. Ahab and Jezebel[8] wanted Naboth's vineyard, so they lied about Naboth. Naboth was tried and executed under false accusations, and Ahab took possession of his land. The legal system was used in combination with lies to make murder and stealing appear legitimate. Stealing someone's land is readily seen as unjust, but, if you first tell lies to depict such a person as unworthy of the land, you are much more likely to get away with it. Similarly, lies can be used to depict particular people as subhuman in order to justify making them slaves or to compel them to work for low wages in inhumane conditions.

Jesus was tried and executed on a case based on lies. The Jewish leaders constantly lied about Jesus. Jesus said, "You belong to your father, the devil - he is a liar and the father of lies." (John 8:44) There is something satanic about people who use lies to take others down for their own advantage. Poverty is not about stuff but powerlessness. Behind that, there is oppression legitimated by lies. Behind the lies are forces of evil.

• **The result is a marred identity.**
The idea of *karma* tells people that they deserve to be in their present condition because of their former lives. If they had lived better lives they would have been reincarnated into better circumstances. Many Asian poor believe this for themselves and think they have no right to education, social services, just employment or decent living conditions. In other contexts, white people tell blacks that they are inferior, and often black people believe that to be true.

In short, lies are used to disempower the poor and, after years and generations, the poor believe the lies. The poor no longer believe that they are created in the image of God: their identity is marred. Bryant Myers[9] wrote, "A lifetime of suffering, deception, and exclusion is internalised by the poor in a way that results in the poor no longer knowing who they truly are or the purpose for which

they were created. This is the deepest and most profound expression of poverty. The poor come to believe that they are, and were always meant to be, without value and without contribution."

The poor have a marred identity and a distorted sense of who they are. They don't know they are created in the image of God and precious in God's sight. They have believed lies about themselves and they need to know the truth. Poverty denies the love and justice of God and the image of God in human beings. Poverty is not just about 'stuff': these are moral and spiritual issues.

Responding to poverty

If poverty is disempowerment, the solution is empowerment. The goal is for people to earn all they need through their own efforts and not to be dependent on handouts. Little of that involves giving 'stuff'. In TEAR Australia projects, a lot of funds go to paying the local project staff to work with the poor in support, training and empowerment. People get 'stuff' but it is in the context of empowerment. For example, they might get goats but that is in the context of goat-rearing training, aimed at setting such people up in their own businesses. That changes the way the poor think of themselves. Empowerment heals the marred identity of the poor. Just giving them 'stuff' reinforces that they are deficient.

"Empowerment heals the marred identity of the poor. Just giving them 'stuff' reinforces that they are deficient."

I asked a group of project participants in Bangladesh how their lives had changed as a result of the project. They said very little about 'stuff', even though they had much more 'stuff' than they did before,[10] but they listed off over 20 ways in which their lives had been empowered. Then one man said: "We now have dignity". Their marred identity was being healed.

What can *we* do here?

- **Give.**
- **Advocate.** In the Psalms, David calls on powerful people to treat the poor differently and we can speak up on behalf of the poor.
- **Pray.** Psalms 10 and 12 are also prayers, where David calls on God to protect the poor and disempower those who oppress them. Only God can save from evil, so we need to pray.

References:

1. D.C. Fleming *The Old Testament Speaks.* Volume 5. Psalms. Page18.
2. Much of the information in Point 2 is taken from Bryant Myers, *Walking with the Poor.* Pages 26-32.
3. See publications like *When Helping Hurts, Dead Aid, and Toxic Charity.*
4. Steve Corbett and Brian Fikkert, *When Helping Hurts.* Page 53.
5. Bryant Myers outlines six views in pages 113-132 but this is reduced to two due to time constraints. Aspects of five of the views presented by Myers are captured in the second view, disempowerment.
6. This is developed by Myers in pages 123-132.
7. http://www.bluegecko.org/kenya/tribes/maasai/livestock.htm Also Steve Bradbury discovered this on TEAR project visits.
8. 1 Kings 21.
9. *Walking with the Poor*. Page 127.
10. They had all established their own businesses as well as received safe water, sanitation and food security as a result of that particular project.

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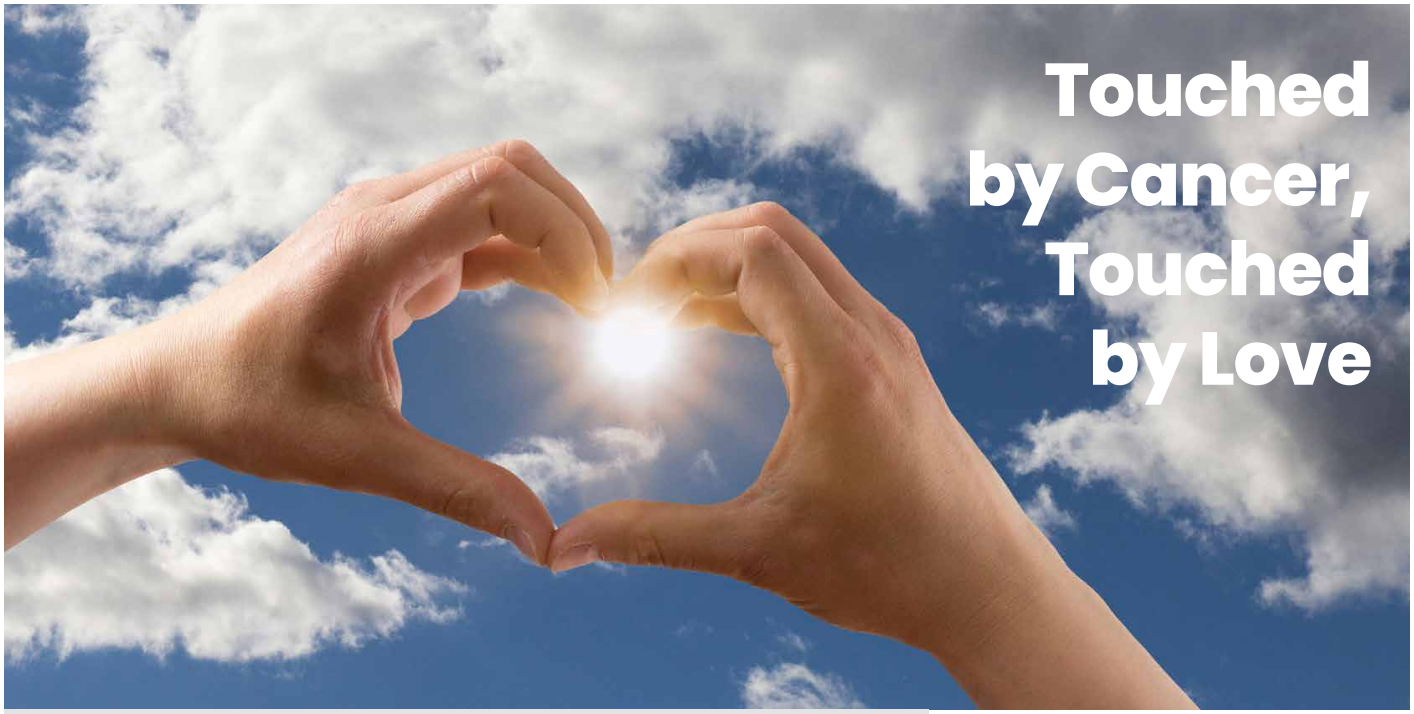
Dr Shazza
Dr Shazza is an RMO in Queensland



Touched by Cancer, Touched by Love

Dr Shazza is an RMO in Queensland. As a junior doctor who has faced their own health battles they have found the QHealth system very difficult terrain to navigate. As such they left their employment, feeling very much alone and nothing more than an employee number. They have, however, found great solace in writing. This is one such piece.

Dr Shazza has now moved to locuming, working when they're well enough and undergoing treatment when required. Their experience as a patient has certainly made them a much better doctor.

The world of patient care and medicine has been forever changed. Ironically, every corner of the globe has been 'touched' by a term now coined as 'touch starvation'. It goes against the grain of humanity. We are in essence 'herd creatures.' From the moment we hurtle screaming into the world, skin-to-skin contact is greatly encouraged. Yet COVID-19 has taught us to isolate, to be 'socially distant,' to avoid hugging or shaking hands. It is the complete antithesis of being human. As Health Professionals it is vital we realise the healing power of touch – even during a pandemic.

As a junior doctor I have found the void of touch an incredible hindrance to the level of patient care I can deliver. But as a Metavivor* I have also experienced first hand the impact COVID -19 has had on my own personal journey as a patient. So how do we 'survive' in times of loneliness and isolation? As practitioners how do we navigate this foreign landscape?

On a personal level my faith has been my rock. I hold fast to this promise: "'For I know the plans that I have for you', declares the Lord, 'plans...and a future.'" (Jeremiah 29:11). We may not understand why we are facing the challenges we face but trust we must. This is a small part of my story, written in 2019....

> ***"The bureau of statistics recently revealed the number of times someone craves a hug each day is thirteen."***

The Australian Bureau of Statistics recently revealed the number of times someone craves a hug each day is thirteen. Additionally, the time a hug lasts is three seconds. But interestingly the duration of a hug that can have medically healing properties lasts twenty seconds. The lesson: hug long and hug often.

I've always been a hugger. In fact, if 'professional hugger' was an occupation I'd be a strong candidate for the position.

Touch is a powerful anxiolytic. It dissipates any worries, frustrations or fears. It lets you know someone is there. It speaks volumes through silence. And best of all, it doesn't cost a damn thing. When words fail us, human touch can prevail.

If a loved one is sick it's sometimes hard to know what to do... what to say... what to ask... But from my experience, the greatest thing you can do for a loved one is nothing at all. Simply put - *just be*. Be present. Be in the moment. Be there.

You don't have to utter a single word. Instead a loving hug, the holding of their hand, simply touching their skin is enough. You are enough.

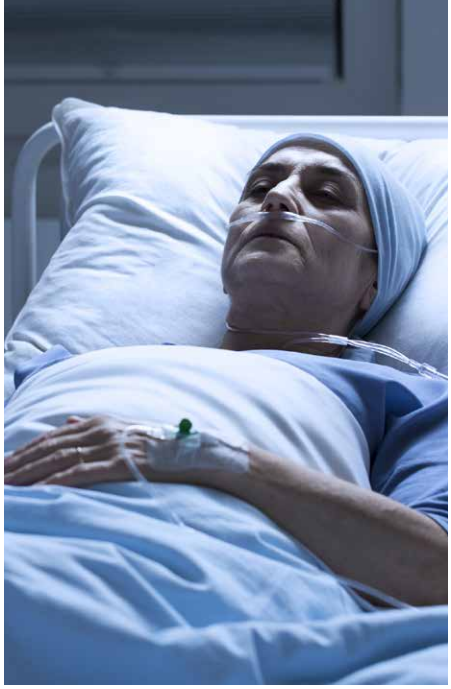
No present needed.
No trinkets wanted.
No flowers required.

Admittedly, everyone has their own language of love. But if there were to ever be a universal currency, then hugging would be like liquid gold.

There is something safe about a hug. I'm not sure if it's the warmth of the embrace, the pressure of the loving squeeze or simply the meeting of two heartbeats that makes them so therapeutic. But in that short space of time, suddenly everything feels OK.

When you're exposed to continual treatments, procedures and hospital admissions you quickly realise how "dehumanised" and "clinical" our healthcare system has become. You become known as the 'blood pressure of 190/110', the 'white cell count of 0.2' and the patient 'awaiting 1g of Ceftriaxone'. Sure, these numbers are important, but sometimes healthcare professionals get so focussed on the numbers they never really see the actual patient in front of them. It's cold. It's confronting and it could all be improved through compassion and the power of human touch.

I'm fortunate in that I have many friends who work in the system, and on the whole I've been treated with love and compassion. However, the greatest doctors and nurses I've come into contact with haven't focussed on the numbers but on the person. They don't give me a yellow jar to pee in, they give me a warm blanket instead. They give me a comforting cuddle before reaching for the complexion-flattering purple chemo gloves and apologise for actually having to wear them. They show a side of humanity that has long been lost in healthcare because of the demands and pressures of the industry. And these are the individuals who you remember because they managed to make your day a little brighter, your anxiety a little quieter and your tears a little drier.



Through the haze of illness I can recall several humbling moments where humanity was on its best display. One moment I will always treasure was when a friend decided to visit. I'd already cancelled on her multiple times and I was wracked with guilt to do it again. But I was feeling more curdled than a bottle of milk left for over a month in the blazing sun. I was nauseated... vomiting... and everything hurt... even breathing. *But how bad could it be? A simple visit wouldn't hurt? Suck it up Shazza and psych yourself...* I decided to get a few Zzzz's in before a shower and her arrival. Upon waking, I noticed the sun had almost set. I heard the familiar screech of the overhead parrots as they made their afternoon pilgrimage home. And I noticed an empty chair sitting right beside my bed.

"When you're exposed to continual treatments, procedures and hospital admissions you quickly realise how 'dehumanised' and 'clinical' our healthcare system has become."

Time can be so fleeting. In the blink of an eye and the snuffle of a snort, my friend had come and gone.

I'd only just missed her. She had only just left. And it was the best sleep I'd had in a long time. I was rested, I was pain-free and my sleep was enveloped with the love of a dear friend sitting watchfully by my side.

"How rude!" I exclaimed at the top of my hoarse voice.

"Why didn't you wake me!?!" I insisted on knowing.

"What did she do?" I enquired, still dumbfounded by my Sleeping Beauty moment.

I was reassured that she wasn't offended. She was the one who insisted I sleep. And she simply sat, held my hand and watched a great episode of Dr Phil and a solid midday movie.

"What a champion!" I declared. And indeed, she was perhaps more than a champion. We attributed my epic sleep directly to her silent presence that day. And it taught me so much about the power of just "being". Just "being" with a loved one in their hour of pain, their seconds of nausea and their breaths of overwhelming anxiety is the mark of a human who cares.

Human touch is a powerful healer. It sings with warmth, talks through silence and smiles through frowns. It's the antidote to loneliness and the treatment to illness. It's the leveller, the equaliser. When you're sick, "things" no longer matter, but people do. Without human touch, our lives would be sadder, our pain would be deeper and our souls a little emptier.

Never underestimate your presence. It's something that can never be unfelt and it streams of liquid gold!!

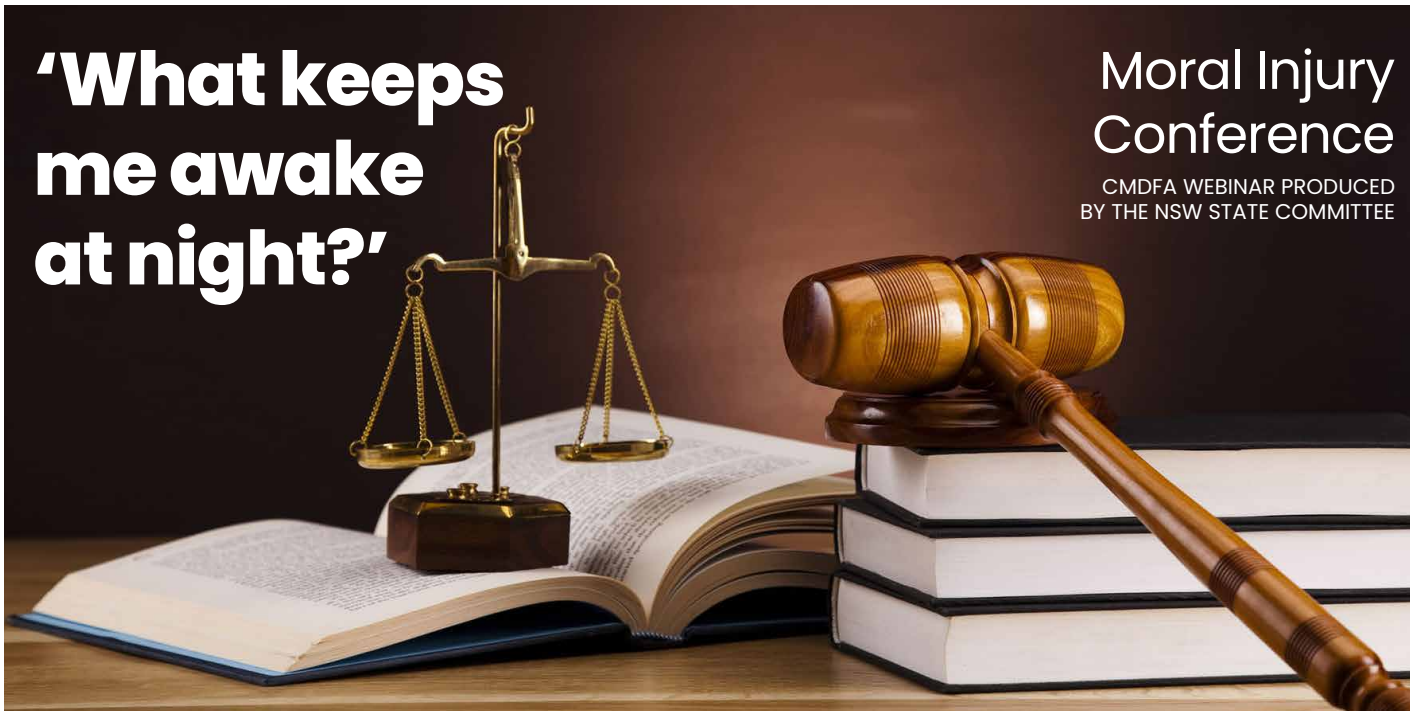
**A Metavivor is someone with stage IV breast cancer who is still fighting but also surviving. We will never be cured and every day we fight this disease we are Metavivors.*

Dr Ern Crocker
Ern is a recently retired Nuclear Medicine Physician. He is currently the NSW State Chair of CMDFA. He is the author of three books: *Nine Minutes Past Midnight, When Oceans Roar* and most recently, *The Man in White.*

'What keeps me awake at night?'

Moral Injury Conference

CMDFA WEBINAR PRODUCED BY THE NSW STATE COMMITTEE



Never have healthcare workers been so pressed or challenged. Never have they been required to dig deeper into their faith or draw nearer to their Heavenly Father for strength and courage. The COVID-19 pandemic, and the introduction of legislation relating to issues such as voluntary assisted dying, gender dysphoria and abortion have challenged us as never before.

In February 2020, the NSW State Committee initiated a weekly prayer meeting on Zoom for members and affiliates to address these issues. Our members began to share their personal circumstances, sometimes specifically, sometimes not, and we were able to pray with and for them. We prayed for healing, against burnout, for practice issues, and for family and personal matters as well. We saw many of those prayers answered. Often people would contact Angela Wang (our National Prayer Convenor) or I after the meeting asking for member's contact details, that they might pray with them and counsel them privately.

It became apparent that even as God was moving, there was a counter spiritual movement against Christians. We were naive not to anticipate that this might happen. Many of our members were deeply challenged at work, in the marketplace, and in their personal lives. There were medical board appearances, legal challenges, and major family issues. We understood that our struggles were *'not against flesh and blood, but against the rulers, against the powers, against the world forces of this [present] darkness, against the spiritual forces of wickedness in the heavenly (supernatural) places.'* (Ephesians 6:12)

Prompted by the discussion paper on Moral Injury circulated by the Ethics Management team and following discussions with Dr Andrew Sloane (Director of Research /lecturer in Old Testament at Morling College), the NSW State Committee elected to run a webinar dealing with issues associated with this subject.

The webinar would deal with those issues that 'keep us awake at night'. National experts would discuss concerns relating to voluntary assisted dying, gender dysphoria, and abortion. Speakers would address pressures upon young doctors in training and upon first responders. Burnout, in particular, would be addressed. There would be discussion on the challenges that face healthcare workers on a daily basis. Problems would be defined, and solutions proposed.

Our purpose in providing this webinar was:

1. To define the issues that face healthcare workers.
2. To raise an awareness of these issues in our members.
3. To provide practical means of approaching these issues in a Christian context.
4. To raise up a body of people willing to intercede on behalf of and support fellow healthcare workers.

The webinar was presented on November 7, 2020. Transcripts and summaries of the eight people who presented on the day follow. These include:

Dr Andrew Sloane
Director of Research/lecturer in Old Testament & Christian Thought, Morling College.
Andrew introduced the concepts of moral dilemmas, moral luck, moral residue and moral injury in pandemics and everyday practice.

John Steenhof
Managing Director of Human Rights Law Alliance.
'Nobody Expects the Spanish Inquisition!' Health Regulators, Codes of Conduct and Implications for moral injury to practitioners.

Prof. John Whitehall
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'Issues facing Australian healthcare workers in relation to gender dysphoria.'

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'The most significant issues'

The topics of moral trauma and moral stress are perhaps the most significant issues that we have dealt with for many years in terms of the welfare of our members and affiliates. On behalf of the NSW State Committee, I want to thank members of the Ethics Management team for their prompting and encouragement to proceed with this webinar, and to thank all of the contributors for their time, their efforts and their prayerful concern. Readers will be blessed and empowered as they prayerfully consider each presentation.

Videos of these talks are available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

A/Prof Andrew Sloane

Andrew is Associate Professor of Old Testament and Christian Thought and Director of Research at Morling College, where he has taught since 2002. He teaches in the areas of integration of faith and work, Old Testament, philosophy of religion, and bioethics. Andrew qualified in medicine and practiced briefly as a doctor before training as a Baptist pastor. His latest book is *Vulnerability and Care: Christian Reflections on the Philosophy of Medicine* (T&T Clark, 2016)

Moral Injury Conference

CMDFA WEBINAR PRODUCED BY THE NSW STATE COMMITTEE

Definitions

Introduction

The COVID-19 pandemic has thrown many complex moral dilemmas our way, requiring us to make hard and costly decisions. We face the prospect — or current experience — of moral dilemmas, bad moral luck, moral distress, moral residue, and even moral injury. I would like us to think about these things theologically.

Some helpful distinctions

Moral dilemma

As health professionals, we are pretty familiar with this category. Moral dilemma is when we face a complex situation in which it is either unclear what we ought to do, or there are two (or more) mutually exclusive options between which we must choose (e.g., who gets the ICU bed?). In such cases, if we make a good decision (even if it's not the only 'right' decision), we should feel neither guilt nor shame, even though we may grieve the human cost.

Bad moral luck

This is hard to define, but easy enough to see. It's where a bad thing happens outside of someone's control, even if it is the result of their action (e.g., a careful bus driver accidentally kills a careless child). It's not their fault; it's just terrible (moral) luck. They rightly feel bad ('agent regret'), but we need to think very carefully about the perceptions which may arise from that feeling. Specifically, we need to distinguish between wrongs and harms. We wrong someone when we (knowingly) treat them in a way that fails to acknowledge what is owed to them. We harm someone when we injure them (or their psyche or their reputation) in some way. In the above example, the bus driver *wronged* no one, but they certainly *harmed* the child. It is entirely appropriate that they feel *regret* for the harm they have done. But they should not feel *guilt* for it. Regret needs to be distinguished from guilt.

Moral distress

Moral distress is: 'Ethical unease or disquiet resulting from a situation where a clinician believes they have contributed to avoidable patient or community harm through their involvement in an action, inaction or decision that conflicts with their own values.'[1]

The origins of moral distress lie in nursing literature, which identifies the following associated elements:

1. It arises when one believes one knows the morally right thing to do (or avoid doing), but one's ability to do this is constrained by internal and/or external factors.

2. It comes in two phases. There is "initial distress" at the time of potential action (or inaction); later, there is "reactive distress" or "moral residue" that occurs in response to the initial episode of moral distress.

3. It involves the compromising of one's moral integrity or the violation of one's core values.

Moral residue

Moral residue occurs when moral distress is prolonged and has a longer-lasting impact on the affected person.

One paper describes it like this:

"In situations of moral distress, one's moral values have been violated due to constraints beyond one's control. After these morally distressing situations, the moral wound of having had to act against one's values remains. Moral residue is long-lasting and powerfully integrated into one's thoughts and

views of the self. It is this aspect of moral distress—the residue that remains—that can be damaging to the self and one's career, particularly when morally distressing episodes repeat over time."[2]

Moral injury

Similarly, moral injury may be defined as: "the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code."[4]

It is worth noting that this category was developed in response to the experience of combatants in the armed forces. Shay, who coined the term, included a clear *institutional* element: "Moral injury is present when:

1) there has been a betrayal of what's right [in the soldier's eyes]

2) by someone who holds legitimate authority

3) in a high-stakes situation."[5]

Moreover, "Morally injurious events can include acts of perpetration, acts of omission or experiences of betrayal from leaders or trusted others. Unlike post-traumatic stress disorder (PTSD), moral injury is not a mental illness… Moral injury is not limited by context or profession. For example, a recent review found that exposure to moral injury was significantly associated with PTSD, depression and suicidal ideation across a range of professions (e.g. teachers, military personnel, journalists) and across a variety of countries (e.g. USA, Australia, Israel)."

Moral injury is always pertinent for Christian healthcare professionals, particularly in contexts where hard decisions are having to be made in the context of overwhelming need and allocation of finite health resources.

Possible responses

The first step is to recognise the importance of truth-telling. People need to acknowledge what they have done, or have witnessed, and the way it has affected them and others. They also need to interpret those experiences correctly: is this an occasion when someone has been wronged, or harmed (or both)? It is important to acknowledge the psychological and emotional impact, and receive appropriate support and counselling — a second, and vital step.

While psychological support and counselling are helpful, they do not address guilt and shame especially well. That, I suspect, is because moral distress and moral injury are real spiritual phenomena as well as psychological/existential experiences, and need an appropriately differentiated response. Church communities ought to be places where spiritual support can be found, and people pointed to the grace of God in the gospel.

While the gospel is the best 'spiritual therapy' I know, we also need to be careful. While we might seek spiritual care as a means of dealing with distress, it is unlikely to 'work' if it is only a 'therapeutic strategy'. However, we also need to recognise the diverse riches of what spiritual care offers us, and discern what kind of response will be most appropriate for the case at hand.

In cases of bad moral luck, people need to be able to articulate their 'agent regret', and lament the harms that have been done and their role in them. However, they also need to recognise that guilt is not appropriate. Lament will also be helpful in cases of moral distress, moral residue and moral injury, but in these situations, there may also be appropriate guilt for wrongs committed or permitted. This guilt needs to be confessed, and the forgiveness of the gospel received (after appropriate remedial actions). Concurrently, they may need cleansing and transformation by the Spirit. Finally, institutional factors need to be identified and, where appropriate and possible, dealt with, to avoid unnecessary repetition.

Conclusion

As health professionals, we will all face situations that challenge our moral compass. Various feelings and perceptions may arise from the conflicts and pressures associated with this, and it is important to recognise the benefits of a multi-faceted response. Psychological, emotional, social and spiritual care can work together to help a person process and move through experiences of moral dilemma and distress.

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

Footnotes

1. Christine Sanderson et al., "Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature," *Clinical Ethics* 14, no. 4 (2019): 195, https://doi.org/10.1177/1477750919886088
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3. E.G. Epstein and S. Delgado, "Understanding and Addressing Moral Distress," *Online Journal of Issues in Nursing* 15, no. 3 (2010), https://doi.org/DOI: 10.3912/OJIN.Vol15No03Man01
4. Victoria Williamson, Dominic Murphy, and Neil Greenberg, "COVID-19 and experiences of moral injury in front-line key workers," *Occupational Medicine* 70, no. 5 (2020): 317, https://doi.org/10.1093/occmed/kqaa052
5. Shay, 2011, 183, cited in Joseph Wiinikka-Lydon, "Mapping Moral Injury: Comparing Discourses of Moral Harm," *Journal of Medicine & Philosophy* 44, no. 2 (2019): 179.
6. Williamson, Murphy, and Greenberg, "COVID-19 and experiences of moral injury in front-line key workers," 317.

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John Steenhof
John is the managing director and principal lawyer at the Human Rights Law Alliance. HRLA is a not-for-profit law firm that was established in 2019 to specialise in matters of religious freedom, freedom of conscience and freedom of speech. John has represented various individuals and organisations involved in religious liberty cases throughout Australia.

'Nobody Expects the Spanish Inquisition!'

Health Regulators, Codes of Conduct and implications for Moral Injury to Practitioners

This paper gives a brief overview of recent developments in health regulation in Australia. It provides a context for understanding the current interplay between health regulators, codes of conduct and health practitioners who are operating on the front line of medical practice, day in and day out all around Australia.

A notable Monty Python comedic routine from the 1970s television show is centred on the surprise appearance of the Roman Catholic inquisitors into an otherwise ordinary domestic conversation. When someone states, "I wasn't expecting the Spanish Inquisition", they appear in a cloud of smoke remarking, "Nobody expects the Spanish Inquisition - our chief weapons are fear, surprise, a ruthless efficiency and an almost fanatical devotion to the Pope."

In Australia, health regulators have extraordinary power to determine what constitutes offences of "heresy" by medical practitioners. In the case of doctors whose political and religious convictions do not align with the latest cultural ideology, these sins are not considered venial, but are considered mortal and worthy of the most serious punishment.

Health practitioners are bound by the codes of conduct and ever-increasing numbers policies that are released by AHPRA and the Medical Board.

Health practice regulators are increasingly kerbing healthcare worker freedoms with regulation of far more than just clinical care and professional ethics. In the standards that bind doctors, there is an increasing creep of contestable ideological concepts about issues like cultural safety, colonisation and systemic racism. These standards for doctors are becoming increasingly politicised and the risk is overreach into practitioners' personal lives and the censorship of their fundamental freedoms.

As such, there is an increasing likelihood that religious practitioners will risk moral injury from the binding of their conscience. Doctors will face the profound psychological distress which results from the choice to speak what they believe or to violate their own moral and ethical code in assenting to things which are fundamentally inconsistent with their deepest held convictions about truth, goodness and proper health care.

> ***"There is an increasing likelihood that religious practitioners will risk moral injury from the binding of their conscience."***

This really is moral Injury – to force a person to call what they believe to be true a lie and vice versa. There is a good reason that in the book *1984*, the Party mentally tortures Smith and breaks him by forcing him to declare that, "2 + 2 = 5." Such a claim to control objective reality causes fundamental stress and moral injury.

That all sounds overly dramatic, doesn't it? And indeed, we don't live in *1984*. But the seeds are there for this kind of moral injury to practitioners to become a more regular occurrence as doctors face a modern version of the Spanish Inquisition.

Case study: Dr Jereth Kok

Dr Jereth Kok is a Chinese-Australian resident of Victoria. Jereth is married with two children. He has been practicing as a general practitioner for over ten years

in a Melbourne family practice. Jereth has never been the subject of any clinical complaint about his practice.

Jereth is a devout Christian with strong conservative opinions. He likes to share them on social media. Many of his opinions relate to life, marriage, identity and sexuality. On Facebook and other social commentary internet sites he would regularly post his opinions and comments on both contentious and mundane religious and social issues.

In March 2018, an anonymous person (not a patient) complained to the Medical Board about one of Jereth's Facebook posts that was allegedly in bad taste following the 2017 Flinders Street terrorist attack.

The Medical Board failed to notify Jereth about the complaint (as required by law) but conducted an investigation without his knowledge.[1] Twelve months later, in March 2019, the Medical Board formally advised Jereth of the complaint and set out four allegations with a requirement for him to explain. Jereth responded within a month.

Unknown to Jereth, in May 2019, a second anonymous person (again, not a patient) complained to the Medical Board that Jereth had made offensive internet posts.

The Medical Board again failed to notify Jereth of this second complaint. The Medical Board also failed to provide Jereth with 3-monthly progress updates of their investigation, as is required by law.[2]

In late August 2019, on a Friday afternoon, Jereth was hit with an avalanche of correspondence from the Medical Board.

(a) Firstly, the Medical Board withdrew three of their four original allegations.

(b) Secondly, the Medical Board advised of the second complaint and provided him with a copy.

(c) Thirdly, the Medical Board wrote Jereth to advise that before he was even aware of the complaint, the Medical Board had met and decided that it proposed to suspend Jereth from practice using emergency powers. He had less than a week to prepare for a hearing before the Medical Board and less than two business days to prepare submissions on a complaint he had just received.

The Medical Board provided Jereth with a document of more than two thousand pages containing his complete internet-posting history. The Medical Board had scoured this in order to cherry-pick around thirty posts from a ten-year period that it used to determine that it was in the public interest that he should be suspended.

> ***"That this law has made it onto Australian law books is concerning."***

Jereth appeared before the Medical Board less than one week later on 22 August 2019. To the extent possible, he had removed all of the identified posts from the internet and he undertook to maintain complete internet silence until the Medical Board investigation was complete. The Medical Board was not satisfied and suspended Jereth immediately pending a full investigation and trial. He lost his job less than a week after finding out that it was under threat.

On the advice of his medical defence insurer, and represented by their legal team, Jereth appealed the Medical Board's decision to the Victorian Civil and Administrative Appeals Tribunal. On 28 February 2020, there was a hearing. On 27 March, the Tribunal published a decision rejecting that appeal.[3] The Tribunal, consisting of a legal member and two doctors, decided that the Medical Board's use of emergency powers was appropriate – Jereth must remain suspended.

Jereth has been unable to work for eighteen months at the time of writing this article, and remains unable to work as a doctor. He is at the mercy of the timing of the Medical Board's investigation and their stated intention to strike him off the Medical Register for good when the matter finally goes to trial.

Jereth is a good doctor. He does his job well. He treats his colleagues well. He treats his patients well. That apparently doesn't matter to the Medical Board. Solely on the basis of his internet posts, this good doctor can't join other doctors on the front lines of the battle against a deadly disease in 2020.

This happened not because Jereth *did* the wrong thing but because Jereth *said* the wrong thing – all this originating from an anonymous complaint.

Jereth's case raises key concerns about freedom of speech and the power of health regulators to threaten those freedoms using legal powers. All doctors are subject to the oversight of the Medical Board of Australia under the

Health Practitioner Regulation National Law. This law gives the Medical Board (a bureaucratic and administrative body) exceptional power over doctors and other health practitioners. It allows them to take immediate action to suspend a doctor in a number of prescribed circumstances. These circumstances are not carefully defined and in fact the laws were amended in 2018 to give the Medical Board wider powers to take action against doctors where it is "in the public interest" to "uphold public confidence in the provision of services of medical practitioners."

That this law has made it onto Australian law books is concerning. It is a great threat to fundamental freedoms to give far-reaching powers of censure to unaccountable administrative bodies. It is also extremely problematic for laws to provide vague and imprecise grounds such as "the public interest" on which those powers can be exercised.

Oftentimes, the people administering these laws are members of a class of society that is uniform in socio-political viewpoint and part of a privileged administrative class that is so isolated from the "public" that they are least qualified to determine what is in accordance with the public interest.

The biggest threat of these laws is to freedom of speech. The Tribunal observed that Jereth has "clear conservative leanings," and he expressed his views strongly. The problematic posts related to abortion, sexuality and transgender issues and there were also suggestions that his posts could be read as supporting violence and racism. The Tribunal considered that there is a risk that Jereth's convictions on these matters might bleed into his practice. The subtext seems to be that there is a reverse onus on conservative voices to positively prove that their views will not adversely affect their medical practice. This has the effect of silencing alternate points of view and dissenting voices.

Consider some of the comments made by doctors when this story was published in Australian Doctor news:

"'There is no doubt that Dr Kok… has clear conservative leanings.' And there you have it folks. What need we have of due process (or even to release the evidence)? 'Thought Crime' is a crime in the Peoples (sic) Republic of Victoria!"

"I would comment but not anymore."

"Far to (sic) dangerous to comment. Disgusting result."

"I've just committed a ThoughtCrime (sic) by reading this."

> ***"More excellent doctors like Jereth will be targeted for their views on life, marriage, gender and sexuality rather than for real tangible issues of clinical practice."***

Jereth's case is also a disturbing example of how regulatory procedures can be weaponised to cancel people who hold and express unfashionable ideas and views. 'Cancel Culture' promotes destroying someone's livelihood because of what they say. Speech is not met with speech. Speech is met with cancellation – boycotting, discipline and career threats. Cancel Culture targets the player and not the ball. Generally, this is done through social media campaigns and public backlash is supported by complicit media reporting to cancel a celebrity or an entertainer.

Disturbingly, this modus operandi appears to be making its way into law and the rules that govern professions in Australia. In Jereth's case, the anonymous complainer(s) could have engaged with Jereth's ideas instead of complaining. They did not. The best way to respond to bad ideas is with good ideas. This allows viewpoint diversity and prevents bad ideas from becoming orthodoxy simply because those who have other ideas are erased. The complainants did not engage with ideas but instead chose to attack Jereth's career. The Medical Board decided to enthusiastically take up those complaints and to use the full extent of their powers to suspend Jereth.

It is also clear that the COVID-19 pandemic has not quarantined this administrative urge towards Cancel Culture. The Tribunal in review acknowledges that there is a public interest for doctors to be able to practice, particularly "in the current health climate where it is readily foreseeable that health services may be stretched to their capacity". It matters not that we are in a world medical emergency not seen for a century and that Jereth has never had a clinical complaint. Jereth's career is cancelled. He cannot practice medicine. He cannot contribute to the fight against the coronavirus, not because of any shortcoming of his practice, but because of the risk that his opinions might bleed into his practice.

Recent changes to social media policies and codes of conduct

AHPRA has recently updated its medical Code of Conduct and Social Media Policy. Unfortunately, the changes impose progressive ideology on doctors, nurses and carers. They also expand the regulator's powers to intrude into the personal lives of health professionals and police the expression of their social, political and religious beliefs.

This is another step towards legislated Cancel Culture and forces doctors into accepting and espousing contentious ideology for fear of losing their jobs. More excellent doctors like Jereth will be targeted for their views on life, marriage, gender and sexuality rather than for real tangible issues of clinical practice.

Changes to social media policy

AHPRA updated its Social Media Policy in 2019.[4] The new Social Media Policy intrudes into the personal beliefs of practitioners. It includes examples that are clear impositions on their ability to speak about their beliefs on the basis of hypothetical "harm" to certain groups.

The policy now includes a requirement stating:[5]

- **Cultural awareness, safety and practitioner and patient beliefs – social and clinical**
  As a registered health practitioner, your views on clinical issues are influential. Comments in social media that reflect or promote personal views about social and clinical issues might impact on someone's sense of cultural safety or could lead to a patient/client feeling judged, intimidated or embarrassed.

- **Example 1**
  A health practitioner, who works in a small town makes their religious views about sex before marriage and homosexuality public by tweeting: 'Abstinence is the best way to avoid HIV. Not sure why we are investing public dollars into developing vaccines. Just do what the Bible tells us to do'. A patient sees this and now feels concerned they cannot reveal their sexuality to the practitioner, thereby compromising their health and safety. They make a notification about discrimination.

The new policy shows the extent to which AHPRA will engage in viewpoint discrimination in favour of socially fashionable ideology. It disguises its progressive left agenda to quash doctors' religious and political expression behind a highly contestable assertion of potential "harm".

Changes to Code of Conduct

AHPRA has also just updated its Code of Conduct (https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx) for practitioners. The new Code mirrors the new Social Media Policy to extend the control of regulators over the personal lives of doctors and legislate contentious ideology.

Significant changes to the Code include:

(a) **Social media guidelines:** AHPRA's social media guidelines have been specifically included as a standard for practitioner behaviour online. Use of social media is now explicitly highlighted as coming under the application of the Code. This encroaches on practitioners' freedom of public expression and their private life.

(b) **New section 2.2:** A new section notes that doctors must consider the effect of their public comments outside of work, including online. This shows that AHPRA is explicit in its oversight of practitioners' private lives and social media interaction. This is a significant overreach. The regulator should concern itself with demonstrable harm through misconduct in professional practice.

(c) **Cultural safety:** The concept of 'cultural awareness' has been changed to 'cultural safety'. This implies that cultural sensitivity is a matter of harm and patient safety. It suggests that a practitioner who does not take cultural differences into account in treatments may be putting patients' health at risk.

(d) **Conscientious objection:** A new section requires practitioners to inform their patients when their personal opinions do not align with the profession's generally held views. This could be used maliciously, if doctors are persecuted for conservative Christian views. Various amendments also reinforce that doctors do not have true freedom of conscience anyway – they still need to give referrals to patients against their conscience.

(e) **Ideological terms:** References to "systemic racism" and "colonialism" have been included as matters that practitioners must be aware of and allow for in practice. These are terms that are infused with ideology and to which not all doctors would subscribe.

(f) **ATSI statements:** A large section has been included concerning Aboriginal and Torres Strait Islander care and safety. Much of this section is political in nature. For example, it indicates that understanding the effects of colonisation will assist in providing medical care. This is asking practitioners to be responsible for political and cultural issues that extend well beyond their profession.

(g) **Bullying:** A large section has been included on bullying and a requirement to report fellow practitioners. Although no one wants bullying in the workplace, the section could capture reporting for political and religious views.

Some overall implications of these changes include:

(a) **Regulators now limit health practitioner's personal freedoms:** The distinction between practitioners' professional and private lives have become blurred under the new Codes. They are an attack on freedom of speech, conscience, belief and political expression. It is concerning and telling that the Social Media Guidance says that a doctor's personal views about social and clinical issues, "might impact on someone's sense of cultural safety or could lead to a patient/client feeling judged, intimidated or embarrassed." A doctor's religious beliefs – a fundamental aspect of their identity – are to be suppressed because of hypothetical embarrassment to someone.

(b) **Vague terminology will be ideologically interpreted to shut down unpopular views:** Codes of Conduct are increasingly being used to shut down speech across a variety of professions. It is a standard feature

of these codes to use vague and broad language so that the regulator applying the codes has maximum discretion and freedom to move in applying them.

(c) **This is the politicisation of science:** The medical profession is not a forum for regulators to bring culture wars. People's physical health and wellbeing should be paramount. A health regulator should not be able to dictate a medical practitioner's politics. It is deeply concerning that the Code says practitioners must acknowledge systemic racism – a concept promoted by cultural Marxism.

(d) **Health Professionals risk their jobs for the personal views expressed outside work.** A doctor can lose his job for posting something on social media that might not even be connected to medicine at all. Dr Kok's case is an example.

A regulator should not be able to compel the speech of a doctor.

Summary

Overall, it is clear that health regulators in Australia have extraordinary power in regulating the conduct of medical practitioners. Unfortunately, Codes of Conduct and Social Media policies are also being used as a means of censoring practitioners' fundamental freedoms. There are many potential legal implications for practitioners, as well as the potential for ongoing moral injury.

The fact that real medical practitioners are actually experiencing this reality also highlights the need for change in the way that doctors are regulated to restore doctors' fundamental freedoms and to pull back the overreach in current regulations that allow unwarranted intrusion by the Medical Board.

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

Footnotes:

1 Health Practitioner Regulation Law (Victoria) Act 2009 (VIC), s 4; National Practitioner Regulation National Law (Queensland) (QLD), s 161(1).

2 Health Practitioner Regulation Law (Victoria) Act 2009 (VIC), s 4; National Practitioner Regulation National Law (Queensland) (QLD), s 161(3).

3 www.austlii.edu.au – http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCAT/2020/405.html?context=0;query=Kok;mask_path=au/cases/vic/VCAT+au/legis/vic/consol_act+au/legis/vic/num_act+au/legis/vic/hist_act+au/legis/vic/reprint_act+au/legis/vic/anglican+au/legis/vic/repealed_act+au/legis/vic/consol_reg+au/legis/vic/consol_reg+au/legis/vic/num_reg+au/legis/vic/reprint_reg+au/legis/vic/repealed_reg+au/legis/vic/bill+au/legis/vic/bill_em+au/other/VicBillsRR+au/other/vic_gazette+au/other/VicOmbPRp+au/other/VicSARCAD+au/other/rulings/vicsro/VICSROBF+au/other/rulings/vicsro/VICSRODT+au/other/rulings/vicsro/VICSRODA+au/other/rulings/vicsro/VICSROFHOG+au/other/rulings/vicsro/VICSROFID+au/other/rulings/vicsro/VICSROGEN+au/other/rulings/vicsro/VICSROLT+au/other/rulings/vicsro/VICSROLTA+au/other/rulings/vicsro/VICSROPT+au/other/rulings/vicsro/VICSROPTA+au/other/rulings/vicsro/VICSROSD+au/other/rulings/vicsro/VICSROTAA

4 https://www.nursingmidwiferyboard.gov.au/news/2019-11-11-social-media-guide.aspx

5 https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Social-media-guidance.aspx

CMDFA CHRISTIAN MEDICAL & DENTAL FELLOWSHIP of AUSTRALIA Inc

Luke's Journal

www.cmdfa.org.au

Published by the **Christian Medical and Dental Fellowship of Australia Inc.**
ABN 95 084 292 464

Please submit all contributions to:

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Prof John Whitehall

Professor John Whitehall has been interested in the growing phenomenon of gender confusion in children since 2016. He has authored articles in *Quadrant Magazine* (https://quadrant.org.au/writer/john-whitehall/) , submitted to enquiries and courts, criticising legislation mandating hormonal affirmation as an affront to human rights, particularly that of children to be free from experimentation.

Moral Injury Conference

Conversion Therapy

In August, legislation was enacted in Queensland and the ACT that is of grave concern to all Christians in Australia. The legislation promises gaol sentences for those who act upon the Biblical injunction of Romans 12, to not 'copy the behaviour and customs of this world' but instead 'let God transform you into a new person by changing the way you think' (Romans 12:2a NLT). By contrast, the Gospel promises forgiveness for human weakness, but also help in overcoming unwanted behaviour.

The Queensland 'Health Legislation Amendment Act 2020'[1] and the ACT 'Sexuality and Gender Identity Conversion Practices Bill 2020'[2] are based on the premise that attempts to restrain sexual behaviour and identity are misplaced: That people indulging in behaviours they do not want should be assured they are not 'broken', and that attempts to 'convert' them towards heterosexual restraint and gender identity congruent with chromosomes are bound to fail and increase suffering in the process. The Acts assume that sexual behaviour is immutable. To the contrary, the Gospel teaches that behavioural change is possible for those who seek it, especially with help from Above.

The current Victorian Change or Suppression (Conversion) Practices Prohibition Bill 2020[3] which is likely to be enacted in February 2021, is even more punitive in its attempts to eradicate so-called 'conversion therapy' and the prospect of relief from unwanted sexual behaviour. If enacted, the definition of 'conversion therapy' is so broad it will become a criminal act for anyone, in any way, to offer counselling to anyone burdened by unwanted sexual pre-occupation, even if that help is freely sought by a knowledgeable adult.

In my opinion – and I repeat that this is my opinion – this and pending similar legislation in other States constitutes the most serious threat against the Good News we have ever faced in Australia. First, its underlying principle is that 'unusual' (my words) sexual behaviour is not a sign of 'broken-ness' (theirs) thus negating the Gospel of forgiveness. Second, it will criminalise (literally put you in gaol) if you help by extending fellowship or by counselling anyone seeking to be liberated from besetting sexual behaviour. Thus, the twin bases of the Gospel, salvation from sin through Christ and sanctification by the Spirit, are to be abolished by parliamentary decree.

> ***"...[The Bill] intends, forcibly, to install the ideology of gender fluidity over society and to silence contrary opinion."***

The argument underlying the so-called anti-Conversion Therapy laws is that sexual behaviour and identity cannot and should not be restrained: that such restraint is cruel, depressing, unnatural and impossible, promoting self-harm and suicide, and, therefore attempts for change should be punished and abolished. Although the stated reason to legislate in this area is to protect a population that is deemed to be vulnerable or marginalised, I don't think that is its primary aim. I think it intends, forcibly, to install the ideology of gender fluidity over society and to silence contrary opinion.

To persuade for the necessity of banishing so-called Conversion Therapy, its proponents evoke the spectre of past

attempts to 'convert' homosexuality to heterosexuality by administration of electric shock or other forms of what can fairly be described as torture, sex hormones, castration and even lobotomy.[3] It should be needless to emphasise such coercive, aversive interventions are no longer practiced in Australia. Indeed, it was interesting that proponents for outlawing so-called Conversion Therapy in Queensland could cite **no** evidence for its occurrence in that state, despite several invitations to do so in the Parliamentary enquiry. Nevertheless, proponents for criminalisation argue that modern, freely sought, psychotherapy, Christian fellowship and counselling are the modern equivalent of the Medieval spectre and, therefore, demand prohibition.

According to the current ideology of gender fluidity, sexual orientation, expression and identity is immutable. Well, almost immutable. Fluidity of expression and identity is alleged to be normal and worthy of chemical and surgical support **as long as its movement does not revert 'back'** towards congruence with chromosomes. In other words, administration of cross-sex hormones with their inherent chemical castration and alteration of the structure of the brain, and surgical attempts to create ersatz genitalia of the opposite sex, involving not only castration but also dismemberment, are now justified as long as they lead **away** from the chromosomes. Castrations and lobotomies are now in vogue. The irony should be compelling.

The extent of moral injury can only be imagined. Hundreds of Australian children and adolescents are, every year, entering the pathway of trans-gendering (see table, right).[4]

Since the Family Court abrogated its gatekeeping role in November 2019, we don't really know how many children are attending clinics, and receiving hormones, etc. Certainly, 'hundreds' are presenting each year throughout Australia. With enactment of recent legislation, it will now be a criminal act to delay, seek to avoid or to offer an alternative form of therapy for gender confusion. ACT and pending Victorian laws threaten *anyone* who does not promote trans gendering for a young person who is arguing he or she is of the opposite sex, *anywhere* such 'conversion therapy' is performed… in the home by parents or grandparents, in schools by teachers, in churches by counsellors, in offices by doctors. Escape will be impossible: attempts to flee states with those laws and seek counselling elsewhere for a confused child will be a criminal act. Free speech will be curtailed. It may soon become a criminal act in Victoria to 'induce' someone to seek change, putting into law the ability of proponents for the ideology of gender fluidity to ban 'public broadcasts' of a contrary point of view.

Australia has never seen such determination to eradicate the promise of John 8:36 that *'if the Son sets you free, you will be free indeed'*. Moral injury will be sustained by anyone feeling bound to promote that promise.

Practical things that may be undertaken to preserve religious freedom include joining in urgent calls to prayer as various bills come before Parliament; and signing petitions being circulated through various bodies, including the CMDFA. People should certainly contact their local member, preferably with an (even short) handwritten letter rather than an email, expressing concerns about the Bill.

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

References and footnotes:

1. Queensland 'Health Legislation Amendment Act 2020' (Part 5 Amendment of Public Health Act 2005 [28 ch5B]) https://www.legislation.qld.gov.au/view/pdf/asmade/act-2020-031
2. ACT 'Sexuality and Gender Identity Conversion Practices Bill 2020' (A2020-49) https://www.legislation.act.gov.au/View/a/2020-49/current/PDF/2020-49.PDF
3. Victorian Change or Suppression (Conversion) Practices Prohibition Bill 2020 https://www.legislation.vic.gov.au/bills/change-or-suppression-conversion-practices-prohibition-bill-2020?fbclid=IwAR1tEqDsh0y0mKxXLDwwNidwWO24r3cUPZPHZutjdmkOUWUnqaZ4oIZ5PHA
4. The Bill declares equivalence between these medieval practices and 'increased anxiety and depression' claimed by a few who have undergone counselling, especially in churches. A survey by the Melbourne-based Coalition against unsafe school education www.freetochange.org is publishing a report on 78 replies of positive help from counselling, as opposed to the one from La Trobe university which the Qld, ACT and Victorian claims to be the scientific basis for their legislation (with 15 replies).

5? Kenny, Diana: Jul 16, 2020. NAPP (National Association of Practising Psychiatrists) Children and young people seeking and obtaining treatment for gender dysphoria in Australia: Trends by state over time (2014-2019) https://napp.org.au/wp-content/uploads/2020/07/GD-Trends-in-Australia_Update-to-2019-13-7-20.pdf

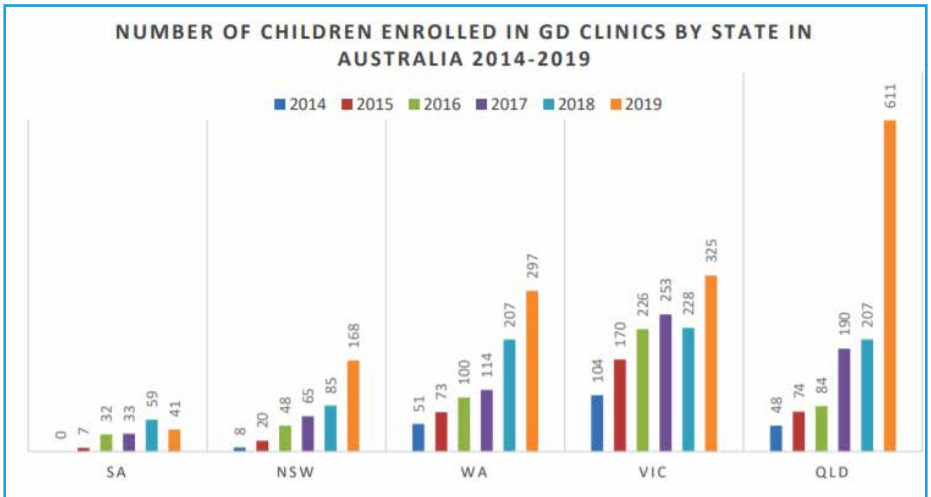

Figure 1

Figure 1 one shows that numbers of children and young people enrolled/seeking treatment for gender dysphoria over the six-year period 2014-2019 in each of the four states of Australia with gender clinics increased for each state but not uniformly. The absolute numbers for NSW were significantly lower compared with the other three states.

Prof Natasha Michael
Natasha is Director of Palliative Care at Cabrini Health in Melbourne.

Moral Injury Conference

Issues Related to Voluntary Assisted Dying

Our Christian faith, along with our palliative care tradition, embodies a moral tradition of fundamental convictions about what it means to die well.

The Voluntary Assisted Dying (VAD) legislation has posed both professional and practical challenges. It asks if our moral tradition should be reaffirmed, or modified to adapt to the new caregiving realities of legislative and patient demand, along with physician compliance. More importantly, we as a community need to ask if this moral tradition can be modified at *all* without compromising our fundamental ethic of care.

This presentation will explore some of the realities faced by practitioners in the current climate. The moral vision of palliative care and medicine articulates that we provide patients with control over the quality of life they can experience in their dying. However, this scope of patient control does not extend to a decision to terminate life by medical assistance, or suicide. We will explore how practitioners experience conflict of conscience in implementing the principle of non-abandonment, whilst still providing ongoing care for those who seek VAD.

The rights-based approach pursued by legislation neglects the relational nature of conscience, as well as the impact that violating one's conscience has on the care that one provides. Likewise, the VAD legislation has neglected to recognise and prioritise the relational nature of ethical decision-making in healthcare. It also ignores the negative consequences of the moral distress that occurs when healthcare professionals find themselves in situations where they feel they cannot provide what they consider to be excellent care.

However, a message of hope remains the antidote to legislation. To engender hope is to hold in front of a person the reality of the love of God for each person, along with His mercy. To know that we are loved fills us with hope, and knowing that we are loved by another is the start of love. Thus, despite our increasing demands to partake in the arena of policy and political debate, our true vocation must remain at the bedside of the patient; to face their laments and hear their pleas, even those for a hastened death.

> ***"[The VAD legislation] ignores the negative consequences of the moral distress that occurs when healthcare professionals find themselves in situations where they feel they cannot provide what they consider to be excellent care."***

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

A/Prof Harvey Ward
Harvey is a busy OBGYN on the Coffs Coast, active in his local church as a musician and apologist. He is a CMDFA NSW committee member and is training as a Saline Process trainer. He is happily married to Kathy and has 3 married children. He is passionate about teaching and making birthdays. His dreams of being a rock star are fading, but he has recorded 2 albums, published poetry and is writing a book.

Moral Injury Conference

Moral Injury in Carers of Early Pregnancy

There are few examples more vexing for the Christian Health practitioner (CHP) confronted with a request or situation that conflicts with their convictions, than abortion.

With advancing gestation, there is increasing desperation in the mother who wishes to terminate her pregnancy and it is increasingly difficult for the Doctor or Nurse/Midwife to object to participate. The law to terminate a pregnancy for any reason up to 22 weeks has been passed in NSW and other States in Australia.[1] The law has included a conscience clause to allow those to abstain from involvement electively in some states.[2]

While the term "moral injury" was originally coined regarding returning military personnel from conflict zones[3], the same term can apply to some degree for CHP managing early pregnancy. When a person's conviction is compromised, moral injury may be suffered. The difference between a conviction and a mere opinion is that the latter may change without much consequence while the former is a line one draws in the sand of the soul and is guided by faith, and a certitude of what is right and wrong in a specific situation. It is deeply held and guides decision making. Convictions are mostly, but not always, formed by faith and reliance on revealed Divine instruction. For example the conviction, "first, do no harm" (*primum non nocere*) is threatened if you are instructed by a soldier to pull a trigger to kill another human. Your refusal to obey may result in your own execution. Similarly, the law may allow for a procedure that your convictions prohibit, but there may be significant cost to stand by these convictions. Indeed, many a Christian martyr has faced the lions for such. How can we approach these clashes of conscience as CHPs in early obstetric practise?

Consider Scenario 1

You are a busy GP and a couple come to see you and open the consultation with the news they are pregnant. They have two girls and ask if they can do a NIPT test to check the gender because they do not want another girl and will abort if they find out this fetus is female.

Moral challenge: By all accounts, this is a healthy 8-week pregnancy, there are no risk factors other than the fetus being female. You are affronted with the callous choice to destroy this pregnancy because of her unwanted gender. This couple may terminate the pregnancy anyway if they can't get a test but you feel that complying with their demand for a test may make you an accomplice. They ask you to do the test anyway. Can you refuse a test where you know the outcome may make you complicit in an abortion?

Moral injury: While legal, their request is unethical and gender discriminatory. In India, this is illegal but in Australia, abortion for any reason is allowed in some states up to term.

Principle being violated: thou shalt not murder[4] – intentionally take innocent human life. No one would argue against the innocence, humanity or vitality of this fetus.

Threat: potential loss of relationship with patients and their community. Possible complaint to HCCC / AHPRA, possible departmental discipline. Personal hypocrisy if you compromise.

Primary: be prepared for these scenarios. Establish the principle and always be ready with an answer for

the hope you have within you, given with gentleness and respect.[5] You may divulge the root of your convictions if asked but it should not be forced without request from the parents. Role play with colleagues to practise what and how to approach this question. Pray daily for your practise and patients, that you would be ready for these events.

Secondary: at the time. Politely let them know of your conviction to protect and nurture innocent life from conception to natural death. Let them know that diagnostic tests merely reveal what is reality, is diagnostic for gender, and violates no principle of your conviction. Let them know what they do with the result is their decision and you would be delighted to assist them in any way to preserve the pregnancy but you would not be comfortable referring to another practitioner for the intent to destroy it. You may let them know that there is a NSW hotline for further advice which is on public notice. Also ensure that you will offer any ongoing physical, mental and social care should complications arising from a termination occur (if they proceed with one), and that you would be there for them if they change their minds.

Tertiary: reflect on the interaction. Pray for the couple in your quiet times, speak to friends, confidantes about the injury you have experienced and revisit your convictions reading the Word of God and authors who have pioneered these difficult paths. (CMDFA resources library).

Scenario 2

A 17 year-old young woman finds out she was date raped and is 14 weeks pregnant and has been admitted for a termination of pregnancy. She is scared but has signed the forms to have it done. You come on duty as a nurse and she seems ambivalent to having the procedure. You escalate your concerns but the doctor and senior nurse on shift insist you oversee her taking the abortifacient the pharmacy has dispensed. Your manager suggests your ongoing employment depends on compliance with departmental policy.

Moral injury: patient is questioning, superiors deny and coerce you to follow

orders. Your personal convictions are being violated.

Principle violated: Thou shalt not murder – take innocent life. Even while recognising the wrong done in the conception, should the innocent life pay for the sins of the parent/s?

Threat: loss of job, career, references, future employment, complaints, demotion, discipline and deregistration. Disrupted personal working relationships, fear, ridicule and anger.

"The law may allow for a procedure that your convictions prohibit, but there may be significant cost to stand by these convictions."

Primary: Recognise the objective value of life in the womb. If this was a wanted baby, the value of the fetus would be radically different and the approach to the mother would be entirely supportive. Prepare beforehand with colleagues and role play. Recognise the injury done to a woman violated. Set up alternative options for the woman exploring the requirements for a pregnancy, support, protection from and prosecution for the assailant, delivery of the baby, adoption options, post-partum care and ongoing protection strategies to prevent it happening again. Pray for such a time as this (Esther 4:14).

Secondary: establish the facts of the pregnancy: alive, in utero, any other medical issues to be addressed. Determine to inform senior or manager about moral convictions and note the law supports conscientious objection to participating in abortion.[2] Inform a sympathetic support person of your situation maintaining confidentiality. Ask for wisdom and prayer.

Tertiary: debrief: with colleagues, write down details of conflicts, pray for the woman, her baby and those around her. Resolve to advocate for the unborn, crisis pregnancies, and practically help with volunteering, supporting financially or materially a local crisis pregnancy clinic or support group.

Scenario 3

A 30-year-old woman with a previous abnormal pregnancy resulting in a stillbirth with lethal multiple congenital abnormalities, is pregnant again and at the 20 weeks scan there are signs that this abnormality is representing. She asks you as the doctor to stop the pregnancy before viability and let them grieve. The husband is heartbroken but does not wish to terminate and would rather let nature take its course.

Moral injury: you feel coerced to participate in fetocide. You grieve at the couple conflict.

Principle violated: taking of innocent life, peacemaking mandate as a CHP.

Consequences: estrangement from mother, loss of trust, family disruption, demotion or career destruction, risk of complaint to AHPRA/HCCC. RANZCOG position on mother's primacy in opinions and decisions about her pregnancy may result in complaints/dismissal.

Primary response: prepare for scenarios by careful thought before crisis. Prayerful study on valuing human life in all ages and forms. Pledge to protect all innocent life with dignity even if unsustainable in the near future. Consider providing practical support and resource development for women to offer viable alternatives to abortion. Inform senior staff of your position on pregnancy management of lethal malformations. Write out what you would say, read up on advice given by professionals, ask colleagues how they would react.

Secondary response: present your personal conviction and acknowledge the legal right of the woman to pursue termination. Offer the opportunity to discuss the course of action with another specialist. Inform the couple of potential ongoing conflict, offer referral for conflict resolution.

Tertiary: Consider future scenarios with lethal conditions and ask what can be done to ease a life shortened by major structural defects and metabolic errors of metabolism.

Principles: the 3 simple rules

A pastor from the Hebrides at a 1983 CMF student's conference in Perth, Scotland once gave us three rules to conduct life-affirming practice in medicine. They have never failed me yet.

1. Do not take **active steps** to shorten life – This is premeditated murder. Nature may be allowed to take its course. This is unless the ongoing pregnancy will result with predictable certainty in the untimely death of them both (ectopic, Eisenmenger's syndrome, renal failure?). Withholding futile treatment in good faith that the intervention has little to no chance of extending life is not intentional killing.
2. Do not **withhold nutrition or hydration** unless impossible to support.
3. **Provide symptomatic relief** as far as is medically and psychologically possible. Develop protocols such as those developed by Dame Cicely Saunders for palliative care.

In early obstetric practice, they have served me well, thus far.

References:

1. Abortion Law reform Act 2019 no 11 NSW Parliament
2. Abortion Law Reform Act 2019 Section 9 NSW Parliament
3. Koenig H (2020) *Journal of religion and Health* 59 (2323-2340) Identifying moral injury in Health care Professionals – the Moral Injury Symptom Scale – HP
4. Exodus 20:13
5. 1 Peter 3.5

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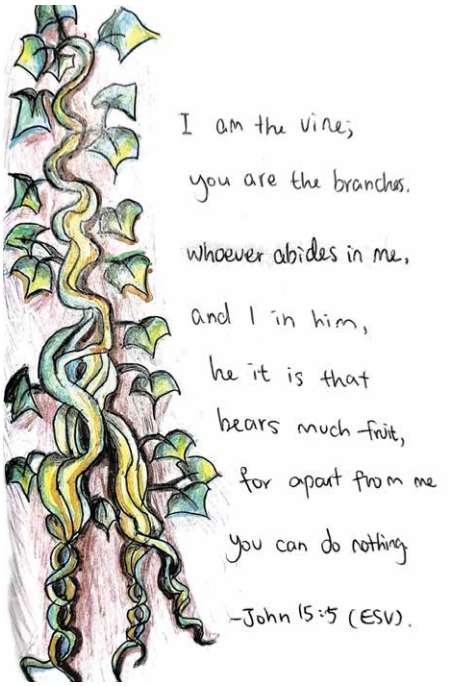
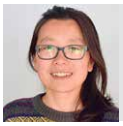
Art by Elle Chou (medical student)



Dr Emily Ivarsson SRMO
Emily is married to Aron. They live in the Eastern Suburbs of Sydney and attend Vine Church in Surry Hills. Emily works at The Royal Hospital for Women and is about to start specialty training in Obstetrics and Gynaecology.



Moral Injury Conference

The Hospital Furnace

Where you can gain a career and lose your soul

The hospital environment offers immense opportunity to be a part of the work that Jesus is doing in the world. We are in the privileged position of walking alongside people in their most vulnerable moments, with the opportunity of showing them care and compassion with the love of Christ. At the same time, the hospital environment can be a gruelling space for our faith. There are constant stresses and temptations that seek to pull us away from trusting in the true God and turn to all kinds of idols.

In my talk, I will cover some of the challenges that I have experienced and have witnessed other Christian doctors-in-training struggle with. I will talk about how our working environment can lead us to lose sight of God and as a result lose sight of who we are. When we have lost sight of these things, we end up losing touch with reality. I want to show how Jesus speaks directly into this in His Sermon on the Mount – He knew that this would be our struggle.

Finally, I hope to offer some solutions and encouragements as to how we can survive and even thrive in this furnace.

Losing sight of God

1. An environment that does not acknowledge the existence or sovereignty of God
2. A career that does not allow much else

Losing sight of yourself

1. Defined by work
2. Purposed by work

Losing sight of all reality

"Do not lay up for yourselves treasures on earth, where moth and rust destroy and where thieves break in and steal, but lay up for yourselves treasures in heaven, where neither moth nor rust destroys and where thieves do not break in and steal. For where your treasure is, there your heart will be also. The eye is the lamp of the body. So, if your eye is healthy, your whole body will be full of light, but if your eye is bad, your whole body will be full of darkness. If then the light in you is darkness, how great is the darkness? No one can serve two masters, for either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve God and money.

Therefore, I tell you, do not be anxious about your life, what you will eat or what you will drink, nor about your body, what you will put on. Is not life more than food, and the body more than clothing? Look at the birds of the air, they neither sow nor reap nor gather into barns, and yet your heavenly Father feeds them. Are you not of more value than they? And which of you by being anxious can add a single hour to his span of life? And why are you anxious about clothing? Consider the lilies of the field, how they grow: they neither toil nor spin, yet I tell you, even Solomon in all his glory was not arrayed like one of these. But if God so clothes the grass of the field, which today is alive and tomorrow is thrown into the oven, will he not much more clothe you, O you of little faith? Therefore, do not be anxious, saying, 'What shall we eat?' or 'What shall we drink?' or 'What shall we wear?' For the gentiles seek after these things, and your heavenly Father knows that you need them all. But seek first the kingdom of God and His righteousness and all these things will be added to you. Therefore, do not be anxious about tomorrow, for tomorrow will be anxious for itself. Sufficient for the day is its own trouble." Matthew 6:19-34

Surviving the furnace

1. Take the time that you need to see God
2. Have good accountability
3. Always be ready to quit.

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

Gabi Macaulay RN

Gabi Macaulay (RN, BA Science App Nursing, Grad Dip Midwifery, Grad Dip Theology, M Ministry) is a Lab Clinical Educator and works in Emergency as an RN. Gabi has also gone on several YWAM medical short term trips to PNG and more recently trained and worked in International Disaster Medical relief. She has taught locally and overseas at various conferences. She serves on the Nurses Christian Fellowship Board. Her passion is caring holistically for her patients and teaching this to the younger generation.

Moral Injury Conference

What keeps nurses awake at night?

A personal perspective

As a career, nursing has allowed me into the most privileged of places humanity can offer:

- I have been present with the rich undergoing overwhelming medical procedures,
- stayed with the poor in their time of fear,
- been a buffer when health news dealt a harsh blow,
- sat with distraught parents,
- lingered as a teen realised a whole new vocabulary involving scarves, hair loss and sore gums,
- and helped gather the chaos of a split second car crash into some form of repair turning terror and fear back towards life, love and hope.
- I have sat with those after a weather disaster attempting to make some kind of sense of the national devastation enveloping them while recognising quietly that there is no sense to be made.
- I have delighted in hearing the first breath of a newborn,
- and gently stroked the hand of someone else while listening to their last.

I am comfortable in acute trauma, ICU and emergency departments, which are highly reliant on complex monitors, complicated machines and abundant resources.

I am also comfortable in primary health care settings in remote regions where there is no currency, electricity or politics.

I have also been a first responder, landing on an island that had only hours earlier been literally flattened by a hurricane[1] (category 5), which hovered for three days and nights to completely destroy the buildings, infrastructure and killed over 1500 people. I delivered medical assistance to those affected in the immediate aftermath.

Am I burnt out? Fatigued? Or edging into Post Traumatic Stress Disorder? Nope.

Clinically, I am doing well, but I do have memories and thoughts that wander back and challenge me – well, at a deep moral level.

'Moral Injury' has been defined as profound psychological distress that results from action or lack thereof, which violates a person's moral or ethical code1. Essentially, one's core morals or core values have been injured or even violated leaving a residual feeling of being powerless, frustrated or sad. Unlike PTSD, Moral Injury is not classified as a mental illness. This in itself is a relief for healthcare workers today.

The term moral injury and its related expressions; complexity, ambiguity, distress, residue, courage and resilience[2], came from a military background where people had been given instructions to follow, yet had little or no say in the matter or its consequences.

Although soldiers have an extraordinary capacity to follow orders regardless of the outcomes, at times nurses are sometimes caught having to follow orders they are very uncomfortable with, and yet are expected to resurface with clear conscience and voiceless memories on the next shift.

A range of factors can contribute to moral injury in nursing, which include:

- poor communication,
- lack of input into clinical decisions,
- disagreements with physicians about patient care, unsafe staffing levels
- inappropriate use of resources.

When nurses find themselves in situations where they feel they cannot

live up to their own values, or where their teams are not meeting high standards of care they may experience negative feelings such as guilt, shame, being voiceless and devalued.[3]

Moral injury from a first responder's perspective takes on further layers of complexities. Some of these include:

- initial jetlag,
- unknown international medical team,
- instant frontline speed,
- continuous 12-hour shifts,
- unknown cultural etiquette,
- language barriers, new routines,
- overwhelming trauma,
- the possibility of no initial electricity or clean sanitation,
- and an exhausted population swimming in crisis.

Let me take you to an island – not too far away and not too long ago

I was present as a primary health care worker and educator. During a visit to a remote village I was asked to see a mother with a 3-day old baby for a check-up. Working in this capacity brings its own series of barriers: walking ten times further than you were initially led to believe, being aware of security and feeling responsible for venturing with another team member, carrying a heavy backpack of equipment, heat and humidity, and difficult-to-traverse terrain. Nevertheless, we were led to a dirty run-down hut, off the ground with a broken ladder to the open entry. It was barely waterproof and clad with bedsheets carelessly strung around. Inside I saw a young woman who appeared shy and vulnerable.

Her friend who had guided us to the hut walked past the mother and showed us the newborn baby lying supine, flaccid and quiet. I noticed the mother did not move toward either the babe or us.

With the use of broken language skills and my poor acting, we established that the babe was three moons (three days old) and last *su-su* (breastfeed) was when the shadow was on that far scrub path (let's assume 5 hours ago).

With the mother's permission, I examined the babe with the little equipment I had - my hands, head and heart. He was small for gestational age, had soft yet deep fontanelles, a reasonable heart rate, low blood sugar level, and shallow respirations - irregular and at times laboured.

He did not respond to my picking him up or follow movements with his dear little eyes. I smiled and asked the mother if she had consumed marijuana during her pregnancy and she proudly claimed she had had a lot of it. My heart sank, but my face smiled toward her as I snuggled him into my neck flicking away the memories of my own son at this age and my heightened protective nature during this time.

> ***"I ... asked the mother if she had consumed marijuana during her pregnancy and she proudly claimed she had had a lot of it."***

The babe was quiet, yet I was captured by his eyes which seemed to be looking but not seeing. Mother had not named the baby (which can be common due to high death rates) and my clinical red flags were wilting my heart as I tried to decide what my part was here.

With absolutely no health resources in or near this remote village, a mother who seemed to be waiting for the inevitable to happen to her boy, and my clinical expectation that the baby had a poor prognosis, I asked if I could watch her feed. Both mother and baby were quite disinterested in each other, and the mechanical act took only a few moments to leave a devastating impression on me.

Playing this scenario out in my home city would have this bundle of innocence, prodded with needles for blood gases, placed in a warm and soft humidicrib, examined by leading experts, monitored day and night then fearfully and wonderfully brought back to the hope and expectation of a full and long life filled with laughter, friends and mudfights.

I had moments to decide my role and responsibility. I was also acutely aware that I had a younger health professional with me who I would need to debrief and help come to some level of resolution in this unexpected situation.

I also had limited time as we were expected to return to the team shortly and knew of the long hike and tidal barriers to get there.

Given the presenting facts, so many questions crowd in:

- Should I give the newborn standard injections, or will this be seen as precipitating his probable dire outcome?
- How will the mother see this intervention? What right do I have to inflict pain on this flaccid babe?
- Is it worth it anyway?
- What resources that this baby should have access to are even remotely available?
- Why are we so voiceless?
- Am I enough?

So, after a silent internal explosion of emotion and helplessness I decide to forego the injection and spend my remaining time alongside the mother teaching her to latch properly, watch for effective swallowing, stroking his dear little feet, encouraging eye contact and bonding with him.

We mimed out the importance of healthy foods and better hydration for her and in what seemed the blink of an eye, I knew my time was at an end.

Walking back to the village, I talked at length to my younger team member, knowing that her spirit would take a few sessions to unpack the injustices of our world.

I lay awake that night – and many thereafter - wondering about my actions, or lack of them;

- The impact on the mother and baby and if I had given them the best opportunity possible.

- Could someone else have done better and was my decision best practice in this circumstance?
- Did my voice count for anything?
- Was I enough?

Fast forward a few months and to another island far far away!

I arrived 33 hours later somewhat jetlagged as a first responder to a new field hospital a few days after a hurricane has destroyed this and many other surrounding islands.

Working straight away in the ED brought new faces, new routines, long hours and although grateful, also a stressed and endless line of casualties.

One of note was a young 6-year-old boy who arrived with his mother and presented with a cough, fever and obvious signs of severe pneumonia. Again, his dark innocent eyes of trust and faith in us captured my heart. The little man deteriorated very suddenly into an arrest situation with us working on him for well over an hour. The early stage of an emergency field hospital is not set up for intubation of a child and we watched this little chap slip from our hands into eternity. As a team we are well versed with death and dying. However, the inability to have had everything that may have made the ultimate difference was devastating, especially as we listened to the howling of his mother alongside us as she realised what was happening.

That night – and many others thereafter – I lay in bed and saw his gorgeous little dark eyes and heard his mother's primal recourse at God.

- We were not enough.
- We did not have more.
- Circumstance drowned us. I am not enough.
- I failed.
- It is all broken.

BUT GOD...

So how are we as Christian nurses able to turn up to the next shift? Somewhere in my heart I need to evolve a capacity to exist, survive and lead a way through this. I expect myself to be present for patients, colleagues and myself.

My value, contribution and identity has been doubted, challenged and nearly discarded by moral injury. Yet my spirit is fiercer, more bountiful and strangely strong.

In the Scriptures I have been able to reclaim my value, contribution and identity and realise that, bold as it might seem, *maybe I was born for a time such as this* (Esther 4:14).

> ***"I do know that the fruits of the Spirit do not include the fear, inadequacies, anguish, guilt or shame."***

Although stringing along Scriptures of convenience to fit my apparent spiritual need may not be the best theological practice at times it sure as heck works for me in these situations. My emotional headspace seems to perhaps outshine the need for true historical context:

"Gabi,

Psalm 139:14 – *You were fearfully and wonderfully made,*
Psalm 139:16 – *Every day of my life was recorded in your book. Every moment was laid out before a single one of them had passed.*
Jeremiah 29:11 – *For I know the plans I have for you, declares the Lord. Plans to prosper you and not to harm you. Plans to give you a hope and a future.*
Ephesians 2:10 – *For you are God's handiwork created in Christ Jesus to do the good works which He has prepared in advance for you to do.*
1 Peter 5:7 – *Cast all your cares on Him for He cares for you.*
Matthew 28:20 – *And surely, I am with you always until the end of the age."*

So, all in all, I do know that the fruits of the Spirit do not include the fear, inadequacies, anguish, guilt or shame I carry back from these events. I cannot unsee some things and I cannot unsmell others.

Christ's resurrection however allows me to bring the BUT GOD back into my internal dialogue. I tell many younger mentees that they are strategically positioned, well equipped, armed and ready for the interactions God has for them. I have remarkable confidence in them. No detail of life has taken God by surprise. It is my turn to take my own medicine.

It takes, frankly, a mountain of effort to believe that **I was** wonderfully **made to do** each recorded day, to walk out **His plans** and purposes **to do good works**, with prayer as an active tool and am **not alone** in the journey. However that looks.

BUT GOD positioned me there and it was better than me not being there.

BUT GOD provided me with a scope of practice that helped.

BUT GOD brought voice to the situation by bringing my presence.

BUT GOD knew that my hug and connection was more important than my shortfall of full medical knowledge.

BUT GOD used my voice to still the waters.

BUT GOD calmed my thoughts before I slept.

Perhaps my perspective is not the ultimate answer. God's perspective is greater than mine and my part was small, but enough. It is sometimes easier to listen to the voice that *criticises* my capacity than the voice that *created* my capacity.

The topic of moral injury is certainly breaking new ground in academic circles and rightly so. Healthcare has a high fallout rate, high burnout, and tragically, high suicide record. It is imperative we identify moral injury and teach a broader understanding to our colleagues.

Ways to move forward

1. Create conversation

As multi-disciplinary health care teams we can lead the way in education on Moral Injury. Many healthcare workers have not heard of the term and are often relieved once they have. On an informal level asking "*How is your moral compass*

holding up?" or "*What's keeping you strong?*" is a start. Using a pre/post huddle shift where nursing leaders can explain the term and introduce the value of mental well-being may create a fuller work environment.

In-service training, speakers, conferences and a safe platform to be heard are more formal approaches. Hot (immediate) and cold (delayed) debriefs, together with conferences and speakers can also address the topic.

Placing value on healthcare worker's morals should become normal conversation.

2. Resources
Let the people you lead be aware of your intentional interest for their well-being and the resources available to them. Allocated times of debriefing in a confidential environment as a regular occurrence may diffuse lingering doubts and normalise the process.

A noticeboard with webinars, articles, information, chaplains and help lines may be helpful.

> ***"Small acts of kindness remain a remarkable way to show compassion."***

3. Leadership
By expressing a genuine care and concern for your team members, others will follow the cultural shift in the work atmosphere. Small acts of kindness remain a remarkable way to show compassion. We must value each other and realise the impact this has on others.

4. Appreciation
Open appreciation and public thanks continue to keep morale up in stressful times and can quieten the voices that cause doubt and conflict.

So what keeps me awake at night on deployment?

- The sounds of my favourite worship songs,
- The reading of my friends' encouraging emails,
- Reading my kid's silly texts,
- My husband's kind and faithful proud words
- My reading of The Psalms and Scriptures, believing that...
- Maybe, just Maybe, I was born for such a time as this...

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Luke's Journal

www.cmdfa.org.au

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Membership of CMDFA is open to graduates and students of medicine and dentistry. Information about activities of CMDFA can be obtained from the website at www.cmdfa.org.au or from Branch Secretaries. Further information and application details are available through the national office.

Web content editor: Peter Shirley
lukesjournalcmdfa.com
Graphic design: Ivan Smith, Lilydale, Vic.
Stock photos: www.dreamstime.com

Luke's Journal Back Issues

Back issues can be accessed electronically at lukesjournalcmdfa.com or on the issuu app at www.issuu.com
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Dr Antonio Rombola (MBBS, DipRACOG, FAICD) is a general practitioner working in Windsor NSW. He has been practicing as a GP for over 30 years. Tony is also an adjunct Senior Clinical Lecturer with the University of Notre Dame, Sydney Medical School and a GP supervisor in the GP Registrar training programme.

Moral Injury Conference

The GP Landscape

General Practice is challenging and complex. Its very nature is unpredictable, with a broad cross-section of medical, surgical, social, psychological, and other issues likely on any given day.

The environment is often chaotic, with frequent distractions and interruptions. There are pressures of varying degrees of urgency from patients, hospitals, colleagues, aged care facilities, and others. The business side of general practice requires attention to government regulations, administration, Medicare compliance, accreditation, accounting, payroll and human resources. Increasing reliance on computer technology demands ongoing maintenance, with the unpredictability of potential outages. Then there are the practitioner's own considerations - issues at home related to their own health, their partner, their family, and other personal agendas. Yet, the pressure to see patients is constant, due to both the patient's clinical needs and the financial pressure to keep the practice running.

Our medical system has squeezed practice income through restricted Medicare funding while demanding ever more in bureaucracy and administration. The rest of the medical landscape is also overloaded, with delayed or blocked access from long waiting times, increased financial constraints, and high out-of-pocket expenses. There is a higher burden of chronic diseases, an increasingly ageing population, and a rise in psychological issues such as anxiety and depression. It is not surprising that patients rely more and more on their GPs to manage their complex needs. With that greater complexity, more time, resources, and expertise are required at the primary care level.

> ***"Patients rely more and more on their GPs to manage their complex needs. With that greater complexity, more time, resources, and expertise are required at the primary care level."***

Moreover, the current COVID-19 pandemic has significantly impacted General Practice, adding further demands on already-limited resources. The immensity and uncertainty of the problem is resulting in rapidly escalating mental health symptoms, both in the community and among health professionals.

Such an overview could make general practice appear quite unappealing, with good reason for many sleepless nights. Despite this, with 30 years of general practice behind me, I still find the opportunities to treat, minister, and interact with patients immensely rewarding and challenging.

As I ponder the things that have disrupted my sleep over the years, I realise that they fall into three broad categories: People, God, and Self.

Patient/clinical issues (People)

The sheer volume and breadth of work in general practice can be daunting. The GP always has a background fear of missing something, misdiagnosing or delaying diagnosis, and potentially harming a patient by omission or by treatment. There are complex and difficult patient

presentations or complaints and sometimes unexpected outcomes. Dealing with death and dying seems to get harder, especially with long-term patients. There is a pressure to deal with issues within set timeframes, sometimes dictated by external factors beyond the practitioner's control.

Christian issues (God)

It is a constant challenge to follow a Christ-centred approach and to maintain a faithful witness. The pressures are amplified by the multiple interactions each day with patients, staff, colleagues, and others. As Christians, we aspire to treat patients as Christ would treat them, which can translate into setting ourselves higher standards of care than might ordinarily be expected. Being human, we cannot possibly achieve this consistently and so we may experience internal conflict. Long work hours and other commitments also affect the time available for prayer, reflection, interacting with other Christians, and attending church.

Personal issues (Self)

Urgent problems may also arise at home. Unpredictable illnesses may affect the practitioner and their family. Raising children brings numerous demands and commitments. Houses need maintenance and cars need servicing or repairs. Work pressures impact social activities. It is sometimes a struggle to get away on a holiday and to relax. Balancing home life with work commitments is a never-ending challenge and can cause or perpetuate tensions.

My Response

My response to these issues can be distilled into five core areas:

1. **Psychological well-being:** It is so important to be intentional about your mindset, and to challenge your thinking. It is easy to fall for the "imposter syndrome" and feel inadequate, leading to a lack of confidence in your judgement. Of equal importance is to be aware of the opposing trap of being overconfident. God wants us to appraise ourselves fairly and appropriately.

"Be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is … Do not think of yourself more highly than you ought, but rather think of yourself with sober judgment." Romans 12:2-3

Keep a lookout for harmful habits. Regularly monitor and review your behaviours and intervene early. Keep stock of your mental health.

2. **Physical well-being:** Take breaks at work, make time for lunch and to connect with others, regardless of your workload. Schedule regular leave. Recognise your particular personal signs which suggest you need time off. Be intentional about eating a balanced diet, sleeping adequately, and exercising. Practice strategies to wind down after a day's work, especially if there have been unresolved or difficult issues.

3. **Spiritual well-being:** Pursue and maintain a spiritual perspective. Pray, read scripture, and listen to worship music. Bring your day to God and lay your worries on Him.

"Come to me, all you who are weary and burdened, and I will give you rest." Luke 11:28-29

Recognise and acknowledge that God is in control. Intentionally seek fellowship, stay planted in one church, and attend regularly. Seek encouragement from other Christians.

"Let us consider how we may spur one another on." Hebrews 10:24

4. **Community connection:** Daily clinical work can be very isolating, even in group practices. Therefore, be intentional in building your key relationships: with your partner, your family, and your friends. We all need a few trusted people in our support network, so foster and strengthen your inner circle. Connecting in meaningful ways can ease stress, lessen the weight of your burdens, widen your interests, and provide accountability.

5. **Connect with a GP:** It's important to see a regular GP and be a patient. Schedule regular check-ups. Review your mental and physical well-being and do not delay seeking help. If you feel isolated, overwhelmed, depressed, or anxious, talk to your GP, a counsellor, or a psychologist. This must be done in a professional setting during a scheduled appointment, and not 'on the fly' in a corridor consultation or a social setting.

In summary, take care of yourself psychologically, physically, and spiritually. Stay connected to God and his people. Have your own doctor and seek professional help if needed. Be deliberate in setting up the best environment for you to thrive - both professionally and personally.

"As Christians, we aspire to treat patients as Christ would treat them, which can translate into setting ourselves higher standards of care than might ordinarily be expected."

A video of this talk is available to members of CMDFA. If you are not a member and would like more information please call the CMDFA Office on 02 9680 1233.

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Photo: HSA in PNG

HealthServe Australia

Bringing health, hope and wholeness

Editor's Note:
Living in the digital age makes our world both larger and smaller. Social media allows us to immerse ourselves in communities with ideas similar to our own, often unaware of differing points-of-view. On the other hand, technology can also interrupt this inward lens, drawing our attention to different people and issues all over the world.

In this edition we are privileged to hear from a team engaging 'beyond the bubble'.

HealthServe Australia (HSA) is a Christian health and development agency that builds sustainable health programs globally. It aims to build a community's capacity for meeting its own health needs, through partnership. Here are some reflections from a February 2020 trip to Java (before COVID halted so many mission journeys), an update regarding the PNG Healthcare Workers Manual, and an invitation...

Connecting in Indonesia

Dear *Luke's Journal*,
The pandemic had barely taken off when four enthusiastic leaders left Australia's east coast for culturally-rich Yogyakarta. Lawrence, Maddie, Jean and Michael were met by friends from the Indonesian Christian Medical Fellowship. Dr Maria Widagdo (Dean of the Faculty of Medicine at Duta Wacana Christian University) extended a warm welcome and we immediately felt at home.

HealthServe Australia's vision is motivating and grounding. It seeks global health, transformed by accessible, compassionate and high-quality health care for all.

The focus of this project was teaching whole person Medicine using the PRIME model (Partnerships in International Medical Education) - https://www.prime-international.org/theprimenetwork.htm Together with our Indonesian partners, Dr Ronald and Dr Teguh, we explored various models of whole person care. We set the stage for medical consultation with a framework that asks: '*What are the physical, emotional, cultural and spiritual needs of the presenting patient ... and of the doctor?*'

We specifically examined the evidence behind different strategies and the practical aspects of making it work. Hot topics included adverse childhood events, stress, burnout and self-care. Over thirty health professionals were in attendance. The program was so successful that a subsequent visit, on the theme of palliative care, is scheduled for 2021.

One of the beauties of HealthServe Australia is the way it links with other program partners, empowering their ministries. On our Indonesian tour we connected with two such organisations. The first was *Torch for Life*. We were encouraged by meeting with their representatives, Dr Jenny, Dr Enny and Elia. *Torch for Life* equips local community members to be a key health resource at times of disaster, such as earthquakes and tsunamis.

In Bali, we met our partners in the ministry **Gerasa Bali**. This organisation works as a bridge of peace for local vulnerable people, especially women, children and those with blood borne viruses.

Perhaps HealthServe Australia is a group you would like to connect with. They partner in primary, secondary and tertiary healthcare settings to deliver holistic, evidence-based, community and individually-focussed health care programs. HealthServe Australia is registered with the Australian Charities and Not for Profits Commission (ACNC) and the Australian Council for International Development (ACFID). Join with us and increase your vision, aims and values.

Note: HSA runs a scholarship program for students and recent graduates with an interest in these visions and aims, via the HeartStart program https://www.healthserve.org.au/programs-of-health-serve-australia/156-heartstart-project

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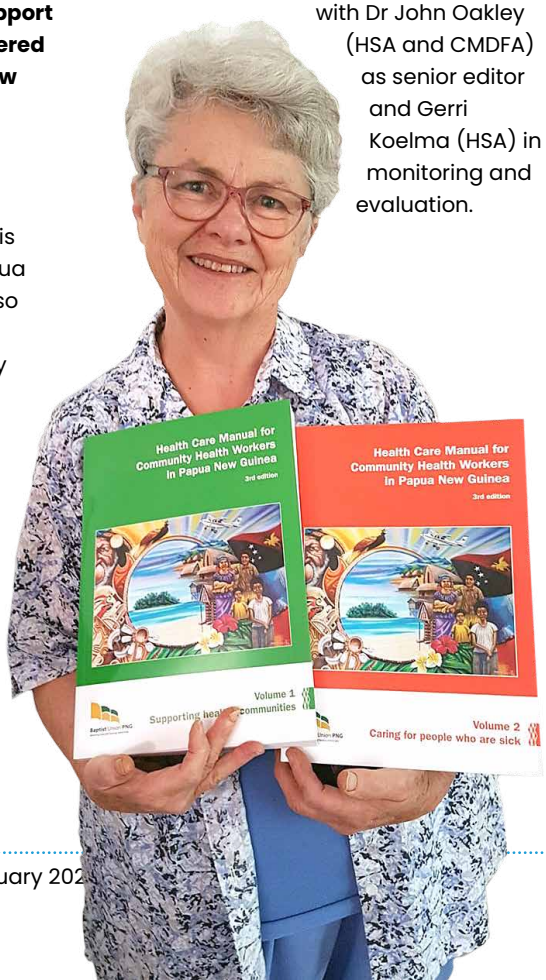
Bringing health, hope and wholeness

Papua New Guinea HealthCare Worker Manual

Photo: HSA in PNG

Papua New Guinea is our northern and nearest neighbour. Australian Christians partner with Papua New Guinean Christians in many healthcare ventures to bring health, hope and wholeness to local communities. HealthServe Australia, with the support of many CMDFA friends, has partnered in the third edition of the Papua New Guinea (PNG) HealthCare Worker manuals.

Our first CMDFA national executive officer, Dr Clifford Smith OAM, and his wife Judy, served the people of Papua New Guinea for many years. Cliff also was the initial executive officer for HealthServe Australia. Cliff and Judy valued health, service, equipping, compassion and wholeness. Together in partnership with PNG health workers, they created a unique resource for healthcare workers in rural and remote PNG – a textbook of unparalleled utility. Cliff and Judy oversaw the first two editions, the second printed in 1996. After this, a newer, more up-to-date third version was needed. Cliff handed over the task to an able team of new partners including HSA, Baptist Union PNG, Christian Health Services PNG, PNG National Department of Health and AusVoc Educational Publishing. We acknowledge the generous support of Australian Aid. HealthServe Australia played a leading role in collaboration with Dr John Oakley (HSA and CMDFA) as senior editor and Gerri Koelma (HSA) in monitoring and evaluation.



While Dr Smith mostly wrote earlier editions, this third edition has a comprehensive range of PNG writers. The manual has two parts – a first part that addresses issues of prevention and health communication and a second part addressing treatment and health management issues. The 2020 printing of fifteen thousand copies of the complete two volumes of the manual has been a significant milestone. Unfortunately, Cliff was not able to see its final publication, passing in 2015.

HealthServe Australia aims to promote wholeness for all partners – physically, emotionally, and spiritually. Our programs seek to bridge the health gaps in diverse communities so that those we serve can embrace their potential in life.

Thank you to CMDFA people who have generously responded to bring health, hope and wholeness.

Please visit our website to learn of further opportunities to engage in a wide range of programs and partnerships: www.healthserve.org.au

Left: Judy Smith with the third edition books.

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Lighting Paths, Healing Lives

Dr Editha distributing roofing materials to Typhoon Yolanda survivors

The **Dignity and Right to Health Award** is an initiative of International Christian Medical and Dental Association (ICMDA). The award provides recognition, support and publicity for the most outstanding role models and champions acting to address health and development issues, including the HIV global epidemic.

It is an international award acknowledging the contributions of Christian doctors, dentists, nurses and other health workers.

The award is an important symbol for ensuring that voices from diverse communities and countries are acknowledged and championed. By granting this award ICMDA aims to model, mobilise and encourage creative and sustainable initiatives that enhance the dignity and human rights of all people, each made in the image of God. https://icmda.net/get-involved/awards/drhaward/

2020 Nominees:

- National *Torch of Love* Foundation – Suluh Kasih Bangsa (SKB), Disaster Relief, Indonesia
- Dr David Mills, Kompian Hospital, *Rural Medicine Program*, Papua New Guinea
- (WINNER) Dr Editha C. Miguel, FPCP, *Agape Rural Health Program*, Philippines

Congratulations to Dr Editha and the other nominees on their excellent work. Read on to learn more about Dr Editha and the work she and *Agape Rural Health Program* are doing in Palawan, Philippines.

Palawan Province in the western Philippines is an archipelago - an expanse of water with many scattered islands. The province is composed of the long and narrow Palawan Island, plus roughly 1,780 islands and islets. Many recognise Palawan as the most beautiful island in the Philippines, and one of the most beautiful in the world.

The Philippines has made significant investments and advances in health in recent years. Rapid economic growth and strong country capacity have contributed to Filipinos living longer and more healthily. Despite substantial progress in improving people's lives and health in the Philippines, achievements have not been uniform and challenges remain. Deep inequities persist between regions, between rich and poor, as well as different population groups.

Dr Editha Miguel, an infectious disease specialist, graduated from the University of the Philippines. She demonstrates visionary and innovative leadership in addressing the health needs of the communities of Palawan. She has felt drawn to serving the poor since she was a medical student. In 1986, Dr Editha and others established the Agape Rural Health Program (ARP) in Palawan - http://agaperuralprogram.org/

ARP seeks to improve the health conditions of rural communities through holistic health development projects. As executive director of the first province-wide health program in the Philippines, Dr Editha oversaw the training of thousands of community leaders and village health workers. She sees the training as a way of "empowering the local people by putting their health care in their own hands." Starting from just one province, *Agape Rural Health Program* now serves five provinces in the Philippines.

Dr Editha has a passion for strengthening programs in reproductive health, domestic violence prevention and HIV care. She and her friends from Campus Crusade for Christ train teachers to teach a twelve month course on character development called '*Life at the CrossRoads*'. She believes that young people, especially women, when appropriately equipped can learn to make wise decisions when faced with life's challenges. She encourages Christian women to be ready to become leaders when God calls them to that role, such as in the case of Deborah in the Bible.

Dr Editha and her team provide essential health services for communities with difficulty accessing care due to geographic isolation. The health of these communities has always been a concern as seventy percent of these communities and municipalities have had little or no access to any healthcare services over the years since Dr Editha's graduation. Dr Editha envisions that physical health and social and community development are best approached concurrently within one program, rather than as separate entities.

Dr Editha believes that unless health workers understand health in a holistic context, taking physical, social and moral/ spiritual needs into account, any health intervention will at most have only a superficial impact.

ARP believes that progress and development is a team effort involving all levels of society - from the grassroots to the top socio-political level - in implementing any program. With this in mind, it has a focus on building strong relationships with various stakeholders, from both government and private sectors.

Dr Editha giving a health lecture at the Urban Poor project

The ARP Mission:

To love and serve the poor by being agents of change, empowering people through holistic development.

Objectives:

1. To train individuals and educate poor and needy communities towards self-reliance.
2. To develop community projects resulting in improved quality of life.
3. To provide compassionate health services to address urgent needs.
4. To develop social marketing tools and strategies to promote the programme.
5. To provide continuing staff training and development.
6. To ensure sustainability and functionality of programme processes.

Strategies:

A. Training
B. Community Development
C. Social Marketing/Programme Information Dissemination
D. Compassion

Dr Editha exemplifies a life that "does justice, loves kindness and walks humbly with God." (Micah 6:8). She is a great believer in the 'multiplication' of workers - "Training a few so that they too can train others. That has become my guiding principle in life." She says her strategy is inspired by 2 Timothy 2:2, where Paul tells Timothy to 'entrust the truth to faithful men who will teach others'. In the same way, she "chose to be involved in programs or jobs that allow me to train others so I can have a greater impact."

"Looking back, I can see God's hand orchestrating everything for me," she says.

Dr Editha lives her life consistent with her motto of 'Lighting Paths, Healing Lives!'. When asked about her ultimate goal, she says, "We seek to bring lasting transformation by beginning with inner transformation in the lives of the people as they invite Jesus Christ to be the Lord of their lives and their dreams.

Only one life it will soon be passed, only what's done for Christ will last."

Dr Maria Haase
Maria is a GP working part time in Private Practice. She and husband, David, relocated to Toowoomba, QLD in February 2019. She has made annual short-term visits to Myanmar since 2006 to work in an orphanage and to hone her clinical skills. (COVID-19 prevented this year's trip.)

What to Take on an Overseas Medical Mission Trip

I have been involved with overseas visits to a certain country since 2006: visiting the same orphanage, watching children grow up, performing health checks on the children, staff, affiliated church members and, time permitting, checking other local orphanage children.

I am also the team doctor, so I can be busy after hours, behind the scenes keeping the team well and functioning. One team member down with illness or injury has a flow on impact on the performance of our whole crew whose duties include running a holiday programme and teaching varying skills as well as having fun. Before we leave, information is required on any medical problems so that I can pack my supplies. A compact but comprehensive supply of medications is essential for the team. Gastroenteritis episodes are common with the change in water and diet.

I have learned much over the years about cross-cultural work and the complexities of packing my kit. In the early years, I worked in a thatched hut with no running water, but more recently in a concrete building, still with no running water. Two years ago, I once left my cake of soap on the nogging of the unlined wall to return the next morning to find gnaw marks all around the edges. Hence one very clean mouse gut!

It takes thirty minutes to set up on the first day. I have a small kit of essential equipment that I haven't changed at all. Spare batteries are always required as occasionally children sneak in before lockdown and leave the auriscope on all night! I have a medical check sheet to complete for each child's examination, with children requiring tests, follow up or hospital referrals marked in red pen and placed aside for discussion with the leaders.

Interpreters are essential and a good one is worth their weight in gold. In 2019, some children who spoke a different dialect had just arrived and two interpreters were required to relay information. This increased the time needed for each examination.

"Medication should not be high-powered for a local clinic situation."

It is often amusing as children line up for their turn, knowing the ropes from staring through the open windows to observe the proceedings. By mid-afternoon, it is the adult session. I try to tailor the examination to adult specific mode but they insist on the same examination as the children, thinking that I am neglecting care if I do not examine their ears, etc!

What I have come to learn is that medication should not be high-powered for a local clinic situation. Simple analgesics, antibiotics, gut medications, asthma medications and topical creams are the most common requirements. In some cultures folk feel ripped off if not given medications. Small plastic bags with a few tablets authenticate the consultation. Local knowledge is essential to know what is appropriate. Teaching sessions are essential at the end of every day, to ensure that medications are being used correctly, and as an opportunity to upgrade skills. If the locals cannot understand a spoken direction, it is important to write it down, as often accents cause difficulty. Body language helps so much. Acting out scenarios provides information and comic relief.

It is becoming increasingly difficult to bring medications into developing countries, so taking money and sourcing locally (mindful of the country of origin of medications) is sometimes easier. Taking a local to help with purchasing can be helpful as prices can soar for foreigners.

My first day's question is, 'What have you run out of and what are your most urgent needs?" Then a trip to the pharmacy that afternoon with a big list is most helpful. Betadine, ear drops, optic preparations and simple meds such as paracetamol can often be purchased much more cheaply locally compared with purchasing in Oz.

One great frustration occurred five years ago when a Pharmaceutical company's charitable arm, under the guidance of their legal team introduced documentation requirements for procurement of medications. Suddenly, one had to supply the name of the local medical recipient for the transported medications. No, I could not supply a name as that would be dangerous for the local doctor. This was a military dictatorship!

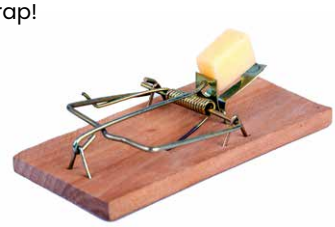
Also, I could not guarantee storage between 4-24 degrees for the medications as the room was in a hut, in

"World views are different, experiences are different, values are different."

stinking hot conditions, where we worked at temperatures between a cool 34C up to 43C. I had to wipe the mouse urine off the stored medication bottles and retrieve the mouse nest from behind the plastic storage drawers, so no, clean conditions are certainly not guaranteed. I suggested the lawyers accompany us to realise that their world was vastly different from the one to which I was to work in. Different rules apply. This is one of the very important facts. Different rules do apply. These are parallel universes! World views are different, experiences are different, values are different.

Another important lesson is to listen to the locals and learn what works for them. New team members often want to impose their cultural values instead of adjusting to local values and seeking their wisdom. Saying that, sharing skills and empowering the tired local workers creates wonderful memories.

So, if you are a first timer, wondering how to pack, read about the culture, try to determine the needs if at all possible and ask for help from others who have walked before you. Learn each time you travel and, most importantly, don't forget your mouse trap!



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You can find an article style guide and template and more information on getting involved at https://lukesjournalcmdfa.com/get-involved/

Articles, letters, book reviews and lengthy news items should be submitted (preferably in electronic form) to the editors with a covering letter requesting their consideration for publication. Photos supplied should be high resolution JPEGs (minimum 500K).

Advertisements and short news items should be submitted directly to the editor: lukesjournalcmdfa@gmail.com

CMDFA Member News

Let *Luke's Journal* know what's happening in your lives – including births and marriages. Some whose spouses have passed would be interested in meeting with others in similar situations for support. Contact lukesjournalcmdfa@gmail.com with information, dates and photos (high res JPEGs) as appropriate.

Dr Thomas Chengxuan Lu
Thomas is a general practice registrar in Sydney and a conjoint lecturer at UNSW. He has a keen interest in the intersection of medicine and faith.

Medicine on YWAM Medical Ships

L-R back row: Soufian (Dentist, Belgium), Thomas Lu, Hannah (PGY2, Germany), Shun (ED Attending, Singapore), Maggie and Kapi (Med II, PNG). Front row: Susana (Dentist, Australia), Rochelle and Ebony (Med II, Australia).

"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

This was declared proudly to all patients waiting in the sweltering sun at the beginning of our primary care clinic. Here we were, Christians and non-Christians intermingled on the shores of our close neighbour, Papua New Guinea (PNG), providing care in the name of Jesus.

Background of YWAM

Youth With A Mission (YWAM) Medical Ships – Australia and PNG (YWAM – MS) are a Christian organisation with headquarters in Townsville. Using a converted cruise ship, YWAM-MS runs approximately ten to twelve outreaches to the rural and remote regions of PNG each year. The ship houses up to 130 temporary and longer-term volunteers from across the world who come from a diverse range of backgrounds and faith systems. 84% of the PNG population live in these areas and for them, such outreaches may be their only access to primary care.

My journey

I stumbled upon YWAM-MS during the end of internship. As a medical student, I had always wrestled with what it meant to live faithfully in the ever-consuming world of medicine. My conclusion was to be a dependent and loving worker, who displayed a life of integrity and grace, with conversations seasoned with salt and truth. This rendered meaning and provided dignity to my vocation as a servant of Christ in the medical field.

However, reality felt incongruous to this with 6pm admissions, the gradual accumulation of overtime and the frequent godless banter which seemed fundamental to modern-day medical teams. This inspired me to explore medical missions overseas. Having seen the YWAM stall at a previous CMDFA meeting, I signed up for an outreach trip during annual leave.

"In 2019, over 30,000 vaccinations were administered, and 40,000 patients reviewed in the primary care outreach clinics."

Outreach medicine

There were many challenges in practising medicine in PNG. Each day we would commute from the ship to our target location. Some of these commutes were long and bumpy, featuring a mix of worn rugged jeeps, wooden stalls on the back of old pick-up trucks, and even a medium-sized dinghy to navigate volatile waves. All the equipment, medicines and vaccinations were carried in multiple heavy, large backpacks.

The focus of each outreach is the provision of primary care, in alignment with the national priorities of the country. Interventions are cost-effective with the goal of providing the greatest quality of adjusted life years (QALY). There is

a strong focus on providing childhood immunisations, and on family planning.

Tropical diseases like malaria, tuberculosis and yaws are prevalent in the country,[1] and occasionally, patients become significantly unwell. Allied health professionals are highly valued as there are many musculoskeletal presentations, secondary to people having hard lives working the fields. The dental clinic can see well over forty patients a day. In 2019, over 30,000 vaccinations were administered, and 40,000 patients reviewed in the primary care outreach clinics.[2]

Medicine in PNG was a cultural shock. Apart from the significant language barriers in history and examination, more specialised investigations and sub-specialist support were unavailable. This made presentations beyond the most basic of issues difficult to tackle. Although more specialised services are available in Port Moresby, there are significant barriers to access due to the rural and remote locations that the medical outreach services.

Holistic development and partnership

The medical work is accompanied by a strong emphasis on partnership with local health providers. Papua New Guinean healthcare workers regularly participate in the outreach trips. Their input on outreach priorities, based on provincial and district health authority, is highly valued. In fact, part of YWAM-MS's funding is locally derived from PNG corporates.[2] With each outreach, there is holistic engagement with the local community. There is a commitment to education, for example, programs which aim to reduce gender violence. Infrastructure is also supported when possible, such as water pumps and water tanks repairs. All of this is built upon a solid relationship with the local community.

Faith and remote medicine

Although challenging at times, PNG offers the opportunity to practice medicine steeped in faith. By tradition, YWAM clinics always begin with a reminder that Christ has provided life to the full. The overwhelming Christian heritage in PNG makes spiritual acts such as prayer prevalent in consultations. For many patients with more complex and chronic ailments, unable to access treatment due to resource limitations, a reliance on God is the only solution. These settings have only reminded me of the natural decay of life, and to put our hope ultimately in the eternal life provided by Christ.

Fellowship and evangelism

Within the ship environment, there exists an amalgam of cultures and people. Christians from across the world, and from all different denominations come to serve on YWAM (See picture previous page). Although their motivations and goals are similar, there is a richness of cultural diversity in worship and relationship to God. Many of the volunteers have not subscribed to faith. Many have a deep sense of personal responsibility that aims to share from what they have benefitted from in Australia. Others have a strong sense of attachment to PNG. Within this environment there is much space for interaction, and for the building of relationships through discussion of culture and faith.

Final thoughts

YWAM-MS continues to provide a continued presence of Christ's love and mercy in PNG through healthcare, education and relationship development. Participating in outreach has never felt like a short-term endeavour, but rather a contribution to a long and successful partnership. For me, it was a reminder to cherish the deeply-valued resources in Australia, whilst contributing to a presence which I very strongly feel will make a difference in the world. YWAM-MS is always looking for keen doctors, dentists and allied health professionals to join its team.

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2. YWAM Medical Ships. 2019 - Annual Report.

A/Prof Alan Gijsbers
Alan (MBBS FRACP FAChAM DTM&H PGDipEpi.) is a Specialist Physician in Addiction Medicine, Melbourne, and President of Christians in Science and Technology (ISCAST). He has a particular interest in a studying neuroscience and theology, the philosophy of the self, and spirituality, topics which underpin his approach to addiction care.

Response to: Do we really save lives?

Andrew Williams's story, "Do We Really Save Lives?" (*Luke's Journal* 2020, Vol 25 No 2), brought back difficult memories of a very similar conversation I had with my vicar in the late 1980's-early 90's, but with a very different outcome.

My wife and I had just come back with our three children from a five-and-a-half-year missionary stint at the Christian Medical College and Hospital, Vellore, South India. There our home on the college campus had been a centre for fellowship and Bible study, where medical students explored their vocation as Christian doctors training for their role, mostly in mission hospitals around the country. Our theme had been David Livingstone's famous statement, "When God sent his Son into the world, he sent a medical missionary." The conversation with our vicar centred on his vision to encourage suitable candidates into the ordained ministry. I recall the event vividly. We were at the beach and I remember a strong sense of being called to become a theologically-sensitive medical practitioner, seeking to integrate Christian faith and clinical practice, bridging the Sunday/Monday disconnect and seeking to incarnate the Christian Gospel into my daily work.

Some adverse consequences followed upon our return to Australia. First, I stopped being part of the church preaching roster. Whereas before I had a role as a missionary sharing my faith in a different culture, now that I had returned, I became one of God's frozen people in the pews – reduced to listening to sermons, usually from trainees who were novices at the art. There was little call in our church for the sort of reflection I was doing. They preached the simple Gospel of God's love, our sin, Christ's atoning work and our need to repent, become a Christian and therefore receive life. Our lives had been saved, and that was that. There was little exploration on growing in discipleship, growing into community, and living as God's people in the secular community. We were saved, that's all that mattered. In retrospect, this is probably a caricature, but that is what it felt like at the time.

> ***"The Gospel is not just for unbelievers, but also for believers."***

In the meantime, I found a niche in the Christian Medical and Dental Fellowship, where we explored what it meant for us to be Christians in the secular environment where God had placed us. I found a further niche with the Institute for the Study of Christianity in an Age of Science and Technology (ISCAST) – an organisation of Christians in the sciences – where we explored what it meant to study God's two books, the Book of Nature, through science, and the Book of the Word of God, Scripture. These explorations were enormously fruitful, enriching my reflections and my clinical practice, encouraging people without faith to come to faith, and encouraging those with faith to have that faith strengthened.

In my vocation as a Christian doctor, I newly learnt the depth and breadth of Gospel proclamation. The Gospel is not just for unbelievers, but also for believers. As evangelicals (Gospel people), we feed on the Gospel for ongoing spiritual nourishment, eating Christ's flesh and drinking his blood (John 6:53-58) as we reflect on how his atoning work impacts all our relationships - in our families, in the church, and in the secular world. Further, I learnt that the Gospel of God's

love is not just preached from a pulpit, but is expressed in word and deed. Jesus embodied God's love by his commitment to the poor, the outcast, the marginalised, the sick, the dying, and even the dead. Further, God's love is not just embodied in word and deed, but also proclaimed communally in the way the community of faith embodies the love of God in their daily relationships. The church, in all its diversity, embodies the love of God, and invites others into that community.

My neuroscientific reflections in addiction led me to see that the Gospel is not just a statement for intellectual assent, but a reflection of God's loving passion for humans, who are more than just thinking beings. We are first emotional beings and our passions drive our thinking and behaviour. I explored this in my paper, *Neuroscience, Addiction and the Gospel (2008)*.[1]

My clinical practice in addiction medicine caused me to reflect deeply on how to address damaged relationships; relationships with ourselves, other people, our higher power, and the lived environment. Humans are not isolates whose ideas need correction or else they will not be saved, instead we are embodied people, living in community, in a physical environment. God has entrusted us as stewards of this environment, and one day we will be accountable to him for the way in which we have discharged the creation mandate that he has given us. Our sin is not just individual disobedience which needs repentance, but also our corporate responsibility to care for the earth – for ourselves and for future generations. For a reflection on how the Atonement affects my clinical practice of addiction medicine see my paper *Addiction and Atonement (2020)*.[2]

Trying to integrate my Christian faith into the secular world has caused me to become bilingual. So, when I talk with people of little or no Christian faith, I explore with them the meaning and purpose of their lives and what relationships they have. When I talk in a Christian context, the language is the fundamental Christian virtues of faith, hope and love. Further, in ethics, Charles Taylor[3] described the modern moral dilemma (which in fact is ancient also) of why should I do good, and how do I get the power to do good? The Christian answer is that the love of Christ constrains us and the power of the Holy Spirit is there to develop in us the virtues of the fruit of the Spirit, empowering us to flourish as we become more and more like the Christ we serve.

"We need good clergy, but the secular world also needs Christians called by God to shine for him in their vocations."

I have the privilege of mentoring HMOs and registrars in a secular space. I commented to one, not a believer, that if I had my time over again, I would like to explore psycho-spirituality in more detail. He commented, "Don't you do that now?" Indeed. I was able to give a grand round at the Royal Melbourne Hospital, a secular hospital, on spirituality in clinical practice. I explored meaning, purpose, love, and empowerment, as well as passion, and I told the audience two formative stories which shaped my outlook - the story of the Prodigal Son, and the story of the Good Samaritan. I discovered again that day how attractive the gospel is to those who are thirsty. On another occasion I spoke to hospital chaplains about addiction and spirituality and explored with them the skills of the Master Clinician as he sat with the much-married, now living-in-sin, woman of Samaria, gently peeling off the layers of defence until he had told her everything she had ever done. But that was healing, not condemning! I follow Jesus as he skilfully addressed this lady's deep thirst for God, and how she found that through him, in spirit and in truth, she could have direct access to the Father.

The Christian Medical and Dental Fellowship as a member organisation of the International Christian Medical and Dental Association sees itself as empowering Christian doctors and dentists to live for Christ. We encounter a lot of patients in our practices who would have little contact with Christians if they did not see us. It is one of those unhelpful dichotomies to say that doctors save physical lives whereas clergy save spiritual lives. Most Christian doctors subscribe to the bio-psycho-social-spiritual model of clinical care and the Saline program empowers Christian doctors to explore the spiritual dimension of the clinical consultation in a sensitive and appropriate way. There is a lot of literature on the value of spirituality in medical care.[4]

So then, what do I make of Andrew Willams' journey to the ordained ministry? He felt he could do more being a clergyman than being a doctor, as did his mentor. I hope his education has been broad enough to still be able to speak into the everyday world of his parishioners. Helmut Thielicke describes docetism in the pulpit - when the Word does not become flesh and stays within an ecclesiastical enclave. There is a great need for Christians to be salt and light in the secular world, and we can do that as medical missionaries to that world - encouraged, prayed for and supported by clergy aware of these broader issues. We need good clergy, but the secular world also needs Christians called by God to shine for him in their vocations. We are not all hands or ears or whatever, and each of us cannot say to the other we have no need of you (1 Cor 12:4-25). However, there are other calls than the call to the cloth, and I encourage medical students to follow in the footsteps of the Great Physician and his disciples, like David Livingstone, and so many in Australia through the CMDFA, and around the world through the ICMDA.

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3. Taylor C. The secular Age. Belknap Press of Harvard University Press, 2007:695ff.
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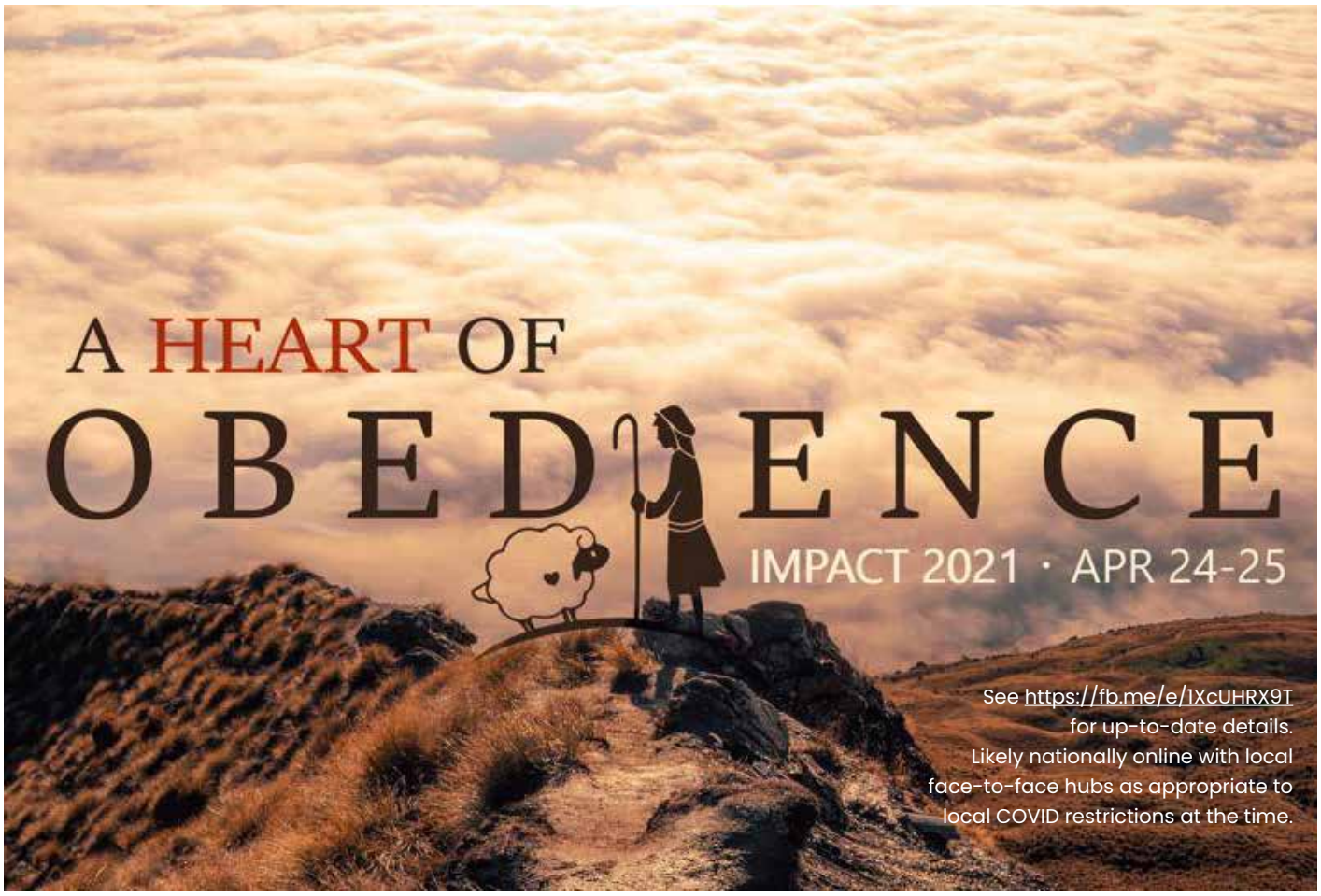

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