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Nutritional Medicine

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The Pilgrim's Quest to find the best of East and West

Redefining the Art of Medicine

Complementary Medicine/Dentistry

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editorial

Complementary Medicine/ Dentistry

In this edition of *Luke's Journal*, we open a conversation about "complementary practice." The modern age has given us the scientific 'evidence based' approach to medical and dental practice. Post modernism places truth more in a category of personal choice. Complementary practice has flourished in this environment. Alternative practices and products are layered with enough 'science' in terms of research to appeal to a wide range of health consumers.

Some time ago I began to write an article where I was seeking to explore my attitude and stance regarding complementary medicine. I started by recognising that my mother who had supported me wholeheartedly through my medical training and who was always proud to spruik her son's achievements nevertheless preferred to utilise complementary products rather than conventional treatments. With a number of chronic disease problems now challenging her well-being, Mum still lists 'ginger' as one of her treatments. So after starting I experienced writers' block.

Folk medicine has always been with us. Despite the ascendency of science, which we acknowledge in this edition, pharmacopoeias have always involved a mixing of conventional and unorthodox therapies. The post-modern context has allowed a resurgence of complementary products and treatment modalities i.e. acupuncture. At the time of Jesus the Essenes were interested in all possible treatments for illness and ailments. The name Essene means healer. Roman baths and hot springs were regarded as having healing qualities. We are given the story of Jesus healing a disabled person at the pool of Siloam. We have an article which picks up on healing in this New Testament context and also from contemporary medical practitioners who practice 'complementary' or 'integrative' medicine today.

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LUKE's journal

Theme for next editions:

"Conscience in Medicine"
— copy by mid June 2013

"Historytaking and Historymaking"
— copy by mid August 2013

"International Health & Mission"
— copy by mid October 2013

"Shining as Lights"
— copy by February 2014

Complementary Medicine/Dentistry

Health Issues and **M**
in 1st Century Palestine

The good news of Jesus the Healer is proclaimed over and over again in the New Testament Gospels. But what kind of healer was he? At the historical time of Jesus many people identified themselves as miracle workers, local folk-healers and exorcists, as well as professionally trained physicians. Local folk-healers were the most accessible to ordinary people. These folk-healers blended in with the predominantly superstitious tribal religious understandings of their era. While practising historical healing methods, including a wide range of herbal remedies that had been handed down through the ages, they also explained illness in terms of traditional demonic spirits. Alongside local village midwives, these folk-healers were valued highly by their own communities. Jewish communities valued also the prayers and specific surgical skills of their Rabbis who regularly circumcised both newly born male Jewish babies and the occasional adult convert to Judaism.

In contrast, established elite medical schools in Egypt, Greece, Rome and Asia Minor trained recognised professional physicians. As students, these physicians were educated to distinguish between clinical examination, diagnosis, therapy and prognosis, and to practise an orderly triage system. This resulted in their patients being assessed in analytical rather than intuitive terms. Some patients were seen to have an immediately treatable illness, others a long-term disabling illness, and others may have been assessed as completely untreatable.[1] But access to these biomedical physicians appears to have been limited largely to military personnel and a privileged civilian minority.

Physicians in 1st century Palestine

There is some archaeological evidence of professional physicians in Palestine during the time of Jesus. Recent excavations of several Roman military camps throughout the region of Palestine show remains of valetudinaria, or medical centres, where injured and ill soldiers and other personnel were treated. Most consisted of several well ventilated rooms where patients and visitors were accommodated. Some valetudinaria had an operating room, as well as a dispensary, a kitchen, baths, a mortuary and herb gardens. Occasionally they had latrines.[2] Lead and bronze medical instruments discovered in some excavated valetudiaria include hooks for retracting skin edges, small spoons for cleaning wounds, probes, catheters, spatulae, scalpels and fibulae (safety pins) to approximate wounds, Almost certainly sutures of flax, hair, silk and animal gut were also used in wound repair.

Doctors probably used forms of cannabis for pain relief. There is some evidence of the usage of henbane (*Hyoscyamus niger*), and the Romans are known also to have used a concoction of mandrake (*Atropa mandragora*) in alcohol for pain. The ancient Roman historian Pliny the Elder (23-79 AD), who was a contemporary of Jesus, writes that the juice of mandrake was: 'administered in doses proportional to the strength of the patient, this juice has a narcotic effect... it is given... for injuries inflicted by serpents, and before incisions or punctures are made in the body, in order to insure insensibility to the pain.'[3] There is even an argument that the 'gall' described as a palliating agent for Jesus to drink during his crucifixion may have been opiate, although there is no current evidence of opium crops in Palestine (Matt 27:34).[4]

While the archaeological evidence is somewhat limited, literary evidence of professional medical care abounds. Ben Sirach, a Jewish scholar in Jerusalem 200 years before Jesus, advised his people to 'honour physicians for their services, for the Lord created them; for their gift of healing comes from the Most High and they are rewarded by the king... Then give the physician his place, for the Lord created him, do not let him leave you, for you need him' (Sir 38:1-2). But not everyone

edical Care

by **Merrill Kitchen & Paul Kitchen**

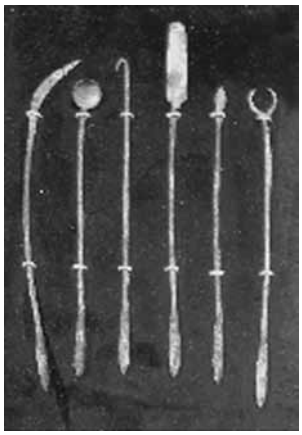
This paper was written by Merrill Kitchen and based on some of the PhD research being done by her husband, Paul Kitchen, before his untimely death due to a brain tumour in late 2011. Paul was a Senior lecturer in Surgery at the University of Melbourne and a General Surgeon at St Vincent's Hospital, Melbourne. Merrill was a Medical Scientist and Lecturer in Microbiology before undertaking theological studies after she and Paul had returned from working at Christian hospitals in Israel and Palestine. She is currently a Fellow of the MCD University of Divinity.

was convinced about the divine oversight or the professional skills of physicians. As Pliny the Elder recorded, 'Medicine changes everyday, and we are swept along on the puffs of clever brains of the Greeks... thousands of people live without doctors, though they still need their medicine.'[5]

In the Gospels, several quoted sayings of Jesus refer to physicians (*iatroi*). For example, Jesus is depicted in all three synoptic Gospels quoting a well-known proverb, 'those who are well have no need of a physician, but those who are sick,' presumably alluding to himself (Matt 9:12; Mark 2:17; Luke 5:31).[6] Also, Luke, a companion of the Apostle Paul, is described as a 'beloved physician' (Colossians 4:14).

Medical Treatment in First Century Palestine

Physicians in the first-century dealt commonly with injuries of various kinds. If someone came in bleeding from a leg wound, they would be laid on a couch, the leg elevated and loosely wrapped with cloth. Cold water would be applied around, but not into, the wound. Another cloth soaked in warm water would be applied to the patient's head in order to 'draw blood' away from the injured limb. Drops of white sap from a fig tree on a plug of wool or gauze were then inserted into the open wound.[7] Because fig sap curdles milk it was assumed that it would also clot blood. When fig sap was not available, the doctor would use a mixture of wine, olive oil or honey.[8] We now know that fig sap is not a clotting agent but is, in fact, an anticoagulant! On the other hand, olive oil has been long recognised as a healing agent. It was first recommended in the writings of Hippocrates, and has been found to contain components such as antioxidants, omega 9, vitamins C, E and K, as well as relevant amino acids. Physicians, after dealing with the wound, would apply a firm white bandage soaked till dripping with red wine.[9] Interestingly, the bacteriocidal effect of wine is not its alcohol content which is only 9-11% compared to the 70% alcoholic solutions used today to disinfect skin for surgery. But it has been noted that the red or white wine used in Palestine could kill 90% of bacteria in 10 minutes. This strong antibacterial action is almost certainly due to Anthocyanins, a polyphenol subgroup that is present in wine. In red wine, the active component is a pigment known as malvoside or oenoside. The antibacterial effect increases with maturity of the fruit. During the fermentation process, an acidity emerges that splits the pigment from a preventative carbohydrate in the grape. For optimal antibacterial effect, the wine needs to be poured on to the wound directly as the surrounding sub-cutaneous proteins in the wound are highly likely to deactivate rapidly the healing component. Other antiseptic dressings used by first-century physicians included copper acetate, lead oxide, alum, dried pitch and dried pine resin mixed with oil and vinegar.



Reconstructed 1st Century surgical instruments

While a tourniquet may have been applied initially to a bleeding wound, it was well recognised that longer-term use of such arterial and venous compression could lead to gangrene.[10] In ancient times, arteries were thought to contain air, and there was no concept of circulation of the blood with the heart as the pump. However by the time of the first century a small curved clamp had been invented to grasp the bleeding vessels like haemostatic forceps.[11] Bleeding vessels were thus either clamped with straight or curved forceps, or sealed with sutures or cauterised with red-hot irons. This was important to save life from the blood loss that occurred with limb amputations, tumour removals, gangrene, work accidents or war injuries. Celsus said the forceps 'round the wounded spot are to be tied in two places and cut across in between.' He agreed with the Hippocratic school that redness around the wound (which we recognise now as infection) was due to blood stagnating in the tissues, so he encouraged bleeding from its vessels, even recommending that the veins above the wound be slit. At least he put on a firm dressing once bleeding stopped rather than letting the wound stay open as the Hippocratic books recommended! Snake bites were also a regular challenge. The common snake in Palestine, then as now, was the viper whose bite could cause limb swelling and death from bleeding as the venom has an anticoagulant action (Acts 28:4-6). Celsus describes, also, use of a tourniquet above the bite, and the need to draw the poison out with a heated cup perhaps with incisions to make it bleed, or sucking the wound 'because it does no harm when swallowed so long as he has no sore in his mouth.'[12]

First century physicians were competent orthopaedic manipulators and knew how to apply traction and

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put limbs into alignment. Hip and shoulder dislocations had an array of techniques for correction. Fractures were splinted and bandaged, and it was possible to reduce fractures surgically if non-surgical methods failed. One of the interesting operations done on bone was trephination. It involved cutting or boring a hole in the skull to relieve intra-cranial pressure. This would sometimes work for a depressed skull fracture, but was usually lethal.[13]

"Jesus is depicted not just miraculously healing people as he passed by fleetingly, but as seeking out the needy, treating them with compassion, giving them hope and providing new opportunities for a healthy community life."

Other common surgical procedures in the ancient world were abscess drainage, excision of skin lesions, removal of nasal polyps, haemorrhoidectomy (using cautery), and perhaps some small hernia repair. Dental extractions have been demonstrated in a skull found in an ancient mass grave at Horvat en Ziq in the northern Negev desert of Israel. It contains one of the earliest known dental fillings and a 2.5-millimeter bronze wire had remains inserted into the tooth's canal.[14] Roman physicians are also known to have performed reversal of circumcision on circumcised men who wanted to avoid embarrassment when appearing naked at the baths or at gymnasia.[15] Occasional tracheostomy for diphtheria has also been recorded. However, death was the inevitable outcome for commonly seen conditions such as bowel obstruction, strangulated hernia, gallstones, breast cancer, fibroids, enlarged prostate, stomach ulcer, inflammatory bowel disease and kidney stones. Apart from symptomatic relief, there is no evidence that medical intervention was curative for these disorders. Palliative care was available for some, however, as demonstrated in the story of the dying King Herod the Great who had physicians treat him in warm baths near Jericho.[16]

Jesus, the Healer in context

Just as we try to find meaning in disease today, so did the ancients. When Jesus came as a great healer, that question became of acute interest to his followers.[17] The language of healing is woven throughout the New Testament and has both literal and figurative meanings. Nowadays, anthropologists describe two models of illness. There is the biomedical model which removes blame from the sufferer but does not seek to find meaning in suffering (which compares to the Hippocratic teachings) and then there is the cultural model which is the psychosocial experience and meaning of perceived disease, and the subjective presence of symptoms of a disorder. At the time of Jesus the cultural model was predominant and, throughout the Gospels, Jesus is not depicted as a healer who waits for people to come to him in a fixed location and with the expectation of a particular procedure. Rather, Jesus moves around Galilee, Judea and even into non-Jewish areas 'on the other side' of Galilee, reaching out to people in spiritual, emotional, intellectual and physical need.

The original Greek words used by the New Testament authors to describe Jesus' actions are predominantly *iaomi* and *therapeuein*. These words are most often translated into English as 'heal,' 'save' or 'cure,' with salvation as a central holistic concept of healing throughout the Gospels. But these words may also be translated with the more holistic term 'to treat,' as do translators of other contemporary Greek literature about physicians. The assumption is that Jesus' actions have a miraculous element and so the stories are told reflecting instant curative results. This concept can be seen in some early Christian frescoes in the Roman catacombs that depict Jesus carrying a wand. Clearly, some in the early church saw him more as a miracle-worker than a treating physician. But the context of the Gospel healing stories suggests that Jesus was not just an itinerant miracle worker. In a time of conflict, dispossession and dislocation, while the military occupiers and rich may have had access to medical care, the ordinary villagers and refugees had few choices when their illnesses were beyond the skills of their local folk-healers. Jesus is depicted not just miraculously healing people as he passed by fleetingly, but as seeking out the needy, treating them with compassion, giving them hope and providing new opportunities for a healthy community life. He demonstrates a holistic merciful approach to the people he encounters and charges his disciples to do the same. In doing so, the Kingdom of God that Jesus proclaims in words and deeds was experienced in sharp contrast to the oppressive, careless imperial rule of the day.

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3 Pliny the Elder, 'Mandeagora,' *The Natural History of Pliny*. (1956-66) Trans. H Rackham, WHS Jones, DE Eicholtz. Cambridge MA/London: Loch Classical Library / Harvard University Press / Heinemann) Volume 5: Chapter 94.139. Of Pliny's 37 volumes on Natural History 12 volumes (Vols. 20-32) are devoted to drugs and medicine.

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6 See John J. Pilch (2000) *Healing in the New Testament. Insights from Mediterranean Anthropology*. Minneapolis: Fortress Press, 62.

7 This assumption lasted hundreds of years in antiquity. Guido Majno (1975) *The Healing Hand, Man & Wound in the Ancient World*, Cambridge MA: Harvard University Press, p117.

8 < http://lighthousepatriotjournal.wordpress.com/2008/09/11/ancient-health-food-olives-and-olive-oil-in-history/>

9 Majno, *The Healing Hand*, 186-7.

10 Majno, *The Healing Hand*, 153. Hippocratic writings mention use of a tourniquet, but history attributes the discovery and naming of the tourniquet to Ambrose Paré in the 14th century.

11 Majno, *The Healing Hand*, 362, 365.

12 Celsus, *De Medicina* Volume 5.27.1143 cited by Majno, *The Healing Hand*, 362.

13 See B. Arensburg and I. Hershkovitz, 'Cranial Deformation and Trephination in the Middle East,' *Buletin et Mémoires de la Société d'Anthropolgie de Paris* 5, 3 (1988) 139-150.

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Editorial: Complementary Medicine/Dentistry

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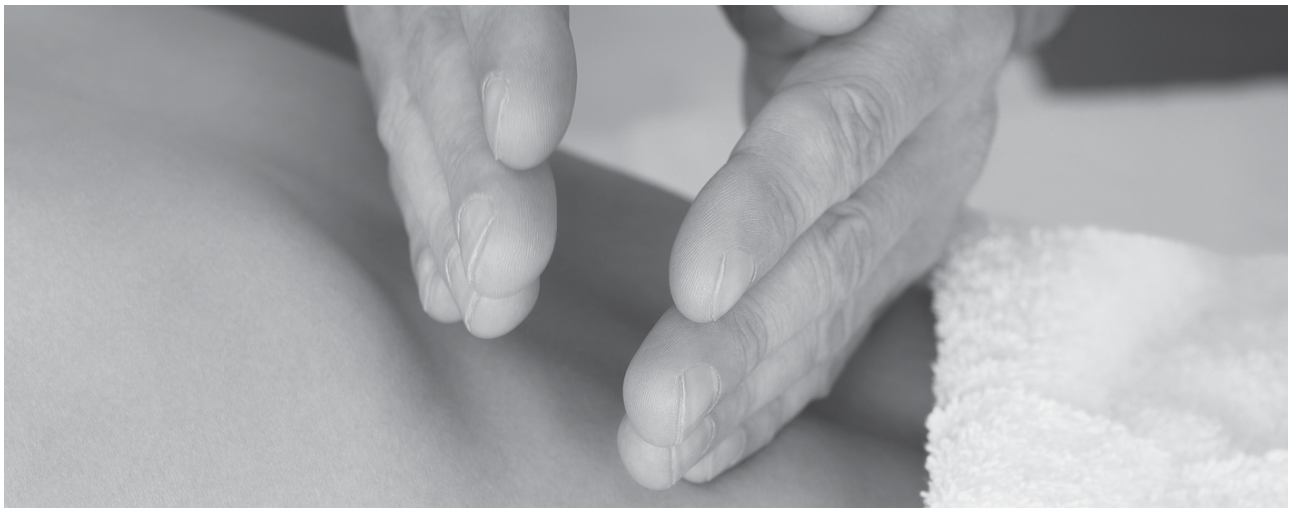

A characteristic of the healing activity of Jesus is the holistic, psycho-socio-spiritual approach He takes. So too, the medical/dental landscape today incorporates the complementary roles of a broad range of practitioners. The remarkable roles of music and art therapists, physiotherapists, occupational therapists, chaplains, social workers and so on, are recognised in articles in this edition of *Luke's Journal*.

The 'complementary' circle is completed when we recognise the health benefits of faith, observing the Sabbath, healthy relationships and good lifestyle choices.

With a little imagination some doctors and dentists have discovered complementary roles to their day to day practice. Clown doctoring, creative writing, Balint groups and so on can round out practice to help maintain enthusiasm and focus.

In a recent editorial in the *Journal of Social Medicine* (2012:105:496-498), the Prince of Wales affirmed his interest in an 'integrated approach' to medicine and health. He observed "By integrated medicine, I mean the kind of care that integrates the best of new technology and current knowledge with ancient wisdom." 'Bible believing' Christians may be quite comfortable with such a definition. What the complementary components of health and well-being demonstrate is that a scientific evidenced based approach to illness does not necessarily lead to healing. As Christians we acknowledge an old dictum 'we treat but God heals".

The rise of science as the basic paradigm in health is associated with a parallel rise in scepticism. Scepticism can be a timely corrective but it also can become rigid to new possibilities and change. In an article in 'Australian Doctor', May 2012, John Kron wrote a piece on 'What's the Alternative?' The author quoted Adelaide GP Olive Frank, who suggests the conventional/complementary medicine divide is artificial. Wherever a medicine comes from, Frank suggests these two questions help define choices. They are 1) "Is the medicine in the best interests of the patient?" 2) "Is it safe and effective as determined by the conventional scientific evidence?" The article goes on to explore the challenge of 400 'Friends of Science' who have described much of complementary practice and knowledge base as 'pseudoscience'. We acknowledge a debate is taking place on this basis.

Such scepticism can make sweeping generalisations about the journey of faith and the openness to healing through the grace of God in the power of the Spirit which many Christians maintain with resolve. Alliances between Christian practitioners and complementary practitioners may be the way to maintain a scientific holism.

My mum needs her cardiologist and respiratory physician these days. Age is no respecter of health choices. She still may well be right about ginger and her supplements and potions. I still may write. Please let us know what you think!

Paul Mercer
Editor, Lukes Journal

LUKE's journal

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

Complementary Medicine/Dentistry

Allied Health Profes

Complementing medical care in the

Medical referral to an individual allied health professional (AHP) for discrete services is a well-established aspect of health care. Referring a patient for Physiotherapy for treatment of an acute muscle injury, or a Clinical Psychologist for counselling is now commonplace in primary health care and supported by Medicare under GP Management Plans and Team Care Arrangements. While complementing medical treatment in this way works well in certain cases, there are also many times when the patient's situation is more complex. Is there a role for AHPs when patients have complex needs?

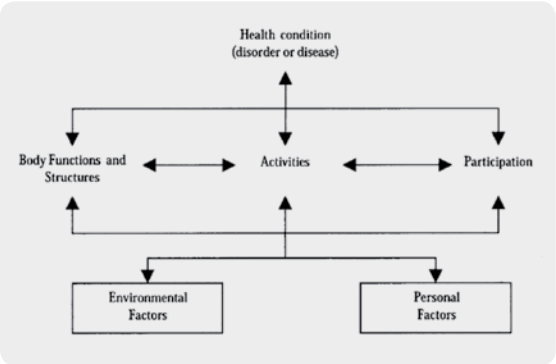
Complex health care needs

The notion of complexity in health care is no surprise for health care professionals, especially doctors, and is becoming increasingly pronounced with the ageing population and the growth of chronic and co-morbid conditions (Plsek & Greenhalgh, 2001; Wilson, Holt, & Greenhalgh, 2001). Experienced health practitioners realise that the array and interrelatedness of factors that contribute to health and illness, and therefore to treatment effectiveness, are often highly complex and dynamic. Such factors include the person's medical condition, lifestyle, behaviour, economic, social, community and access issues as well as the clinical encounter, treatment effects, the service itself, health systems issues, policies and legislation. Christians in healthcare also recognise the importance of the spiritual dimension in the complex reality of health and wellbeing. We know from the literature that complexity in health care is linked to poorer quality and outcomes of care (de Jonge, Huyse, & Stiefel, 2006), diagnostic dilemmas (Gask, Klinkman, Fortes, & Dowrick, 2008), greater service usage, escalating health care costs (Wade, 2011), and decreased practitioner satisfaction (Katerndahl, Parchman, & Wood, 2009). The literature also indicates that people with complex health care needs require care from a team of skilled and experienced practitioners that is continuous and consistent between providers and over time (Grant, et al., 2011), and which has a broad focus on many systemic and environmental factors (Sargeant, 2009). This is where AHPs can play a considerable role.

> ***"People with complex health care needs require care from a team of skilled and experienced practitioners that is continuous and consistent between providers and over time."***

Allied health professionals and complex health needs

Increasingly, the work of many AHPs is characterised by their role in complex health conditions, supported by the use of professional frameworks for guiding practice. For example, many AHPs now use practice approaches, assessments and treatment frameworks influenced by the World Health Organisation's *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001). The ICF is a highly sophisticated classification in the WHO 'family of international classifications' (along with the ICD and ICPC). For present purposes, it is also a useful framework for portraying the inter-related constructs of health conditions and providing insights into ways in which multiple health professionals can collaborate in treatment and care.



As depicted in Figure 1, the ICF reflects the way in which a person's *physical Body Structures and Functions*, the *Activities* that comprise their life, their *Participation* in those activities, work and community, as well as *Environmental Factors* (such as the physical, social, and service environment) and *Personal Factors* (such as personality, age, culture and coping strategies) interact in any health condition. The ICF can also be seen as an effective way of depicting complexity in health care.

The interconnectedness of the ICF model (Figure 1) implies the need for a holistic approach to responding to the interacting dimensions of a person's life and health, and also highlights the areas in which AHPs can complement medical care, illustrated here using the example of an obese patient with lower limb osteoarthritis and

sionals:

context of complexity

by **Pim Kuipers, PhD**
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chronic depression. The patient is dependent on a manual wheelchair for mobilisation due to both her weight and the effects of arthritis. She struggles with motivation regarding weight management, but has recently successfully lost some weight with the assistance of an exercise physiologist (providing supervised, individualised gym program) and a dietician (guidance on healthy shopping). The patient enjoys involvement in a life skills group, but has recently developed pain and weakness in her wrists which have affected her ability to push her wheelchair. Occupational therapy (wrist/hand splinting) has improved pain management and therefore, mobility, as well as addressing maintenance of independence in activities of daily living (home modifications).

In this example, the patient's complex medical conditions (Body Functions and Structures) are inextricable from her involvement in daily life (Participation), and her behaviour, exercise and social contacts (Activities). Likewise, Personal and Environmental factors such as access, use of the wheelchair, values, etc. also influence aspects of her medical condition.

Allied health interventions, which may focus on Activity, Environment, Participation or Body Function dimensions, greatly affect medical dimensions of care and vice versa. Many AHPs use practice frameworks which promote collaboration and integrated care. The simple ICF diagram illustrates how multiple health professionals can complement each other's focus to assist in addressing complex needs.

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"Congratulations!

"Congratulations! You have MS" were the words I heard from my neurologist in 1993. And so began my journey with MS.

I had been hospitalised with numb feet the week before the mid-year exams in my final year of high school with the fear that I had either a brain tumour, bone fragment lodged in my spinal cord, or some other unknown cause. It took a further three years for a diagnosis to be made, by which time I had completed more than half of my undergraduate degree in dentistry.

Following diagnosis, it took a further six years to complete that degree which I have never used directly, as I have never practiced in the field of dentistry. But I knew without a doubt that this is where God wanted me. For some, their identity comes from their qualifications, job, family etc. As for me, I've had to learn that my identity is not in these things. Rather it is in Christ.

"After another 19 years and numerous life-lessons I can say that over the years I have learnt to rely and wait on God..."

I have often wondered why God wanted me to complete my course, and not be seen to use it to any great degree. "If you can work it out, let me know" is what I joke. All I can say is that God wanted me there, so there was no better place to be.

Despite everything else though, one thing that I was able to learn was how to critically assess claims for treatment from a medical and scientific point of view. Many people over the years have suggested to me that I should take this or that dietary supplement simply because they or someone they know had shown "amazing" improvement in their medical condition. I have always been very wary of the 'Sample of One', especially where there was no logical, biological or scientific reasoning for it. In fact, some alternate therapies while purporting to be beneficial are in fact damaging. And so the principle of *Primum non nocere* (First, do no harm) was very important to me.

Fast Forward to 2012

After another 19 years and numerous life-lessons I can say that over the years I have learnt to rely and wait on God, and from early in 2010 my wife and I received a strong leading that God had something more planned for my life. He had something more for me, so we sought healing once more but with no miraculous healing, it became a waiting game to see what He had in store.

In August of 2012, I saw a *Catalyst* programme on the ABC about a new theory and treatment for MS. Like the subject, I had progressed into the Secondary Progressive phase of the disease for which there are no recognised treatments available, so I was just in a holding pattern awaiting inevitable decline in ability and progression of the disease.

On examining this theory and treatment, it actually presented as being both feasible and logical. The more and more I considered and assessed this, the more I felt that familiar leading that this was what God would have us do. We decided to approach our GP about whether there was anything which we had not yet considered and whether he would be willing to write the prescriptions required. We intentionally did not share our feelings of God's leading so that there would be no bias in his responses.

Looking at the proposed treatment regime, he commented about the potential cost involved. As well as potential risks with long term courses of antibiotics (an 18 month course of antibiotics with 21 different supplements to support the body was required). But after discussing the issues surrounding our request, he nearly knocked us over by saying, "Let's do it."

We thought this was a clear affirmation from God that we should trial this treatment. But 4 hours after we arrived home, there was a knock at the door and someone without any knowledge of our plans handed us a Love Gift that covered the initial setup of the drug schedule required. Not only affirmation was received – confirmation as well! Over the next several weeks/months there was still further affirmation from God via other members of our Church/Christian Family.

20 years on – So what changed?

There are four ways in which we can see healing today.

Immediate/Miraculous Healing – This is healing where the condition suddenly and 'mysteriously' disappears.

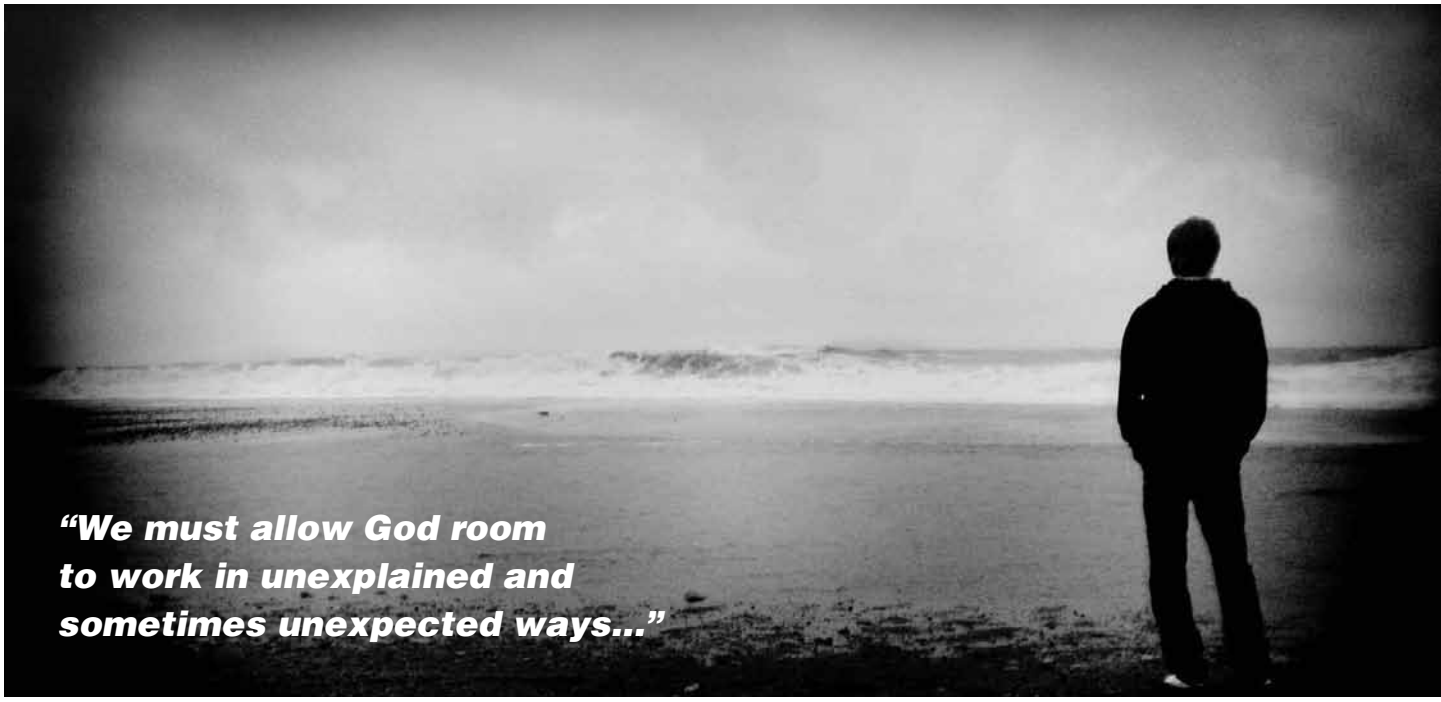
Progressive Healing – There are two ways in which one can be progressively healed.

1. Traditional medical treatment – This may be by a prolonged course of treatment (e.g. Radiotherapy, Chemotherapy, Antibiotics, Surgical)
2. Medical treatment not yet proven – There are many medical treatments which originated from either accidental or vigilant observations. And until these are established as being recognised treatments which do no harm, are regarded as 'Alternate Therapies'

You have MS”

by **Mark Elvery**

Mark Elvery graduated with a Bachelor of Dental Studies in 1995. He went on to complete his Bachelor of Dental Science, graduating in 1999. He lives with his wife and two children in Brisbane, Queensland. Until recently he worked as a Pesonal Assistant/Bookeeper for his wife in her accoutancy business. Due to progression of his MS, he had to step down from this role. He is currently waiting on God to reveal His direction for the next step in life.



Mental / Spiritual Healing – There are times when God says ’No’ to our desires and prayers. But at these times, He heals us in such a way that we can mentally or spiritually come to a point of acceptance and perseverance through the tough times of illness.

For me, it has been nearly 20 years since I heard those words from my Neurologist, “Congratulations, you have MS”. I have sought healing, but there was nothing miraculous. I was guided by the medical specialists to undergo traditional medicinal treatments (Interferon 1-beta). However there was no progressive healing, just slow progression of the disease.

We and people around us felt there was something more yet to come in my life. And it was about this time when we ‘coincidentally’ (even though there are no coincidences in God’s economy!) came across this new treatment which as yet has not undergone clinical trials (and by the author’s own admission, is unlikely to undergo such in the near future, because all energy and funding is currently being directed in other directions).

At the close of the article covering the treatment is the qualifying statement

> “It is important to go into the trial without undue expectation. Nothing at all can be guaranteed.”[1]

And I have found myself thinking, “Whatever you want Lord.” In fact one of my favourite verses in the Bible comes from Philippians 4:6-7

> Be anxious for nothing, but in everything by prayer and supplication, with thanksgiving, let your requests be made known to God; and the peace of God, which surpasses all understanding, will guard your hearts and minds through Christ Jesus.[2]

I can certainly say this is true for me as I embark on this new treatment. There is a responsibility in the medical profession to ensure that no harm is done, however there is room for plausible and logical medical treatments yet unproven (ie alternate therapies). And recognising from a Christian point of view, we must allow God room to work in unexplained and sometimes unexpected ways. Sometimes (and I was guilty of this) we focus so much on doing no harm and in trying to understand how and why things work that we hamstring God from being able to do what he does best. Work despite us!

And so I can say without a doubt that my original neurologist without realising it, summed it up perfectly by saying, ‘Congratulations’. For I have had the opportunity to take the front seat to see God at work over the last 20 years. And He deserves all the glory – whatever the outcome.

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Christianity, Science,

It was the late 70's. Gough was in power and everything was changing. The spectre of conscription and military service in Vietnam had been lifted and there were even political overtures to communist China. I was a fifth year medical student on rotation to the Royal Children's Hospital Melbourne. We were at an international conference on the Management of Burns and the respected Colonel Basil Pruit a US army surgeon was one of the main speakers. He looked every inch a US Colonel, six foot three, muscular, trim with short back and sides. At question time Dr Dora Bialstock, a diminutive paediatrician, asked a question. "On my recent trip to China, they were claiming survival of patients with 90% burns." I will always remember the good Colonel proclaiming in broad American, "Unless Ah see the results of a randomahzed, daable blaanhnd controlled traaal, I will not accept that as eveedence." We moved on to the next question. A lot more was said than a simple discussion about the percent of burns that patients could have and still survive. Dora had a chance to say how radical and progressive she was to go and dialogue with the communists, and Basil had defended the honour of the west against the infidels across the Pacific. That was my introduction to medical epistemology. Every time I think of double blind controlled trials I think of this encounter.

"We live in interesting times with the wane in confidence in science and with a pluralism which allows almost anything to be believed."

Double blind trials have not always been around. Digitalis, aspirin, morphia and other drugs had been in use before such rigidity had been introduced. Surgery was largely uncontrolled. No one doubts an appendix needs to come out, or that a crooked bone needs to be set straight. The first penicillin trial was a single case study, but a spectacular one in which a highly fatal condition was cured. However the double blind trial came into its own in studying tuberculosis. Defined endpoints were introduced and the placebo and blinding became necessary to prevent confounders and bias.

The world has moved on. Double blind controlled trials were the gold standard of therapy at the time of the good colonel, but, because they could show false negative results, metanalyses were introduced to give studies more power. Treatments over which we equivocated could now be proven to work, or rejected. However metannalyses were averages of averages and did not really address the particularity of this patient, in front of this doctor, in this setting. So N=1 trials were suggested. Here the patient would be given either placebo or treatment randomly for set period and the results were blindly recorded. However these studies only work in stable conditions needing one therapy at a time. The general problem of proving the value of different forms of treatment still remain.

How then do we prove a treatment works?

It is worth looking at an extremely old medical book to get an idea of how far we have come. John Wesley (of Methodist fame) wrote a book called *Primitive physic* subtitled *An EASY and NATURAL METHOD of CURING most DISEASES*, first published in 1747.[1] James Cook would not explore the east coast of Australia for another 23 years! It is worth reading some of Wesley's journal on the Internet to get an idea of the power of this servant of God and how he transformed lives. His approach to illness is described in Wesley's preface;

> Thus far physic was wholly founded on experiment. The *European* as well as the [native] *American* said to his neighbour, Are you sick? Drink the juice of this herb, and your sickness will be at an end....
>
> But in the process of time men of a philosophical turn were not satisfied with this. They began to inquire how they might *account* for these things? How such Medicines wrought such effects? They examined the human body, and all its parts;.... And hence the whole order of physic, which had obtained to that time, came gradually to be inverted. Men of learning began to set aside experience; to build physic upon hypothesis; to form theories of diseases and their cure and to substitute these in the place of experiments.

Wesley goes on to argue that simple remedies were forgotten, complex remedies were introduced, "medical books were immensely multiplied; till at length physic became an abstruse science, quite out of the reach of ordinary men." "Physicians now began to be had in admiration, as persons who were somethng [sic] more than human. And profit attended their employ as well as honour; so that they had now two weighty reasons for keeping the bulk of mankind at a distance, that they might not pry into the mysteries of the profession." Wesley advocated simple remedies proven by experience, hence Primitive (as opposed to learned or sophisticated) Physic.

The bulk of his book recommends many interesting remedies. As new editions of his work were published, he would annotate "Tried" to some of his recommendations. Thus for The Gout in the Foot or Hand:

> 377. Apply a raw lean beef-steak. Change it once in twelve hours, till cured. Tried.

Therapeutics & Scepticism

by ***Associate Professor Alan Gijsbers***

What would he make of the scientific philosophy which talks about aberration in purine metabolism, about the deposition of uric acid crystals in joints and about the inflammatory response which can be modified by anti-inflammatory drugs? Would he still complain about the abstruse science which now dominates our culture?

More amusing is his further comment about gout. "Regard not them who say, 'The gout *ought not* to be cured. They mean it *cannot*. I know it cannot by *their regular prescriptions*. But I have known it cured in many cases, without any ill effects following. I have cured myself several times." Sounds like one of my patients with a drinking problem saying, "I don't have a problem stopping drinking, I've stopped many times!"

What about the treatment of 'Iliac (ileac) passion' (bowel obstruction)? Item 435 suggests "...hold a *live puppy* constantly on the belly (Dr *Sydenham*)." Does this mean the famous Thomas Sydenham, the father of English medicine, the English Hippocrates, (a hero of Health and Hope, the ICMDA's 2006 Sydney World Congress) suggested such a remedy? It looks like it.

The retrospectoscope gives easy 20/20 vision. It is harder to imagine oneself back into those times and to sit with a patient in agony with the gout, or the obstructed bowel. No one really understood what was going on. They had little idea of the mechanisms of why these conditions came about, so they tried desperate methods to resolve these dilemmas and to give relief to the sufferers. Shades of the way I feel before some of my complex chronic pain patients – the so-called "failed back syndromes" or patients with recurrent operations for endometriosis who now have regular episodes of subacute bowel obstruction. Maybe a lively puppy on their belly might work!

Medicine has progressed. William Withering (1741-1799) learned from an old 'wise woman' who was a herbalist to use foxglove to treat cardiac failure. His principle of study was simple. "We shall sooner obtain the end proposed if we take up the subject as altogether new, and, rejecting the fables of the ancient herbalist, build only upon the basis of accurate and well considered experiment."[2] Withering established the best form of the foxglove to use, he determined the need for the correct dose and detailed the side effects (or toxicity) of the foxglove. He also delineated the types of dropsy in which the foxglove was either effective or ineffective. He did not quite know why it worked. He knew it had something to do with diuresis and he noted that it might improve the 'tumultuous action of the heart' but he had little idea of atrial fibrillation or inotropy. Withering thus represents the movement away from pure empiricism (or hearsay) of Wesley towards a more careful study of therapeutics without yet succumbing to the rigidities of the methodological fundamentalism of current controlled trials.

We could go on, but the key question in this as in any other evaluation of any therapy is, what then constitutes good clinical practice? What place is there for the order of physic which men of philosophical bent have developed, and by which they have developed these hypotheses? Do we once again abandon our science in favour of anecdotes of efficacy? This problem is more acute these days when TV stars and sportspeople promote a whole range of health products of dubious necessity in our society. They even quote double blind studies (of dubious value) for their efficacy.

We are selective in our evaluation of evidence. Peter Saunders CMF UK was recently criticised because he commended sexual orientation change studies.[3] Unfortunately gay critics critical of his approach cannot mount evidence according their own criteria to 'prove' that maintaining orientation is scientifically proven. You can see here how ideology biases our burden of proof.

Christians particularly, committed to truth and therefore to evidence and conscious (hopefully) of their own biases and blind spots, need humility to critically evaluate unproven anecdotes, protect their patients from unscrupulous snake oil salesmen and the gullible, and carefully go forward to continue to discover new possible treatments without being either blinded by science or fooled by unfounded claims. We live in interesting times with the wane in confidence in science and with a pluralism which allows almost anything to be believed. Christians believe, but believe on the basis of evidence.[4] Let's be cautiously sceptical and yet cautiously accepting.

For further discussion on the science of clinical medicine and its relation to the Christian faith see my 'From where I stand, a personal story about medicine and science ISCAST 2011'. http://www.iscast.org/journal/opinion/gijsbers_a_2012-01_prophets_from_where_i_stand.pdf

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Community – The

Dave, his wife Ange, and their family, have lived and worked in intentional communities with marginalised groups of people in Australia, Afghanistan, Pakistan and India for over forty years – see www.daveandrews.com.au

Dave and Ange and their friends started Aashiana, Sahara, and Sharan, Christian community organisations working with slum dwellers, sex workers, drug addicts, and people with HIV/AIDS in India; and they are currently a part of the Waiters Union, an inner city Christian community network that is walking and working alongside Aborigines, refugees and people with disabilities in Brisbane, Australia – see www.waitersunion.org

Dave is interested in radical spirituality, incarnational community and the dynamics of personal and social transformation. He is author of many books, including 'A Divine Society', 'Compassionate Community Work', 'People Of Compassion', 'Down Under', 'Out And Out' and the 'Plan Be' series www.wecan.be

Dave is an educator for TEAR Australia and a lecturer in Christian Community Work at Christian Heritage College.

Community – The Life

When we talk about a *'community,'* we are usually talking about a *'particular context in which we feel at home' – 'a place, or a group of people, or a tapestry of meaningful relationships which creates a gracious space that embraces us in a strong-but-gentle, undeniably-beautiful sense of belonging'.*

The community scholar, David Clark, says it very well in his study of Basic Communities, when he writes that: '*community is essentially a sentiment which people have about themselves in relation to themselves*: a sentiment expressed in action, but still basically a sentiment or a feeling'. Clark says that 'People have many feelings, but *there are two essential feelings for the existence of community: a sense of significance and a sense of solidarity.*[1]

Activist comedian, Fran Peavey, says, 'We are taught to think of ourselves as separate creatures with individual personalities and independent nourishment systems. But crabgrass is a more accurate description of our condition. *Human beings may appear to be separate, but our connections are deep and we are inseparable.'* [2]

(My wife, Ange, born and bred in our local community, agrees with the crabgrass analogy; adding, with a smile – 'some of us are crabbier than others'.)

Aussie commentator, Hugh Mackay, says that human beings are like mobs of kangaroos. (We even name our Australian rugby league football team after them!) Because – like them – 'we are creatures who thrive on our connections with each other. *We are at our best when we are fully integrated with the herd; we are at our worst when we are isolated*.' [3]

We are most honest when we are most connected. In relationships, long-term credibility is worth a lot more than any gain from short-term treachery. So there are a lot less shonky used cars returned to second-hand dealers in small-town communities.[4]

We are most generous when we are most connected. The most common reason for giving – is being asked. The most common reason for not giving – is not being asked. People are more likely to be asked if they are in contact with others. Thus people in clubs and churches are ten times more likely to give help than those who are not.[5]

We are most prosperous when we are most connected. When people know one another, they are much more likely to share access to jobs, promotions, bonuses, and other benefits that are available.[6] Moreover, when people trust one another, there is a significant reduction in expenses from the cost of security to insurance.[7]

We are most safe and most secure when we are most connected. The willingness of neighbours to look after one another, and to actually intervene to protect one another when someone causes trouble, can reduce all kinds of crime in a neighbourhood. A neighbourhood watch can reduce graffiti, muggings, even gang violence.[8]

We are most happy when we are most connected. The best single global indicator of happiness is connectedness. Those who have strong relationships with family and friends are much less likely to experience loneliness, low self-esteem, eating and sleeping disorders, sadness and depression - than those with weak relationships.[9]

And we are most healthy when we are most connected. Due to the encouragement of healthy norms, assistance in ill health, advocacy for proper health-care, and 'herd immunity', people who are connected are less likely to have heart attacks, strokes, cancer, even colds! And they are two-to-five times less likely to die prematurely.[10]

Community – The Truth

People of faith seem to make a big commitment to community. A *New Society* study of community volunteers, showed volunteers are more likely to perceive themselves as religious and to have had profound religious experiences – and three times more likely to attend church, at least monthly, than non-volunteers. And a study conducted in 2002 by Peter Kaldor, Keith Castle, and Robert Dixon on

Life, The Truth, The Way

behalf of the Church National Life Survey called *Connections For Life* confirmed these results. They show that church attenders are more likely to be involved voluntarily in community activities than non-attenders.[11]

Peter Kaldor says that 'the size of this volunteer workforce is huge, with hundreds of thousands of people making a regular commitment of time and energy. Their investment in society shouldn't be underestimated or undervalued.'[12] In Australia, *30 per cent of local churches are currently providing 'up to 50 per cent of the self-help groups in for their local community'; 40% of them are providing personal counselling; and 60% of them are providing material assistance. And large church and para-church agencies are by far the biggest non-government providers of social services, including family welfare, child care, youth work, aged care, employment services and disability supports.*[13]

Robert Putnam says that in countries like the US, *local churches are 'arguably the single most important repository of social capital*.' He says that '*as a rule of thumb, our evidence shows, that half of all philanthropy (or charity) is religious in character, and half of all volunteering occurs in a religious context*.' [14]

Putnam says that '*American religious communities spend roughly US$15-20 billion annually on social services*. Nationwide in 1998 nearly 60 per cent of all congregations reported contributing to social service, community development or neighbourhood projects; 33 per cent support food programs for the hungry; and 18 per cent support housing programs' for the homeless. '*Black churches have been prominent in recent efforts to rebuild inner-city communities*.' [15]

I think the magnificent contribution that churches – and other faith-based community groups – make to society is often overlooked in a resolutely secular society such as ours. I can remember going some years ago to an award ceremony for community volunteers at state parliament. It was a very special occasion for our family, because my father-in-law, Jim Bellas, was being given a government award for 50 years of community service to 'New Australians'. As I watched the proceedings with great interest, I noticed that out of the dozen volunteers who were given awards that day, for decades of selfless service to migrant and refugees, at least nine of the twelve were actually church-based volunteers. But their faith – which had been so obviously such a significant common factor in their commitment to volunteering – never got a mention.

However, when it comes to commitment to involvement in community activities, not all is as healthy on the faith-based community front as some claim.

Firstly, *while interest in religion continues, interest in religious institutions like the church, is on the decline*.[16, 17] And those churches not in decline tend to be more *inward looking* than *outward looking*, and more likely to be involved *in the church* than *in the locality*, or in *church activities* in the locality.[18]

Secondly, many growing churches have opted for large regional models rather than small

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local modalities of church growth. And *the larger the congregation is, the less likely it is for its members to be involved in local community activities*. They are more likely to be involved in in-house at-church activities.[19]

Thirdly, *the people involved in a lot of in-house at-church activities are increasingly out of touch with their local communities*. A recent survey reported that twenty-one percent of people in church said they still had contact with more than ten people in their locality for more than fifteen minutes per week. But *twenty-three percent of people in church said they only had contact with only one or two people in the locality – and sixteen percent had no contact all!* [20]

Fourthly, *as people in churches have less contact with their local communities, they have less commitment to involvement with their local communities*. A recent survey reported that twenty-eight percent of people in church said they were involved in serving people outside the church in a local group or organisation. However, *seventy-two percent of people in church said they weren't involved in a local community group or organisation in any capacity at all!* [21]

Community – The Way

Richard Rohr recently published a book on Spirituality and the Twelve Steps. In it he says: 'We are all addicts'.[22] One way or another, we are all part of addictive cultures, societies, institutions and nations, which often destroy any real possibility of developing healthy communities. Consider how modern culture, for example, gets us hooked on sensual desires and material rewards and exercising control over others to get what we want – and to get it now! He says the Twelve Steps represent a 'way out' of the co-dependency we are in to inter-dependency and the possibility of developing healthy communities.[23]

Rohr says the Twelve Steps translates The Way of Jesus for today's world. He says it's not so much the gospel *about* Jesus, but the gospel *of* Jesus.[24]

> *'We suffer to get well.*
> *We surrender to win.*
> *We die to live.*
> *We give it away to keep it.'* [25]

Rohr says it is The Way Jesus asked his followers to follow, Step by Step.[26]

As important as the Twelve Steps are, The Way out of our dependency and co-dependency will only work for us if we follow that Way '*in spirit and truth*'.[27]

But Rohr says that the Twelve Steps has too often been used as a '*problem-solving' program* rather than *a path towards 'spiritual transformation'*.[28]

Bill W said: 'When AA was quite young, a number of eminent psychologists made an exhaustive study of a good-sized group of "problem drinkers". They came up with the conclusion that shocked AA members at the time. *These distinguished men had the nerve to say that most of the alcoholics under investigation were still childish, emotionally sensitive and grandiose*'.[29]

Bill W said, *'How we alcoholics did resent that verdict! We would not believe that our adult dreams were often truly childish. And considering the rough deal life had given us, we felt it perfectly natural that we were sensitive. As to our grandiose behaviour, we insisted that we had been possessed of nothing but a high and legitimate ambition to win the battle for life'.*[30]

Bill W said that '*there was no real or long-lasting recovery without what he calls "vital spiritual experience".*' [31] Or, as I say, *we cannot be the change we want to be unless we walk the Twelve Steps in the Spirit of the Be-Attitudes*.

The original Twelve Steps as published by Alcoholics Anonymous are*:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood God*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked (God) to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood God*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

* In this version we have edited the gender-biased language as Rohr does. Where other twelve-step groups have adapted the AA steps, they have been altered to emphasise principles important to those particular fellowships

Let's look at each of these Twelve Steps in turn – one by one.

1. **We admitted we were powerless over alcohol – that our lives had become unmanageable.**

   Rohr says the problem is what he calls our 'imperial ego' – our quest to control everyone and everything. Rohr says that if we operate out of our 'ego' rather than our 'soul', we will try to win, but we will lose.[32]

   Rohr quotes Paul confessing the powerlessness of his 'imperial ego'. 'I cannot understand my own

behaviour. For what I want to do, I do not do. For what I do is not the good I want to do; no, the evil I do not want to do – this I keep doing'. (Romans 7.15,19)

2. **Came to believe that a Power greater than ourselves could restore us to sanity.**

   Rohr says the Power greater than ourselves is the Power of the Spirit. Rohr says to be 'filled with the Spirit', we need to create space for the Spirit to fill our minds through 'some sort of contemplative practice'.[33]

   'I pray (God) may strengthen you with power through his Spirit in your inner being, so being established in love, may have power, with all the Lord's people, to grasp how wide and long and high and deep is (that) love, and to know this love that surpasses knowledge—that you may be filled to the measure of all the fullness of God'. (Ephesians 3.16-19)

3. **Made a decision to turn our will and our lives over to the care of God *as we understood God*.**

   Rohr says 'We wasted years arguing over whose God was best instead of actually meeting *the always best God*. AA was smart enough to avoid this obstacle by simply saying "*God as we understood him (sic)*".' [34]

   Rohr says 'the always best God' is a 'God is love'.[35] As John says: 'God is love'.[36] And as Francis says 'Love responds to Love alone.'[37]

4. **Made a searching and fearless moral inventory of ourselves.**

   Rohr says we all have a light side and a dark side. The dark side is in 'shadow'. He says it's our 'shadow self' – it's hard to see. The shadow is not evil, but is 'that bit of chosen blindness or what AA calls denial' that 'allows us to do evil things without recognising them as evil.'[38]

   Though Rohr is cautious about giving too much power to our 'constant inner critic',[39] the scripture calls for people 'to examine themselves'.[40]

   He says 'people only come to a deeper consciousness by intentional struggles with inconsistencies, contradictions, conflicts and confusions'.[41]

5. **Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.**

   Rohr says most of us are scared of admitting our mistakes because 'retributive justice' – the 'punishment for sin' – has been the dominant 'story line of 99% of our history'. He says it is only when we embrace the alternative story line of 'restorative justice – the restoration of the sinner – through confession and restitution, will we be free to confess.[42]

   Rohr says that AA stresses the importance of confessing our sins – and being accountable for dealing with our sins – to another person.[43] 'Confess your sins to one another and pray for one another and this will heal you.' (James 5.16) This accountability is mutual – not hierarchical.

6. **Were entirely ready to have God remove all these defects of character.**

   My friend CB Samuel, an Indian Christian leader, often tells the story of how a goldsmith in his country removes the imperfections in his gold. CB says what he does is heat the gold over a fire until it melts; then he looks for all the impurities that float to the surface of the molten gold; and he keeps picking out the impurities, one by one, till none are left. And CB says that the goldsmith can tell the gold is 'pure' when the goldsmith can see his face perfectly reflected in the surface of the gold.

   I think is a brilliant analogy of what God wants to do in our lives. God wants to melt our heart in the fire of struggling with the crucible of suffering; so all the impurities in our lives can float to the surface. We need to be ready to have him remove these defects, one by one, till none are left, and we are truly, really, and purely compassionate.

7. **Humbly asked (God) to remove our shortcomings.**

   Rohr says, in one way, we don't need to ask, because 'God already knows what you need'.[44] He says, in another way we do need to ask, 'not to change God, but to change ourselves', in order to get over any 'sense of entitlement' we may have, which destroys relationships, and so we can develop 'a symbiotic (or synergistic) relationship with God.'[45]

   Rohr quotes Jesus who says 'Ask and you will receive. Seek and you shall find. Knock and the door will be opened to you.' (Matthew 7.7)

8. **Made a list of all persons we had harmed, and became willing to make amends to them all.**

   Rohr says this is 'quite programmed, concrete and specific. "Make a list" it says, and that list is of "all those *we* have harmed". It does not say those who have harmed us. AA *is the only group I know that is honest enough to tell people up front: "You are selfish".' Deal with it.*[46]

   Jesus says 'If you are bringing your gift to the altar, and remember your brother or sister has anything against you, go first and be reconciled to him or her, and then come and present your gift.' (Matthew 5. 23-4)

9. **Made direct amends to such people wherever possible, except when to do so would injure them or others.**

   Rohr says 'we have a myth of "total disclosure" in our culture that is not always helpful. Just because it is true, does not mean everyone can handle it or even needs to handle it.' What we need to do is practice "careful - or care-full – disclosure" rather than "total disclosure".[47]

   We need to discern 'what the other needs to hear and also has a right to hear' Then we need to 'speak the truth in love' as best as we can.[48]

10. **Continued to take personal inventory and when we were wrong promptly admitted it.**

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Rohr says this more about being 'mindful' rather than 'judgmental'. He says 'don't judge, just look'. And look 'with the very eyes of God'.[49]

We would do well to pray: 'Search me, God, and know my heart; test me and know my anxious thoughts. See if there is any offensive way in me, and lead me in the way everlasting'. (Psalm 139.23-24)

11. Sought through prayer and meditation to improve our conscious contact with God *as we understood God*, praying only for knowledge of God's will for us and the power to carry that out.

Rohr says that there are two levels in spirituality. 'The first is the 'calculating mind' and the second is the 'contemplative mind'.' He says when most of us pray we make 'petitions' with a 'calculating mind'. He says that is where all of us start. We he says we need to move on to maturity we need to pray as 'meditation' with a 'contemplative mind'.[50]

Rohr says that when Bill W used the word 'meditation', it was 'not common in Christian circles at all at the time'. But Bill 'was right'. Only meditation 'touches' the unconscious and 'heals the unconscious'.[51] The Psalm says 'Be still, and know (contemplatively) that I am God'.[52]

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Rohr says 'a person will suffocate if she just keeps breathing in'. We need to breathe out as well as breathe in'.[53] We need to give as well as we receive. 'Freely you have received, freely give'. (Matthew 10.8)

Two of the most significant traditions in AA are self-support and free service. In the Big Book it says: 'Every AA group ought to be fully self-supporting, declining outside contributions'. AA 'should remain forever non-professional, but our service centers may employ special workers'.[54]

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For years I have been involved in running lots of support groups, including a Twelve-Step group in West End. The Twelve-Step group we started in our locality was called 'Grow'. Grow is a self-help, peer-support group which seeks to enable people to struggle more effectively together with issues that tend to cause mental and emotional trauma in our society. Grow began in Sydney in 1957, when a group of psychiatric survivors decided to use a twelve step program as a method for their own rehabilitation. They said:

1. We admitted we were inadequate or maladjusted to life.
2. We co-operated with help.
3. We surrendered to the healing power of God.
4. We made a personal inventory and accepted our selves.
5. We made a moral inventory and cleaned out our hearts.
6. We endured until cured.
7. We took care and control of our bodies.
8. We learned to think by reason rather than by feelings
9. We trained our wills to govern our feelings.
10. We took our responsible and caring place in society.
11. We grew daily closer to maturity.
12. We carried the Grow message to others in need.[55]

Since they started, more than 500 Grow groups have been set up around Australia, helping people who have had breakdowns put the pieces of their lives back together again, and develop, maintain and sustain a healthy way of life by showing them how to avoid unnecessary pitfalls in future.

Grow is both anonymous and inclusive, and open to all people, regardless of colour, class or creed, who respect the group and would like to participate in the group in order to enhance the mental and emotional health of our society.

Those of us who have been a part of Grow believe individual problems require individual solutions, collective problems require collective solutions, and a 'sick society' like ours desperately needs out and out 'healthy community'. This is put beautifully in one of the books of readings we use in Grow:[56]

'Beyond the whole humanity of the person and (their) close relationships, the developing adult cannot but be concerned with the wholeness of (their) human community. For, to the extent that (they) do not participate in building a community of persons, the progressively depersonalised social body which (they) go along with will tend to undermine and deform (their) personal life and (their) choicest relationships. There can be nothing static or neutral in the life of society any more than in the life of an individual.

In other words, there can be no such thing as free and whole persons outside of *free and wholesome relationships*; nor can there be either of these

profoundly healthy human realities, for any length of time, outside of a vigorously growing *free and whole community*, however small to begin with.

The libertarians, who have been aggressively bent on building a society based on freedom without wholeness, are as hostile to authentic human life and growth as the totalitarians who have been just as insanely committed to building a society on wholeness without freedom. Both of those one sided social theories have been, especially during this last century, complementary opposite formulas for destroying integrity of character in persons, and civilisation in society.

Friendship has always been the constructive bond linking integrity of character in persons, and civilisation in society. Authentic freedom and wholeness can only be achieved *together*.' "It starts with you and me caring about each other, doing things with each other, and sharing the striving of our hearts, giving each other constructive leadership.

The more deeply we are affected by the loving acceptance and support we experienced from our earliest attendance at (the) group, the more unshakably we believe in the importance of sharing with others and nurturing them through the painful early stages of their growth with the group...

Outreach is the indispensable starting point with each new person who comes... for help, no matter how slightly troubled or how severely disfigured by... suffering he or she is. This elementary meeting of human beings contains implicitly the offer of, and invitation to, friendship... We don't limit our outreach only to those... who easily appeal to us and with whom we feel an affinity.

The more truly we love our fellow human beings, the more likely we are to be affected by a sense of their immense worth when we see them most scarred by their background environment or experience. So much the more generously, then, will we be led to reach out to them and to bring to light the treasure buried and obscured within them. For we all have a treasure within us, and we're more able to realise it when we ourselves are on the receiving end of a genuine manifestation of love.

Once touched to life by love that we have experienced, our vision enlarges to include many whom we would never have related to before, and, potentially, all suffering people... The sicker the person is the more we must be prepared to reach out to them, to get them moving with us again at the point where they stopped growing to believe in them all the more when they no longer believe in themselves.

In treasuring our friends we reveal their best selves to themselves,

"summoning them forth,
bidding them to live,
inviting them to grow..."

This, in my opinion, is what real love is all about. For 'love is the consistent active concern for the whole welfare of another human being as equally important as one's own'.

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How many of us can say with feeling that we've been 'loved back to health'? That is not to deny that we've had to do a great deal of work on our thinking, and our actions as well.

But how many, once tormented and shattered, do you know who will tell you that they were motivated to struggle and grow only because some one significant person, or the group, dared to be generous with their love, their time and patience in between the weekly meetings?

To the extent that we have grown to a certain maturity through the experience of friendship ourselves, and the example of other friendships round about us, we are able to give of ourselves with like generosity to help so many other lost ones who still have to find themselves.

The seeking and finding of ourselves only comes about through a sharing with another person who is prepared to cherish us as another self. For we are all other selves to each other.

I like to recall often a beautiful thought I heard years ago, attributed to Rabbi Brasch. Commenting on the commandment 'Love thy neighbour as thyself', he explained that in the original Hebrew the precise meaning was: 'Love thy neighbour for s/he is thy self'.

In the group we find our... personalities constantly undergoing change. The moving principle in this change is growth into adult relationships by dependability, helpfulness, appreciation and compassion and then... into fully shared living, or friendship.

Not only friendships within one's own sex, but real and precious friendships across the sexes. This is one of the features of our life together that so often provokes comment... 'How easily you people express your feelings for one another. And how relaxed men and women... are in relating to one another'.

The fact is that in the community we have come to believe in the real possibility and the inestimable value of these friendships which can minister to each other's vital needs to be somebody, to be at home, and to be going somewhere.

Recently I was present at a meeting in which one lonely person spontaneously invited another lonely person to play tennis one weekend. As a result of the group's enthusiastic support, that person now has the opportunity to play with four men and women every second Saturday of the month.

Our regular live in community weekends are another happy occasion for growing into one another's lives and enjoying (in some cases for the very first time) the delicious experience of feeling at home.

Usually we have a guest speaker to address us on a particular topic. It could be, for example a subject such as 'Managing Close Personal Relationships'; 'Sexual Maturity'; or 'Guilt', to mention only a few. The speaker only introduces the subject, highlighting key perspectives and any special areas of doubt or disagreement.

The aim of the discussion is threefold: to make us think, bring out our thoughts, and come to a better

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understanding of life and ourselves. The point is, we find we do all this so much better by doing it together. On the subject discussed, we deliberately aim to summarise and keep, from what has been said, what we call the highest common factor of agreement.

As such it becomes potential material for the program... In this way the program... can go on expanding, being refined, and being renewed, which is the condition of its staying alive and continuing to meet people's needs.

Saturday night at these weekends is always popular. The emphasis here is on using our talents by playing games, dancing, singing around a piano, guitar, or nothing at all when there's no instrument, getting to know one another better in a relaxed atmosphere...

Sharing – shared living, shared growth in maturity – is the feature that characterises a real... community... Growth in... community is a gradual experience... However, once we are on growth curve, we know we can outgrow mediocre expectations...

* * * * * * *

Con Keogh remembers when 'Mary' came. 'Mary came to (the community) after years of struggle in rearing two children on her own.' Con says, at that time, Mary was 'a bitter woman, a mainlining drug addict with a long way to go...'

She made no secret of the drastic disorders she was battling with or what she had to do to change. Within two or three years she quit shooting up and from then on never looked back. She became a living example of God's healing work amongst us, and a personal link with many people to hope...

When I first met Mary I found her very strong personality difficult to cope with, for I was also very sick then. But, strange to say, Mary and I soon forged bonds of easy affection and became firm friends. From those earliest years we grew out of maladjustment together...

She was often like a stiff dose of shock treatment to me. I remember when, to my tormented mind, *everyone was watching me, talking about me, hating me*... However, Mary broke through to me bluntly: 'Gawd, just who do you think you are that other people would want to be talking about you all the time!'

'I needed this devastatingly strong message. From then on I stopped saying those things, and eventually stopped thinking them'.

'Community can bring the best out of us all'.[57]

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This article is based on excerpts from two of my most recent books – *Down Under and Out And Out. Down Under* addresses the adverse effects of professionalisation and institutionalisation in community work and seeks to explore effective ways of resisting demands for compliance, holding the line and creating space for change. *Out And Out* explores the emergence of incarnational mission and the need to go beyond New Monasticism to embrace Christian Mystic Community Work in the midst of ordinary everyday life. It considers creative models of "way-out" community work, including the "up-an-out" Initiatives of Change and the "down-and-out". Twelve Step Movement which helped facilitate one of the most transformative community movements for change in the world today. J

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Integration as Christian Clinicians

Introduction

This article is for medical professionals who want to live as integrated and wholistic beings, at home, at work, personally, socially or spiritually. It focuses on the various relational needs of the people we come across in our lives, others, ourselves, and, God! Finally, it offers a reliable and memorable framework and systematic approach – CUREe – to assist us to complete these above two goals, promoting integration with integrity. Some of the issues addressed invite you to evaluate yourself so start by asking how you may line up with the following (*0 – 5 = not well – so so – somewhere in between – fairly well – very well*). To what extent am I….

- walking the steps God wants me to walk in, spiritually, personally and socially? (0 – 5)
- integrating my faith with my practice? (0 – 5)
- consistent and congruent in my spiritual, personal and professional life? (0 – 5)
- progressing with the essential areas of my life?(0 – 5)
- meeting whole person needs of my patients, colleagues and indeed myself?

by ***Dr John Warlow***

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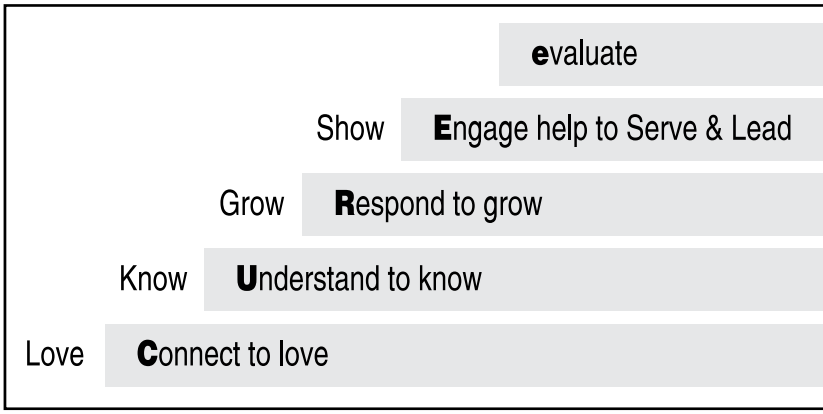
As Christian clinicians, we want to actively integrate our faith into our practice, to have a sense of integrity in terms of aligning our personal and professional lives. Putting it simply, we can be either clinicians who are Christian, where God makes little difference in our professional life, or as intentional Christian clinicians in medicine and dentistry where there is a desire to integrate and line up the 3 areas: our personal life, our spiritual life with God, and our social/professional life with others (whether that be friends and family, church, mission, or at work with patients, staff, trainees/trainers). In each of these areas, with God, others and ourselves, there are the same processes (also called, "steps"), which allow for an integration between these domains in our lives.



The 5 "C.U.R.E.e steps and processes

The 5 steps. These 5 processes, phases, or steps, can be summarised under the acrostic, C.U.R.E.e., for the *connection, understanding, response* and *engaging help* and, *evaluation*. These 5 phases or **steps** are integral to the Christian Wholeness Framework (CWF), the basis for this article. The 5 **shapes** have already been addressed in a previous article relating to sin and suffering (*Luke's Journal* Vol 13 No 2 Sept 2008 pp12-14). These are steps which align with the Gospel story in the scriptures and will help us with the way we are with others as well as the way we relate to ourselves. Not surprisingly, they are also connected with the clinical processes we use all the time with our patients, which is sometimes called the medical model.

Personally, and beyond. The application of these issues in my life (personal, social and spiritual as well as my priorities and plans) are detailed in the textbook regarding the CWF, "Living Wholeness". In essence, this framework has developed over the last 25 years particularly in the context of my being with patients, family and friends, church, and my own personal and spiritual life. From a professional perspective, I've had the privilege of seeing this framework, or operating system expressed in the context of a Christian mental health centre (the "Christian Wholeness Counselling Centre"), in Brisbane, Australia, over the last 19 years. Apart from being foundational in my own walk with God and my personal life, the CWF has also been of service to mental health professionals in Brisbane, and over the last 6 years has now been the underlying operating system to a Christian counselling centre in Asia (country not identified for security reasons), which in essence has now become the centre of the CWF, serving that country and beyond. From here, it has also served not just in the context of counselling, but also in the development of people helpers or lay counsellors. More recently, it is also been applied in the context of informing small group development in my local church.

Patients. In our clinical practice and relating with patients, the first step or phase is to develop a professional working alliance (*connection* phase). Secondly it is to undergo the assessment, and investigations (*understanding* phase), and then to move on to the management/therapy stage (the *response* phase) followed by referral as needed (*engage* help phase). The understanding step, while focusing on the pathology at hand, needs to go deeper, to include the underlying person, in the context of holistic care. Apart from asking the obvious demographic questions (which can give us a good *understanding* of their social circles), just asking a couple of generic understanding open-ended and non-leading questions is simple and in the end will save not only time, but possibly a clinician/patient relationship from eroding. One is the entry question to the person of, "how are you… really?", followed by a second, deeper and centering question regarding the impact of the particular pathology on the person, such as, "what is that like for you?" The ongoing *evaluation* of the progress of these is the 5th step.

"...as Christians, we should be different not only as Christian clinicians, but also in every part of our lives."

These steps and processes also correspondingly meet the internal needs of our patients. Thus, while a patient might come to us with the need to treat (*response* need) their presenting pathology, behind every piece of pathology is a person who at least to some extent needs to be known and understood (*understanding* need). Both of these 2 phases can only be built on an underlying awareness by the clinician of the patient's need for connection (*connection* need). The depth and extent of that foundation of connection needs to be appropriate to the extent of their need for understanding and response. Thus, in the acute setting it may be brief and relevant to the needs at hand, while in the context of chronic care, these underlying needs for connection and understanding by the patient will be correspondingly greater and deeper. Finally, the patient needs to know and *evaluate*, at least to some extent, the clinician's level of competence, and have an awareness of their own strengths and weaknesses as that the patient's needs are clearly paramount, and as necessary, that the clinician will *engage* the appropriate help of the team approach which the patient needs.

The clinical team. These 5 needs of our patients are the same for our staff, colleagues, trainers and trainees. They need *connection*, respectful *understanding*, to be empowered (*response*) in a supportive team (*engaging help*), which is transparent to *evaluation*. Similarly, the processes of relating with the team follow the above 5 steps noted above. So, in essence, the workplace/ training flourishes more (as defined by informal / formal *evaluation*,) when the tasks and the training requirements at hand (the *response* step), are underpinned by a *connection with* and an *understanding* of the people. For anyone within our team/work environment, we can then, with integrity, have the *response* aspirations for others to grow not only as professionals but also in their attitudes, skills and knowledge.

Our own personal lives. Likewise, these processes apply to ourselves. Thus, in the context of our busy tasks and professional development of skills and knowledge (*response* steps), we can often lose a grasp or an awareness (*understanding* step) of who we are underneath this, as well as have a life which is like a wheel with the balance off centre. This particularly occurs when the outer stressors crush into our inner depths. As a result, our heart attitudes, so essential in every area of our life, can and do suffer, and the transformation of the inner core of our lives has a diminished capacity to be expressed. Underlying this, we can lose touch with ourselves (*connection* step) and become more like disengaged robots, not understanding our deeper attitudes and motivations. To then find time to have

a life outside of work, let alone *engage help* from others (family and friends, church, people helpers and professionals) in any sphere of life can become even harder, resulting in a vicious cycle of these diminishing essential processes. Not very nice!

Our spiritual lives and God. As I look at scriptures as a whole, I see a God who right from Eden through to Revelation wants to have a *connection* with us – in essence a relationship of love. This connection is not just one of intimacy and trust, but also one of knowing and being known, and of a mutual *understanding*, in a life of faith. However, this relationship, built on loving God and knowing God, extends further to a life of obedience, and *response* to God and what he has done in our lives in and through Christ. The actioning of this transformation puts our spiritual position of being in God (the act of salvation, or being born again into a new kingdom) into practice (the process of sanctification). This is worked out through our attitudes, skills and knowledge (A.S.K.) in whichever domain we may be. We can then have aspirations for growth firstly in the dimension, of transformation (sanctification), and secondly in the dimension of personal and professional development. In doing this, there is a transformation of our attitudes skills and knowledge (T.A.S.K.), which is the reason why as Christians, we should be different not only as Christian clinicians, but also in every part of our lives.

This spiritual life is not meant to be done on our own, but in the context of the body of Christ, the church. Here, we can *engage help* with each other and with God. Church itself should be built on a *connection* which is deeper in terms of knowing (*understanding*) each other, and where love can be under-girding any truth which is spoken. This connecting with and knowing of each other is then the foundation for our *response* to God and each other, allowing for growth of our lives to move into a practice of servant leadership and *engaging help* for others. As Christian clinicians, we then have the opportunity not just to be people who are engaged at work and at home, but also in the context of the church, inwardly into ministry and outwardly into mission.

The "great commandment" (Mark 12:30-31), emphasises loving God with our whole person, pervading all our relationships. It was in response to what is the most important thing we should be doing... to, "Love the Lord your God with all your heart, with all your soul, with all your mind, and with all your strength (and) love your neighbour as yourself." The person who answered Jesus' question was close to becoming a Christian. As Jesus said, "you're not far from the kingdom of God" (Mark 12: 34). The same text in Luke 10:27 is in response to what we need to do to be Christians or "receive eternal life" (Luke 10:25). Jesus said, "do this and you will live!" (Luke 10:28). Doing the great commandment is the way to integrate our faith and our practice.

Doing this great commandment is in fact doing the 5 steps with another person. This was illustrated by a non-Jew (a Samaritan) who had integrated them into his life, even to a stranger (who was not a part of his family or friends, faith community or work setting). Firstly, he *connected* with the half dead Jewish man, just by coming along, feeling pity, and kneeling beside him (the 10:33 – 34). The *understanding* step was simple in that he, "saw the man" (33) – or in medical terms, did a brief examination! He then moved on to the *response* step of soothing his wounds, putting the man on a donkey, taking him to the right place where more care could occur (34). Then he *engaged other help* (in this case the inn keeper – 35), and said he would return, and *evaluate* the costs, and no doubt, benefits. All of this involved not only the loss of time and money for the Samaritan, but also selfless and Christlike love to another.

Conclusion. Bringing this together, as we ourselves are connected with the God of *connection*, we have a greater capacity to *connect* as the good Samaritan did, and to express and live out the great commandment in the context of our personal life (holistically, with all our heart, soul, mind and strength), and to others. This emerges firstly with family and friends, then into the church context (inwards with ministry or outwards in mission) and also into our work place. Here with colleagues, staff, trainees and trainers alike, we can participate in being *with* others; their greatest need is for *connection*, which is the foundation for good relationships, and on which can be built a workplace where people are cared for and known. With our patients, we apply the same principles in terms of the doctor-patient relationship (*connection*), on which we can build not only the knowledge of the pathology, but more importantly, the knowledge and *understanding* of the person behind it. As we grow in and *respond to* the dimensions of both professional development and also transformation / sanctification, then we can bring these also into the workplace in appropriate and ethical ways, just as we can bring it into our local church, and also into our family life. Just as we may refer patients for greater support, so we ourselves can *engage* other help so that we can get support to show servant leadership in the workplace, in our churches and in our families, whilst becoming more like Jesus in an integrated way.

So, in conclusion and in the context of the above steps and the initial questions, *evaluate* yourself, asking: How *connected* am I? How *understanding* am I? How much am I growing in *response* to God, myself and others? How much do I *engage help* and receive support so that I can serve others to empower them and receive their support to serve others, leading to an ever increasing circle of influence for the kingdom? And lastly: What weaknesses and obstacles could be hindering these…in addition to busyness!?

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Complementary Medicine/Dentistry

The **Pilgrim's Quest** to

I am a Christian GP acupuncturist and martial artist – an apparent paradox. While studying medicine at Newcastle University, I started doing taekwondo (Korean martial arts) and rediscovered the gospel through AFES (Australian Fellowship of Evangelical Students). As a medical student I chose to do two formative extended learning tasks: one on pain, including the mechanisms of acupuncture, and later, "The Anatomy of Taekwondo." After 6 years of taekwondo, I changed to Goju Ryu (Okinawan karate) in 1994. In 1997, as soon as I finished my residency, I did the Monash Course in acupuncture for Part 1 of FAMAC (Fellowship of Australian Medical Acupuncture College) and as part of the requirements for the FRACGP. I completed my FAMAC in 2004, and left a wonderful group general practice in 2007 to practise acupuncture from home.

Over the years, I have been warned by some Christians that I should not do martial arts or acupuncture because of the roots in Eastern religions. There are also many acupuncture skeptics in the medical profession, despite the level I evidence that acupuncture is a safe effective treatment in chronic pain.[1,2,3] This is my journey of how I can be a Goju Ryu sensei and a Western medical doctor practising evidence-based acupuncture with a traditional chinese medicine (TCM) perspective, as a child of God.

One Lord, One Being

> *"Hear, O Israel: The LORD our God, the LORD is one! You shall love the LORD your God with all your heart, with all your soul, and with all your might."* Deut 6:4

In Matthew 22, Jesus sums up the Law and the Prophets and the first and greatest commandment by quoting Deuteronomy 6:4. In two sentences, Jesus sums up our purpose, our being and our relationship to God and each other. Just as Yahweh is one, so our purpose is one: to love God with our unified whole self, "that it may be well with you". When we are not unified and whole in loving the LORD, then it follows that we are not well or whole.

> *"The concept of holism in relation to health care was once promoted in the West, influenced by the ancient Greek Hippocratic tradition. However, this concept gradually declined and was replaced by the development of Western Medical science based on scientific knowledge, method, or practice. This new medical approach is defined as objective, demonstrable, and measurable with scientific evidence."* Joseph Wong.[4]

The frustration that I had as a Christian GP was the modern Western medicine emphasis on treating the physical disease, before considering the emotional, and rarely considering the spiritual. It is no wonder that many people are attracted to the more holistic Traditional Chinese Medicine (TCM). TCM considers the harmony of the mind, body, spirit, environment. However, medicine without God in the picture will never achieve complete harmony. It is only God who will bring total healing and harmony.

Order Out Of Chaos

> *"In the beginning God created the heavens and the earth."* Genesis 1:1

God created order out of the formless chaos and filled the dark void. God filled the expanses of light/ darkness, waters/sky and land with the sun/moon, fish/birds, and animals/ man.

This supreme order is evident in the remarkable physiology of the human body and in the acupuncture meridians. I have never understood how scientists can look at the amazing detailed design of humans, and indeed all of creation, and not believe in God.

Yin And Yang

> *"Then God said, "Let us make man in our image, according to our likeness; let them have dominion..." So God created man in his own image, in the image of God he created him; male and female he created them... and God said to them, Be fruitful and multiply; fill the earth and subdue it; have dominion..."* Gen 1:25-26

> *"And the LORD said, " It is not good that man should be alone. I will make him a helper suited to him.... And he took one of his ribs, and closed up the flesh underneath. And the LORD formed the rib which He had taken from the man into a woman, and brought her to the man."* Gen 2:18-25

God created man in his own image – for relationship with the purpose to procreate and fill the earth and to lovingly rule the rest of creation, just as God fills the void and lovingly rules all creation.

Man = male + female, just as God is triune but one. In Genesis 2, Adam is not complete without Eve. God sees that it is not good for man to be alone, and makes woman out of his rib, rather than making his helper out of the dust like Adam.

So God made men and women to be equal, different and complementary to reflect God's image. This is also reflected in Yin-yang theory: Yin (female) and Yang (male) are opposites, interdependent, interconsuming, intertransforming and infinitely divisible. Yin-yang theory arose during the Yin and Zhou Dynasties (770 BC) and first appeared in the Book of Changes (I Ching). The universe, the natural world and environment reflect

by **Lucy van Baalen**

find the best of East and West

the duality of yin and yang (night/day, dark/light, cold and hot, winter/ summer, water/fire, interior/ exterior.[4,5]

In physiological terms, Yin is represented by the parasympathetic nervous system, and Yang by the sympathetic nervous system. The human body requires both to be working in balance for proper homeostasis – think of the autonomic control of the heart, bladder and bowel.

The biblical view of creation, Yin-yang theory and science are by no means contradictory. They answer different questions. Genesis is an account of the character of God and his creation (good and orderly) and his purpose for man. Yin-yang theory describes the interconnectedness of creation, but unfortunately misses the character of the Creator who desires to be in relationship with man. Science is just a detailed description of observations of the order that God has created.

When answering questions from patients about pain, I can explain in terms of the biblical purpose of pain and suffering (well expounded by Phillip Yancey and CS Lewis[6,7]), or the neurophysiology (A delta, C fibres, spinothalamic tract, limbic system) or in TCM terms ("qi blockage or imbalance"). I can describe the efficacy of acupuncture in terms of meta-analyses, the meridians in terms of connective tissue planes, and "de-qi" in terms of connective tissue whorls. Or I can talk about how the emotional stresses have led to a blockage in the flow of liver qi, leading to tension headaches. It depends on the patient and their preferred method of communication.

Martial Arts and Acupuncture

> *"A person who studies quanfa should by all means also understand the principles of medicine. Those who do not understand these priniciples and practice quanfa must be considered imprudent."*
> Shaolin Bronze Man Book.

Over the centuries, an unending line of devout and observant physcians detected the existence of internal energy passageways and recorded their relationship to a number of physiological functions. Physicians came to observe specific hypersensitive skin areas that corresponded to certain illnesses. This ultimately led to the recognition of a series of recurring points that could be linked to organ dysfunction. By following these fixed paths, the points came to be used to diagnose organ dysfunction. The route linking these series of points to a specific organ became known as a meridian.

The idea for attacking the twelve bi-hourly vital points surfaced from research surrounding the polarity or "Meridian Flow theory" of acupuncture. By the Song dynasty, Xu Wenbo, an eminent acupuncturist and the official doctor for the Imperial family, developed this theory into science.

Responsible for remarkable advances in medical science, Xi Yuan, an eminent 13thC Chinese physician, standardised methods of how to improve a sick patient's prognosis by stimulating the points of a corresponding meridian.

Over thousands of years of acupuncture and moxibustion practice, many locations on the human

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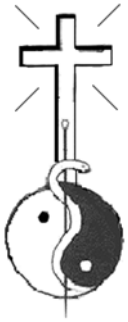
body not suitable for needling or cautery were discovered. Pricking at these points would worsen the disease, rather than curing it, and at certain points, needling could cause immediate death.

Daoist martial arts expert and acupuncturist Zhang Sanfeng (b.1270) discovered that by striking specific vital points, alternative areas became much more vulnerable to even less powerful attacks; thus by pressing, squeezing, or traumatising one point, striking other points would have a critical effect.[8]



My Business Logo

"Paul then stood up in the meeting of the Areopagus and said: "Men of Athens! I see that in every way you are very religious. For as I walked around and looked carefully at your objects of worship, I even found an altar with this inscription: TO AN UNKNOWN GOD. Now what you worship as something unknown I am going to proclaim to you..." Acts 17:22-23

When Paul evangelised the men of Athens, he used their own religions and beliefs as a starting point. So when I designed my business logo, I used symbols of Taoism and Greek mythology. I borrowed the yin/ yang symbol with the serpent coiled around an acupuncture needle from the Australian Medical Acupuncture College logo (http://www.amac.org.au). The serpent-entwined needle is a reference to the Asklepian or the staff of Asclepius that became the traditional symbol of medicine. It is depicted by a single serpent encircling a knarled rough-hewn knotty tree limb, not to be confused with the caduceus of Hermes.

In Greek mythology, Asclepius was a half-mortal (son of Apollo and Coronis) who learnt the art of healing, surgery, drugs, love potions, incantations and had the power to heal the dead with the blood of Gorgon. However he offended Zeus by saving a dead man killed by one of Zeus' thunderbolts. In the eyes of Zeus, Asclepius' action upset the natural order of the universe – a mere mortal helping man evade death, so Zeus killed Ascelpius with a thunderbolt too. Zeus later relented, realising the good Asclepius had brought to man, and Zeus made him into a god of healing and medicine, placing him among the stars, transforming Asclepius into the constellation Ophiuchus (the serpent-bearer).

In honor of Asclepius, a particular type of non-venomous snake was often used in healing rituals, and these snakes crawled around freely on the floor in dormitories where the sick and injured slept.

The symbol of medicine may also refer to the serpent wrapped around a pole mentioned in the bible in Numbers 21:6-9.

Then the LORD sent fiery serpents among the people, and they bit the people, so that many people of Israel died. And the people came to Moses and said, "We have sinned, for we have spoken against the LORD and against you. Pray to the LORD, that he take away the serpents from us." So Moses prayed for the people. And the LORD said to Moses, "Make a fiery serpent and set it on a pole, and everyone who is bitten, when he sees it, shall live." Moses made a bronze serpent and set it on a pole. And if a serpent bit anyone, he would look at the bronze serpent and live.

The Empty Cross

"See to it that no-one takes you captive through hollow and deceptive philosophy, which depends on human tradition and the basic principles of this world rather than on Christ. For in Christ all the fullness of the Deity lives in bodily form, and you have been given fullness in Christ, who is the Head over every power and authority." Colossians 2:8-9

In my logo, the empty cross stands above the yin/yang acupuncture symbol and the Greek mythological symbol representing medicine. To say that God does not influence all religions, as He is in all things, is to deny God's sovereignty. Unfortunately human religions distort God's truth, and this can be more dangerous than an outright lie, as demonstrated by the serpent in Eden (Genesis 3). However, the resurrected Jesus is the Head over every power and authority. Whether it is pagan mythology or religions or science, Jesus is in charge. Jesus brings the order out of chaos and rules over all things in Heaven and under Heaven. Looking at the world and creation through these eyes, I am not afraid of any knowledge and do not view human paradigms as threatening God's truth.

The paradigms are not contradictory – they are just different languages. Neurophysiology and pathology is the scientific explanation; the TCM approach is the artistic interpretation. Western medicine gives the dry facts (strange that it is called "the art of medicine") whereas TCM paints a picture with poetry. Looking through the eyes of the Cross gives the eternal perspective.

John 8:31-32:

"If you hold to my teaching, you are really my disciples. Then you will know the truth, and the truth will set you free." J

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by **Neil Pearson**

Neil made the tree-change from Brisbane to the Kilcoy area in 2010. Moving around the state as a primary principal, Neil was involved in local church leadership. Through relationships with Aboriginal people in Townsville, Neil and wife, Marg, became chaplains in correctional centres, while maintaining jobs within secondary and special education. Retirement from teaching in early 2013 has allowed more time and energy for jail chaplaincy.

Walking together on the journey to healing

Pastoral care and Prison Detainees

Healing is not merely physical. We are not merely physical beings. That aspect of us is just the tip of the iceberg, and sometimes the physical is symptomatic of other pain. As a prison chaplain over the last 13 years, my involvement with incarcerated human beings in four Queensland correctional institutions (both moderate and maximum security) has become a major focus in my life. These inmates are people: mothers, sons, fathers, grandsons, brothers, sisters and even grandparents. My journey with them is very simple: Taking an interest in their family (as well as remembering the details) shows someone cares. "How's your woman liking her new flat?" "How's your little girl who's just started school?" "Is your son still going to youth group?" There are not too many inmates who want to know the basics of Christian theology, but some may discuss football or cricket, and few ignore a smile, a "G'day mate" or a kind word. Kindness shown has the effect of calming a person (albeit temporarily in most cases) in the stressful jail environment.

Sometimes I sit, relax and read a magazine in a fifty cell unit, so inmates can come and talk, if and when they want to. A long-term inmate explained to others that "he shows respect and doesn't butt into our card games." I am conscious that I am a visitor in their space. Fellas inside sometimes offer me a coffee and I usually accept the invitation. Many inmates, when some relationship is established, are able to share their stories; I have become convinced that there is no such thing as the Brady Bunch. Learning to trust is slow, brick on brick. It takes time to get to know a person. Their journeys often involve horrific memories of their own abuse. Feelings of fear, guilt, shame, rejection and hate are buried. Even love and joy can lie fallow, the inmate not daring to feel or hope. Incarceration further alienates and brutalises, through the peeling away of rights, simple choices, basic freedoms and acts of independence. The way to healing and health is involved with tiny reversals of some of this dehumanisation. The Bible speaks of a ministry of reconciliation: "being" is required more than "doing", as basic as being interested in another's journey, coming alongside, listening with a non-judgmental ear.

Many families of inmates can attest to the premise that hurts which are not recognised and listened to, will lie within and be passed on to those around. Our own vulnerability and acceptance as chaplains, provides a climate which defuses our brother's self-loathing, addresses his wounds and opens the way for healing. Forgiveness and acceptance can transform the wounded and the flow-on communication to others.

I regularly visit the medical section in jail. One day I met an elderly inmate who was very ill and wanted Jesus to heal him. He had requested prayer from a number of chaplains including me. This request was in response to the biblical text, where those who are sick and desperate to be healed are instructed to "call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven." *James, chapter 5, verses 14 and 15.* I think of healing, not as a matter of "either … or," but "both…and." We did pray together and the next day the patient was much improved. When I am presented with the option of praying for healing for someone, broken in body, mind or spirit, I pray for the person's recovery, as well as thanking God for the skill of the medical personnel. The Christian experience down through the centuries has not always been that God spares people from severe sickness, pain and anguish but that, in these trials, He provides forgiveness, peace and acceptance that calms and strengthens. I enjoy helping provide spiritual comfort, working alongside the medical staff to help support the patient.

We are not one-dimensional beings; surgery and pills don't fix all. In Townsville Correctional Centre in the early 2000s, Aboriginal inmates often greeted us with, "Pray for me!" My wife and I would readily agree, "Yes, we'll remember to do that." They were adamant that this needed to be done, "Now, brother! Here!" Suicide of a nephew, court next week, gall stones and demons in the cell could all be on the one prayer agenda. Visiting the family later, often in the local metho camp and bringing them to the jail to visit, further cemented relationships. Regular calls to the Townsville General ICU followed, resulting from this acceptance by Aboriginal people in town and their extended family further west. Confronting the pain and being with people in their woundedness is slow and personal; this is what Jesus did. It opens us all up to healing, inside and with one another.

Redefining the Art of

How does the art of medicine – as old as practice itself – work in tandem with science?

Just what is the art of medicine? Is it a kind of sixth sense, or clinical wisdom, not accounted for by the hard data of evidence-based medicine? Is it the judgment required when population data must some-how be applied to an individual patient? Is it everything in the treating relationship except the science? Or, more positively, is it the empathy, the compassion, the receptiveness to, and support of, suffering, about which science remains silent?

Here is a suggestion: the art of medicine comprises a non-judgemental and supportive approach in which the doctor provides accessible, evidence-based advice for patients to consider in the light of their values and preferences.

This makes the evidence-based component of care part of the art. It also reflects the fact that, as Kathryn Montgomery and others have pointed out, medicine is not a science, but a practice that draws on science.

"Medicine is not a science, but a practice that draws on science."

It also rejects the frequently encountered notion that medical practice consists of a balance between the art and the science. The idea of such a balance misconceives the relationship between scientific evidence and patient values. It is conceptually flawed and risky in practice, because it looks to ideas such as medical intuition, experience and wisdom, which are – by definition – inexplicable and can masquerade as legitimate authority while masking incompetence.

In a recent clinical account, a GP referred an elderly man with right-sided abdominal discomfort for colonoscopy, but the surgeon decided that was not required. When a later colonoscopy, following the onset of additional symptoms, revealed a cancer of the ascending colon, the GP concluded that his initial referral resulted from his sixth sense about the patient, in the absence of evidence. Perhaps a better explanation is that the GP acted competently, on the basis of sufficient evidence in the circumstances of an elderly patient, while the surgeon made a significant clinical error.

Unless intuition, experience and wisdom are understood correctly, they will continue as unquestioned sources of traditional authority, substituting for adequate evidence. Much has been written about the wisdom that results from experience. However, clinical experience abstracts from lines of cases, searching for patterns, tendencies, associations and relationships – precisely what evidence-based medicine attempts to do.

So what's the difference? It lies in the fact that clinical experience is likely to be more biased, non-systematic, unreliable, and self-referenced than the results of evidence-based medicine. And if we regard clinical experience as a different kind of knowledge we are also less motivated to undertake evidence-based inquiries to obtain better quality data.

Another way in which the art and the science of medicine are perceived as requiring balancing is in situations where patient preferences are thought to become more important when the available evidence is weak. However, patient preferences are crucial, no matter what the quality of evidence, although they may appear less evident when evidence is good.

The law has strongly entrenched patients' rights to refuse medical treatment. Consequently there are cases where, despite very strong evidence of potential benefit with treatment, patients will refuse such treatment. Patients will have preformed ideas, albeit vague at times, about the meaning of their symptoms, their diagnoses, or their treatment options, and these may be modified as new information is provided. In some cases, the doctor may then need to respond further to these modified ideas, particularly where there is a misunderstanding or mistaken inferences. But through this process of clarifications, patient preferences are expressed in response to the evidence guidelines and options made available. This process does not consist of any balancing of these elements.

A crucial aspect of the art of medicine is to provide an understanding, non-judgemental and supportive environment. But this is entirely consistent with ensuring that patients are well aware of the evidence that is relevant to their particular problem.

Although medicine has been somewhat commercialised over the past decade, it remains a profession, and should not be submerged under the influence of consumerism. Diagnostic and treatment options are not analogous to consumer items, but should be carefully prioritised by the doctor-patient partnership, in the context of the values that emerge in the dialogue. This may require, indeed demand, an element of rational persuasion that might be frowned on in traditional consumer settings. Rational persuasion appeals to the idea that the patient, unless shown to be otherwise, is a competent agent who will reason with the information provided.

Medicine

Of course, great care must be taken to avoid crossing the line that separates respectful, rational dialogue from influence that is in any way coercive. And the principles supported here allow for different ways of communicating with patients, depending on their levels of education and conceptual and practical familiarity with facts and evidence.

A final implication of the art of medicine concerns the concept and social phenomenon of medicalisation.

The ABC's Caroline Jones recently wrote of her father's coronary bypass surgery at the age of 94, and of her misgivings that this had even been contemplated. You will, no doubt, be familiar with similar stories. Somewhat paradoxically perhaps, the art of medicine involves the ability to work with patients to establish the point beyond which standard medical modalities can no longer usefully serve them. This is clearly not a criticism of modes of support such as palliative care, nor would it exonerate the surgeon's failure to diagnose colon cancer. But it is an appeal for a deeper appreciation of the complex relationships between different concepts of health and disease, and how these are managed by individuals, families and wider groups.

An important part of the art involves determining, with the patient, how appropriate it will be to implement the management suggested by the evidence, thus preventing harm to patients from unwanted investigation and treatment.

The most challenging aspect of the art of medicine arises just where ordinary expertise ends, and where the clinical task may be just sitting with, and being with, the patient. Even the term "empathy" has taken on a somewhat clinical tone, and fails to indicate what is ideally required but often not achieved.

In the current socioeconomic environment, including the demise of the house-call and the lack of time to attend to non-technical matters, the retrieval of this fully human aspect of the art of medicine is our greatest challenge. LJ

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Mental Wellness

– a good place to practice Integrative

As a small part of the organism that is general practice in Australia, and a bit part player in the research community examining primary care mental health assessment, the thoughts laid out in this article are necessarily only one voice that is part of a larger choir.

I am a General Practitioner who served my local community for about 10 years, and found a pattern amongst the usual 'tears and smears': a significant group of people describing traumatic life stories and varying degrees of feeling heard and cared for within the mental health system. Many of those afflicted with despair, loneliness and hopelessness were survivors of childhood trauma and neglect. A post graduate course in grief and loss and ongoing professional development and supervision in the areas of trauma and attachment, as well as personal growth understanding the God who cares for each one and seeks to provide comfort, has influenced my thinking about whole person care

As a GP I became convinced that our role in primary care necessitated that we did not see people through only one or even a couple of paradigms of care (eg. medical physical, or psychiatric diagnostic frameworks, or psychological paradigms of illness and their treatment). Instead I became passionate that general practice hone and honour its long tradition of attending to the whole person within their social and historical life context. I also became aware of how many other paradigms were researching in their own fields with a growing understanding of how to look after the mentally unwell and improve their life experience and care for their whole selves.

"Integrate is an action word with a core goal of producing unity, something that I believe is very close to God's heart."

This led to further research in the area of primary care mental health assessment, looking 'beyond symptoms'[1], and also the establishment in 2009 of a pilot project in delivering mental health care to adult survivors of childhood trauma and neglect – Integrate Place.

Integrate Place is situated in Manly, Brisbane, in a welcoming house. It is piloting transdisciplinary therapeutic care of those in mental distress. The culture of Integrate Place aims to actively work against reductionist expertise (what some would call 'fragmenting reality'[2]) and instead highly value a generalist approach to knowledge and therapeutic process. Through multidisciplinary group case based supervision (started independently, but now under the banner of the Mental Health Professionals Network) we practice valuing each other's paradigms of care – learning from each other and applying what is learnt in the service of each person we care for. This intentional transdisciplinarity[3] is one way to stay generalist and provide holistic care in a world that seeks to define treatment to ever reducing areas of technological expertise.

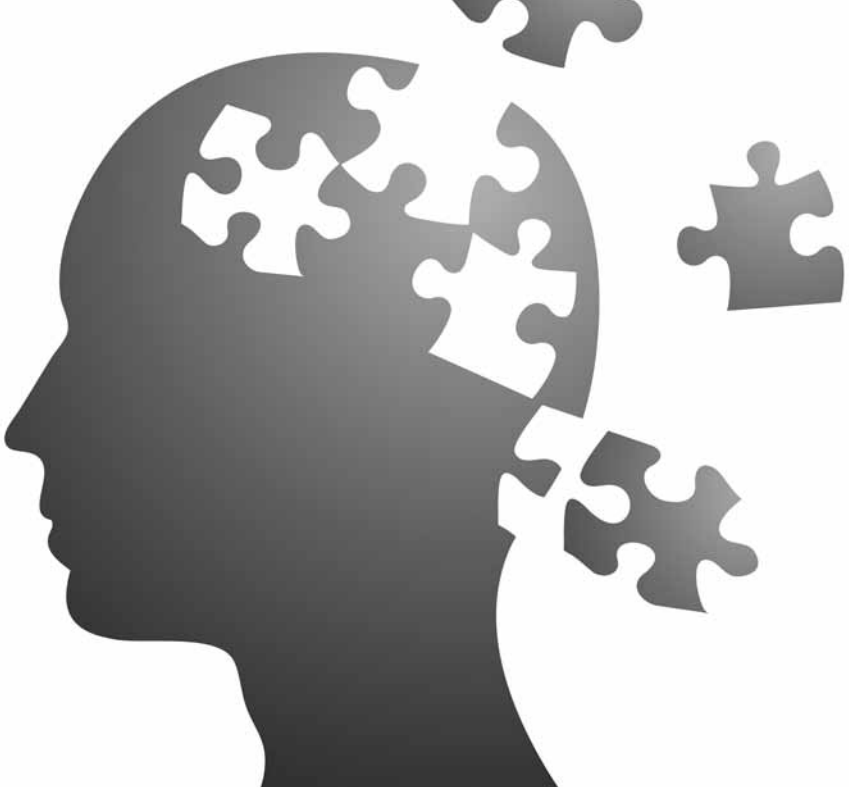
Freeman[4] reminds us of the centrality of the person: "An approach to health and medicine that is not reductionist is an implicit part of the comprehensive care provided by GPs. We are not doctors for particular diseases, or particular organs, or particular stages in the life cycle – we are doctors for people." Perhaps that should be the measure of our science and our therapeutic process?

Our clinic currently hosts a few counsellors, art therapists, a drama therapist, a mental health nurse, a couple of GP therapists, a psychologist, a music therapist, a social worker, and a youth support worker from a local school in our monthly group supervision times. The pilot day to day clinic is composed of a GP therapist, a mental health nurse, a social worker who teaches trauma sensitive yoga therapy, an art therapy student, a couple of visiting art therapists and a visiting local pastor. We would wish for a full-time chaplain, a family therapist as well as psychiatrists and other general practitioners who have a willingness to learn from each other and our patients, and take on this area of health!

Integrate Place is named carefully – seeking to be a place that integrates the spiritual and the medical, the body and the mind, the person and their community, the latest research with practice, the creative and intuitive with the cognitive and theoretical, values into practice, as well as practitioners from different paradigms, and their own hearts and spirits. Integrate is an action word with a core goal of producing unity, something that I believe is very close to God's heart. It is also linked to concepts of wholeness and integrity, and it describes a key therapeutic process in recovery from those who have experienced the internal disunity that results from neglect or trauma or grief.

It is within this environment that we have been learning about the neurobiology of trauma, attachment, affect regulation skills, dissociative defences, the use of music and art to help soothe and develop a unified sense of self, as well as be challenged in our own hearts and minds. Therapists describe personal and professional relief at being

clinical care of the whole person?



by **Johanna Lynch**

able to work within the literature of their own paradigm and find others who understand and can relate new findings to current practice in their own different field. Many therapists also describe feeling disrespected or 'on the edge' of their professions as they seek to prioritise integrating research and other paradigms's insights into their care of each person. In fact many have pursued more than one field of training in order to try to integrate knowledge from different paradigms and attempt to restore their professional credibility.

It is within this context that we have encountered the question 'What is mental wellness?' and how do we measure and define it and use it as a treatment goal? Great minds in many fields of investigation have wrestled with this. Some have pointed out the lack of a model of mental wellness in those professions that treat mental illness.[5]

We are aware of what a healthy heart looks like, and even know ways of living that protect and care for the healthy heart most of us were born with. We know ways of measuring and treating and restoring cardiac health, and also how to accept and care for a physical heart that will never be healthy again.

And yet, in medicine and psychology there remains a lack of definition of what we consider a healthy mental state. Is it found in existential peace? or selflessness? Is it a place of safe connection to others? Is it the ability to titrate our own emotions? Is it the freedom to speak up on our own behalf, and maintain safe boundaries in relationships? Is it openness to creativity and generosity? Is it defined by normal sleep and eating patterns? Or lack of craving and addictions or obsessions? Is it a life not dominated by fear? A mind able to synthesise and hold dichotomies or dialectics? Is it a mind able 'mentalise' – to hold others in mind? Or a heart full of compassion and gentleness? Is it a mind that never feels pain or sorrow ? Or a person who feels hope in the midst of these human experiences? Is it freedom from despair? Or comfort in the midst of despair?

Different paradigms, would define mental wellness differently. As Sadler[6] mentions: ' the way a question is posed constrains the possible answers'. In our quest to offer best quality care, surely more questions, from many viewpoints, is the way to the most scientific and humane whole person care? Is this not the challenge of caring for complex human beings?

An example of a body of research that embraces transdisciplinarity, is the recovery literature that seeks to understand what those who have suffered mental illness and recovered found to make the most difference. These include hope, healing, empowerment and connection[7]; movement from despair to hope, passive to active sense of self, others in control to being in personal control, and disconnectedness to connectedness[8]; finding meaning in life, redefining identity, and taking responsibility for recovery[9]. Addressing these needs necessitates seeking to provide care in many ways that might be considered humanities and soul care[10], or even pastoral – not 'mainstream', 'professional' or even 'medical' – but does offer humane and effective whole person care. LJ

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Nutritional Medicine:

A few years after attaining my FRACGP and settling into general practice I became aware of increasing dissatisfaction with GP work. I found myself diagnosing illnesses and then writing scripts for these illnesses but the medications I prescribed were very often just dampening the symptoms, not really addressing the underlying condition. Also, lots of 'conditions' were medicalised or seemingly made to fit a certain 'shape' so that a drug could supposedly fix this disorder – except in a lot of cases it didn't.

I had always been a person with a large degree of curiosity – about the world, people, science, medicine etc. As a fifth year medical student I had sat in on a homeopath friend of my family, watching him take a history, make a diagnosis and then treat using very different modalities from the ones I was currently studying in medical school. I maintained a healthy scepticism about some of this, but at the same time was open to why it was that this homeopathic practitioner was quite successful.

So, several years into general practice grew an increasing dissatisfaction that I was merely a pharmaceutical medication prescriber. The defining incident for me was a patient who came to see me with severe eczema. I prescribed cortisone creams and at one time a course of oral steroids, knowing fully that this wasn't addressing any underlying disorder but only dampening her symptoms. I also referred her to see a dermatologist who did exactly as I had done, but then charged the patient four times as much! One day, this patient returned to see me with much improved looking skin. She requested a script for her corticosteroid cream which she wanted to have on hand for a flare up of her eczema. She said she wasn't using the cream anywhere near as much as she had previously. I, in all honesty, commented that this was a good thing and asked her what had changed in the past six months. She, somewhat sheepishly, said that she had seen a naturopath. I asked her what the naturopath had recommended and she replied that the naturopath had advised her to trial 3 – 4 months without dairy or gluten products in her diet, and also advised her to take evening primrose oil and vitamin E. She said that after three months she noticed an improvement in her skin and that she felt much better. Internally I was thinking to myself "Why would you take someone off dairy and wheat?" and "How come I don't know what evening primrose oil and vitamin E do when I have a six year medical degree?"

This case was the tipping point for me in causing me to start searching for answers. I found out about ACNEM – the Australasian College of Nutritional and Environmental Medicine – and started attending their courses in Melbourne in 1997. What I learned blew my mind – it was a whole paradigm shift in thinking about disease and treatment, diet, inflammation, food intolerances, nutritional deficiencies and insufficiencies, environmental toxins, heavy metals, vitamins, minerals and probiotics.

I was quite tentative at first, and simply began looking for zinc deficiency (white spots in nails) and magnesium insufficiency (twitchy eyelids, tense muscles, inability to relax etc) and asking patients about their diets and advising regarding some simple dietary supplements. It took about a year for the paradigm shift to really change how I practiced medicine. Once this occurred I realised that there was no looking back. I couldn't go back to simply prescribing medication without looking more deeply into the cause of conditions and ways to treat them without using drugs, knowing that medications have a place, but are not the be-all and end-all.

Now I would describe myself as a medical practitioner with a large nutritional bent. I sat for my Fellowship with ACNEM, in order to satisfy myself that I had reached a certain stage where my nutritional knowledge was safe and practical, but the journey of learning never stops! Indeed, venturing into this area opens up a whole new world of learning which is enormous, and at times overwhelming. One has to live with the knowledge that one has a certain amount of expertise but there are oceans of information out there and the horizon is limitless. Amongst doctors who practise nutritional medicine, we tend to end up with little areas of expertise. For example, my colleague in the practice where I work, largely treats children with Autistic Spectrum Disorder and ADHD, whereas I don't touch this area at all and have developed a practice mostly dealing with women's health, menopause, thyroid and adrenal dysfunction, chronic fatigue syndrome and fibromyalgia. Oh, with ordinary general practice stuff thrown in the mix as well. What is interesting is that without any advertising, and only through word-of-mouth, my practice has grown to where there is now quite a wait for new patient appointments. The first appointment with a nutritional doctor is often very long because a lot of the stuff we are dealing with is complex and patients' histories are often very involved and confusing. One of the major tasks I face is to take down a very complex story and make sense of it and then communicate to the patient the steps involved in gradually dealing with all of the issues involved. This takes time, so patients have to be prepared to pay for consultations,

My Story

by ***Dr Catherine Bartholomew***
Graduated University of Queensland 1987, internship at the Mater, Brisbane. I worked in Biloela for a year and then Launceston hospital for a year before entering general practice. I completed my FRACGP in 1995 and my FACNEM (Fellow of the Australasian College of Nutritional and Environmental Medicine) in 2005. For the past ten years I have been working in Clayfield, Brisbane with a colleague who also practices nutritional medicine.

for as we all know, long consultations are not rewarded financially by Medicare. So overtime, I have acquired a population of patients who are very involved in their own care, are usually very motivated about their health and are proactive in both acquiring good health and maintaining it.

It's only on reflection that I look back and see where the journey has lead me. When I graduated from Medical School I never imagined myself in middle age doing what I am doing! One of the rewarding aspects of my work is teaching patients to look after themselves. Preventive medicine is very rewarding in that over time patients report to me that they have less colds and flu, better energy and less aches and pains. On the other hand, preventive medicine is frustrating because I never know what I may have prevented! For example, patients with very low vitamin D levels are known to be at much higher risk of developing breast cancer and osteoporosis. Recently, I have picked up several girls in their late teens and early twenties with vitamin D deficiency. With advice and treatment I hope that I may prevent one of them developing a cancer or an osteoporotic fracture in the future, but of course, this I will never know. I sometimes envy colleagues who do procedures or surgery because they see results before their eyes. Preventive medicine is medicine with a huge dollop of faith!

Recently I was asked to speak to a group of elderly Christians at a north side Brisbane church. This church organises a regular morning of talks by various people – a policeman spoke about safety issues for the elderly, a local politician spoke about community issues of concern and I was asked to speak on nutrition. I searched my brain for something relevant and practical and gave a talk on several of my 'favourite things' – green tea, curcumin, probiotics, broccoli, coconut oil and dark chocolate. Researching the evidence for these nutrients made me realise that I am passionate about good health and that nutritional medicine is utterly fascinating. I gave a copy of the talk to the organisers and heard back that almost everyone in the audience fronted up to reception for a copy. So, this was very satisfying. I like to think that making small but permanent changes in diet may make a significant difference in health, vitality and risk reduction.

In my dreams I have often thought that I would like a benefactor to fund me to study for three months so that I can research more deeply. One frustration is having to maintain a practice and not have long-service leave! Like everyone else I struggle with tiredness both physically and emotionally.

"I sometimes envy colleagues who do procedures or surgery because they see results before their eyes. Preventive medicine is medicine with a huge dollop of faith!"

Personal self-care is so important! I have discovered that I need to look after my physical, mental and spiritual health. Patients who see a nutritional doctor probably expect them to look healthy! Spending too much time bent over computers and desks resulted in some significant neck pain and vertigo two years ago, so I have had to factor in exercise on a regular basis and now attend Pilates classes twice a week and try to swim once a week – basic stuff which we doctors all know but don't always do until something goes wrong.

My spiritual journey has been one of moving towards more meditative and reflective spiritual practice. Learning to listen to God, to take time to wait for Him, to hear that still small voice is a huge challenge in a busy working week, but is one of the greatest blessings. Listening is vital not only spiritually, but in the practice of medicine. Paying attention, pausing, waiting, listening to what is spoken and unspoken – a skilled art that requires practise and patience. An ongoing journey of learning. LJ

BOOK REVIEW

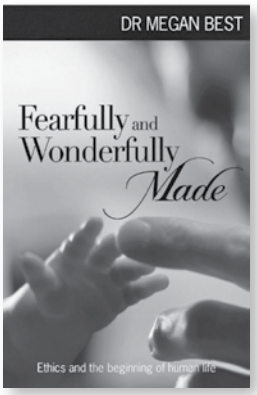
Fearfully and Wonderfully Made

Ethics and the Beginning of Human Life

Megan Best

Paperback. 532 pages. Price: $34.99
Available from: www.koorong.com

A woman has just fallen pregnant and needs a battery of tests as part of their antenatal care. A couple is seeking advice on 'what next' because they are having difficulty falling pregnant. A young woman is pregnant and doesn't want to be.



These are regular scenarios in my practice as a GP, and they regularly cause me heart ache. As Christian doctors, we know they all have gigantic ethical impact. We can feel a responsibility to say something to save a life, or stop a death, and at the same time sensitively and carefully inform our patients of some of their legal options. As you know, legal and Christian are not the same thing today. The direction of flow in obstetrics today that patients find themselves in is convenience and self-centredness. Our patients are often bewildered and confused, and don't realise they have choices.

I am very glad I have read Megan's book and can't recommend it to you highly enough. It's a long read (508 pages) but every page is worth the effort. She is meticulous in her research. I cannot begin to think how long it must have taken for her to put this book together and can only suppose she has had a lot of help from colleagues, both medical colleagues and theological ones. There was so much that I found helpful and interesting. Of particular note, her survey of the history down through the ages, of society's view on abortion, helps us see how the unravelling of a Christian view of procreation has occurred in the West. There are sections throughout "for doctors" which are of a more technical nature. There are all sorts of practical applications which will help us as we advise couples suffering from infertility. She is scientific and backs up her findings with evidence. She is wonderfully compassionate and pastoral. It is a book for Christian couples, pastors, and I believe most of all, Christian doctors.

Megan takes the reader in a logical sequence, from the biology of pregnancy, through to the complex scientific minefield of human embryo research. However, I feel the real strength of this book is its putting together in one volume, both the medical facts we need, and an evangelical ethical framework we also most definitely need. We need both medical knowledge and a biblical ethic if we are to have any hope at helping our patients and their families in this very complex and changing field. I'll let you read the book and find this out for yourself, but on the medical side, for example, she examines every type of contraception on the market, and soon to be on the market! I have already used the book as I counsel women on which contraception they might like to use. On the ethical side, in the first few chapters Megan teaches a framework for thinking ethically which is holistic and biblical-theological.

What do we mean by holistic? Take having a child as an example. Having a child is not in itself sinful. It is a godly, sacrificial, other-person centred action. God creates life and gives himself for his creation in redemption. And he tells us to "fill the earth". But is it always, *entirely* right? What if the main motive in having a child is to make my life fulfilling and worth it? What if having a child is my life's dream, my all in all? Then it becomes an idol. The child replaces God, and we risk making our child's life misery because they will never be able to meet all the expectation we have just placed on them. Megan recognises and teaches that motivations and Christian character are just as important as the act. Motivation, intentions, consequences, as well as actions are important.

Ethics is a fascinating subject. It's the sharp edge of life where we think and act and interact with the world, using our knowledge of God and life, to make decisions. We need the Bible and we need each other (pastors, church, commentaries, testimonies, theologians and historians). We need to be students of the Bible, we need to develop in Christian character (put on virtues, take off vices). We need development of a Christian world view to think things through in a gospel context, and we need prayer that God's Spirit will give us wisdom and grace. As doctors we also need accurate, evidence based medical knowledge. Megan Best's book, "Fearfully and Wonderfully Made" is a gift from God. She has achieved so much in this one book. We will do well to read it.

Dr Andrew Moore

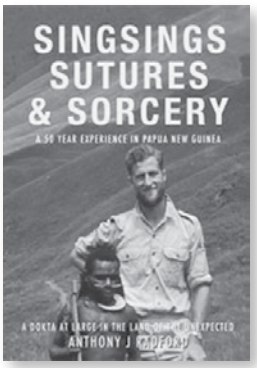
BOOK REVIEW

Singsings, Sutures & Sorcery

Anthony Radford, 2012

Preston:Mosaic Press. 396 pages with illustrations, maps and photographs
ISBN 9781743240601
Available from leading bookstores (RRP $45) or online with discount from Rainbow Books,
(Preston, Victoria from the author at anthony@radford.id.au

It's been a long time coming, but the wait has been worth it. Here we have a vivid and well laid out account of the life and work in New Guinea of a distinguished medical educator and his family. Like many other careers in that fabled land, his began with a student trip in his summer holidays. But unlike many others, it continued on and off for fifty years.



True to form in those days, Anthony's first posting was changed at the last minute, and instead of being sent to a remote outstation he became a temporary lecturer in medicine at the fledgling Papuan Medical College where, with the exception of the principal, every foreign staff member was a committed Christian. The Radfords were to become active members of Anglican congregations wherever his work took them.

Soon he realised that doctors and other health personnel needed specific preparation for rural practice, and for many years rural training was an important part of the medical course. We can thank him for that, and for his recent efforts to revive it. The Radfords lived on outstations for years, at Kainantu, the gateway to the Eastern Highlands, and at Saiho, in northern Papua, close to Anglican mission headquarters. Anthony gives a faithful picture of the trials faced by a rural doctor, written with a whimsy that seems to soften his memories of those challenging years. Because the whole family became involved with the local community wherever they lived, and where they remain much loved to this day, this book gives a delightfully rounded picture of outstation life that should interest medical and non-medical readers alike. Descriptions of diseases are clear enough for anyone. There is enough history for those who need it, and many good photos.

His PNG experience led to an appointment at the Liverpool School of Tropical Medicine in the UK from 1972 to 1975, when he made a seminal contribution to the teaching of community-based medical practice. Since that time he has been a much-sought consultant on various aspects of public health in about fifty countries, happily including PNG, and has run a famous short course in Adelaide for health professionals intending to work abroad. Little of this is more than hinted at, and we await his next book(s) to learn more of a remarkably productive career.

Ken Clezy

CLASSIFIEDS

LUKE's journal

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What is the CMDFA?

Aims

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

Origins

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

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

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

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

Why join the CMDFA?

• Fellowship • Evangelism • Discussion • Mission • Student Work

CMDFA seeks to:

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

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

By Joining the Fellowship you can:

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